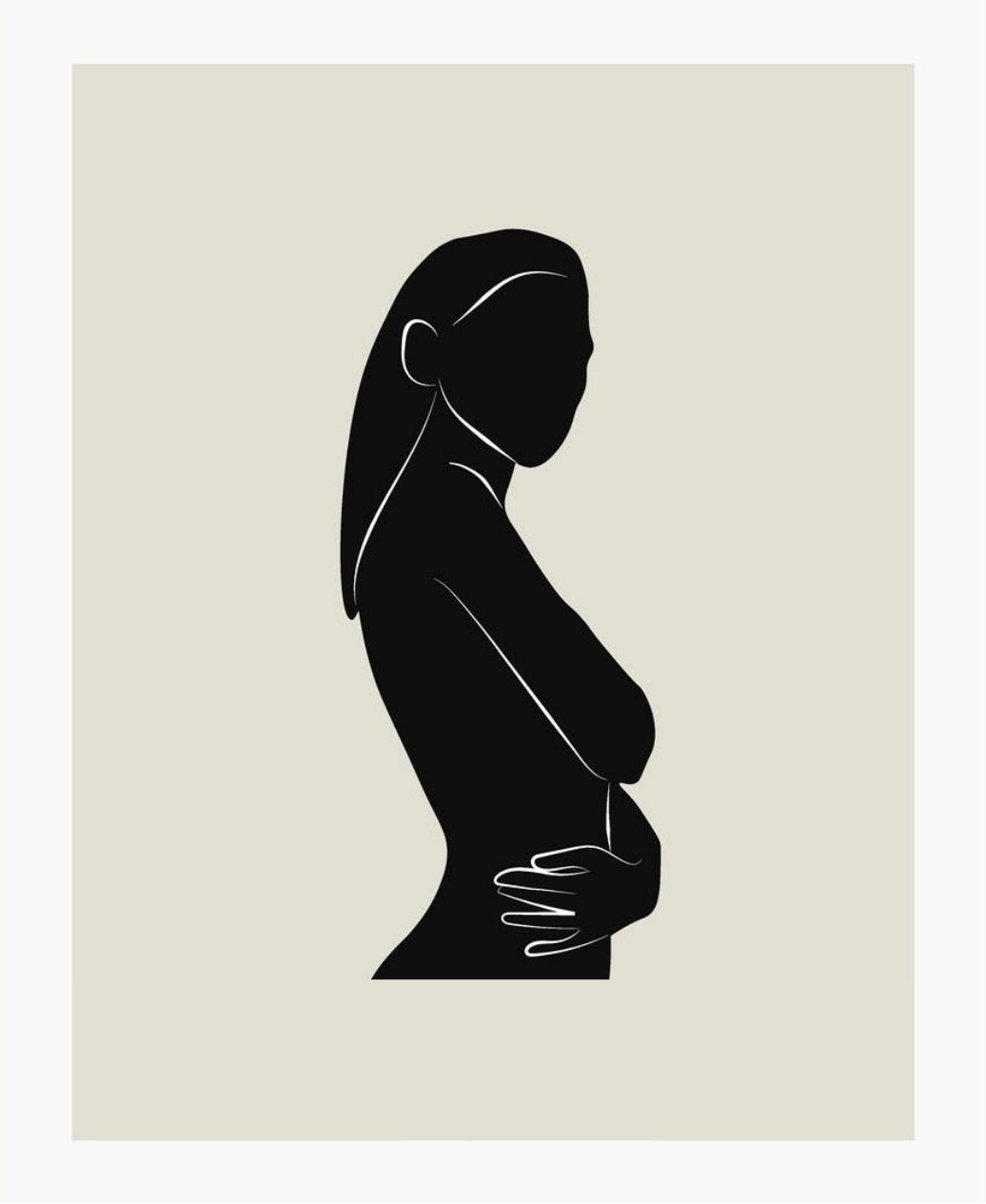
"He said to me: If you are pregnant, I don't know the pregnancy, I only know you."



The role of male partners in young women's pathways towards an unsafe abortion in Kilifi County, Kenya

Master's thesis International Development Studies - Iris van Velsen – 20-02-2024

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This master's thesis is dedicated to the brave young women in Kilifi County that shared their stories.

May your stories inspire the changes that are necessary to provide safe and legal abortions for all in need of care.

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Executive Summary

Background

Up until today, unsafe abortion remains a major public health issue in Kenya claiming the health and lives of thousands of women each year. Various studies suggest that male partners play a significant role in women's pathways towards an unsafe abortion. Research points out that in Kenya, men act as primary decision-makers within sexual relationships and decide about sexual and reproductive matters like sexual initiation, contraception, pregnancy termination and (post-)abortion care. Yet, most reproductive health programs that aim to reduce unsafe abortions in Kenya focus almost exclusively on women. Therefore, this master's thesis will look into young women's experiences with unsafe abortion in Kilifi County and the ways in which they perceive and experience the involvement of their male partner in their pathways towards an unsafe abortion.

Methods

Due to the COVID-19 pandemic and the subsequent travel and safety restrictions, this master's thesis took place remotely by participating in an established research project set up by Rutgers and the African Population and Health Research Centre in Kilifi County, Kenya. The data that was used for this master's thesis was collected during a 6-month ethnographic research project that looked into the lived experiences, social determinants and pathways towards an unsafe abortion of young women in Kilifi County, Kenya. In the field, four Kenyan research assistants located in Kilifi town, Gotani, Matsangoni and Mariakani made use of participant observation within healthcare facilities and communities, in-depth interviews with 54 young women, 18 male partners and 33 relatives of young women who had a previous abortion experience (e.g., fathers, mothers, sisters and others), and 12 focus group discussions with community members to collect data. The data were analyzed remotely in Kenya and the Netherlands by using a thematic analysis approach and discussed the results by making use of relevant theories and literature.

Findings

The data show that male partners play a significant role in young women's pathways towards an unsafe abortion in Kilifi County, Kenya. Whether male partners are involved directly or indirectly, supportively or unsupportively, consensually or non-consensually, they greatly influence young women's experiences with unintended pregnancies, abortion decision-making and (post-)abortion care.

Before they fell pregnant, young women in Kilifi County shared that their male partner played an important role within three sexual and reproductive health domains that affected their experiences with unintended pregnancies that ended in an unsafe abortion, namely: contraceptive non-use, sexual violence, and transactional sex. Firstly, in most of their sexual relationships, young women indicated that contraceptive use had to be approved by their male partner and that their male partner often had rigid preferences for the contraception methods young women could use and when. This left young women vulnerable to unintended pregnancies as they are dependent upon their male partner's willingness to use contraceptives. To navigate this power imbalance, young women confided that they occasionally withheld sex to pressure their male partner into contraceptive use or used (emergency) contraceptives secretly despite their male partner's disapproval. Yet, this was often inconsistent and discontinued. Secondly, multiple young women shared that they fell pregnant unintendedly after experiencing sexual violence. Young women shared that their male partners could be verbally abusive, made threats or made use of manipulation and blackmail to obtain

(unprotected) sex which caused them to fall pregnant unintendedly. Additionally, 5 young women that participated in the research project fell pregnant unintendedly after experiencing defilement and rape by a male perpetrator. Lastly, young women that engaged in commercial or transactional sexual relationships shared that they experienced unintended pregnancies as it could be difficult to negotiate safe sex with clients/transactional partners due to disparities in wealth, age and social status. Especially, when the need for (financial) resources was great, young women struggled to refuse their client/transactional partner unprotected sex.

Once young women in Kilifi County were pregnant, they shared that their male partners could play an important role in the decision to terminate an unintended pregnancy. In the early stages of the pregnancy, the reaction of male partners was extremely influential on young women's decision to pursue an abortion. While some male partners reacted supportively, many male partners denied paternity and ceased all communication with their female partner. This caused many young women to consider an abortion as they often did not have the (financial) resources to raise the child as a single parent. When male partners were willing to engage in the abortion decision-making process, the abortion desires between both partners could be concordant or discordant. In cases of concordant abortion desires, the decision-making process proved to be quite straightforward and male partners would often support their female partner in seeking abortion care. In cases where abortion desires were discordant, both partners could employ various strategies to exert power over the abortion decision. In several cases, partners were able to convince each other to pursue their abortion desires by outlining their arguments in favor of an abortion. In other cases, male partners made use of threats, emotional blackmail or deceit to pressure their female partner into an abortion. Additionally, in four cases, male partners made use of extensive force to ensure an abortion. In a few cases, young women navigated discordant abortion desires by pursuing an abortion secretly. In these cases, young women left their male partner out of the decision-making process and often only told their male partner about the abortion after it already had taken place.

When young women underwent (post-)abortion treatment, they shared that their male partners could influence their experiences in various ways. When male partners were involved in the care-seeking process, they often proved to be a great resource of information. Male partners could have a larger social network that young women and could approach male friends, male family members and male healthcare providers more easily than young women to gather information. Additionally, male partners could offer much needed financial support to finance the abortion method that young women preferred. In cases where male partners were absent, young women were often left with little choice to select an abortion method if other actors in their social network were not able or willing to offer (financial) support. In most cases, male partners were absent and young women underwent the abortion on their own or relied on the support of family members and close friends. A lack of support from their male partner, could leave young women feeling very lonely, sad and disappointed. In several cases, male partners were present while young women underwent the abortion. These male partners could assist young women with managing the bleeding and pain while they underwent an abortion at home or could offer emotional support during a traditional, medical or surgical abortion by an abortion provider. For many young women, their unsafe abortion resulted in moderate to severe complications that led them to be admitted to the hospital. Male partners were often not involved in seeking (post-)abortion care, but in a few cases, they brought their female partner to the hospital when she experienced complications and paid for the treatment. Without financial support from male partners of other actors, young women often had to delay seeking post-abortion care or had to travel to other healthcare facilities in the hope that treatment would be cheaper there.

Conclusion

The findings of this master's thesis affirm that male partners play a significant role in young women's pathways towards an unsafe abortion. They affect young women's experiences with unintended pregnancies, abortion decision-making and (post-)abortion care in various ways. Male partner's influence over young women's abortion experiences can be linked to gendered power imbalances within Kenyan society that affect women sexual and reproductive health. While young women try to navigate these power imbalances, gender transformative interventions seeking to improve women's sexual and reproductive health will be crucial to improve women's experiences with unsafe abortions. In light of these findings, it is highly recommended to include male partners in new research and projects that aim to address unsafe abortions in Kenya.

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List of abbreviations

APHRC	African Population and Health Research Center
CHV	Community Health Volunteer
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
IDI	In-depth Interview
KII	Key Informant Interview
MVA	Manual Vacuum Aspiration
NGO	Non-Governmental Organization
SDC	Sociology of Development and Change
SGBV	Sexual and Gender-Based Violence
SRHR	Sexual and Reproductive Health and Rights
PAC	Post-abortion Care
WUR	Wageningen University and Research

Introduction

Chapter 1: Unsafe abortions in a social context

Unsafe abortion in Kenya

Up until today, unsafe abortion remains a major public health issue in Kenya. An induced abortion is characterized as unsafe when ''the termination of an unwanted pregnancy is performed by a person lacking the necessary skills, or in an environment lacking minimal medical standards, or both'' (World Health Organization, 25-09-2020). In Kenya, abortions are legalized under the 2010 constitution when ''in the opinion of a trained health professional, there is need for emergency treatment, the life or health of the mother is in danger or when permitted by any other written law (Kenya Const., 2010, Article 26, §4).'' Furthermore, the constitution states that ''every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care'' (Kenya const., 2010, Article 43, §1, Cl. a). The Health Act of 2017, defines "health" as ''a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'' (Health Act, 2017, §2). Taken together these laws establish women's rights to legally access safe abortions. However, the Kenyan penal code still prohibits abortion unless it is performed to save the mother's life (Penal Code, 2008, Articles 158-160, 228 and 240). In practice, the contradictions between these laws creates an ambiguous legal environment for the provision of abortion services. As a consequence, abortion services are highly restricted and women and providers are still prosecuted for inducing an abortion (Mutua et al., 2018). Besides this, access to abortion services is limited by stigma, socio-economic disparities, religious and cultural beliefs, and a lack of knowledge and resources to provide safe abortion procedures (Rehnström Loi, 2020).

Despite these restricting factors, abortion remains a common feature in the reproductive lives of Kenyan women. In 2012, the most recent year for which data are available, it was estimated that 464.690 abortions were induced in Kenya. This corresponds to an abortion rate of 48 abortions per 1,000 women aged 15–49. The vast majority of Kenyan women in need of abortion services resort to unsafe methods to terminate their unintended pregnancy to avoid legal, social, cultural and economic repercussions (Mutua et al., 2018). Consequently, 320 Kenyan women are hospitalized after undergoing an unsafe abortion procedure every day. Seven of them die each day as a result of the medical complications that they suffered (Ratcliffe, 2018, December 21).

Abortion as a social event

Because of the impactful consequences of unsafe abortion, a lot of research has been done concerning the determinants that influence unsafe abortions. Social-economic status, marital status, educational level, family-building preferences, contraceptive failure, religious beliefs, maternal and fetal health, and pregnancy resulting from sexual violence are all factors that inform a woman's pathway towards an unsafe abortion which have been studied within the scientific community (Rehnström Loi et al., 2018). However, abortion is rarely studied in the context of interpersonal relationships even though it is well-known that abortion does not exist in a social vacuum (Chiweshe et. al., 2017). Interpersonal relationships are of great influence on individual's sexual and reproductive health. Social support, social engagement, social influence, social learning, and the availability of (financial) resources within one's interpersonal relationships may hinder or promote the adoption of positive health behaviors and practices. In this way, interpersonal relationships can significantly influence women's abortion trajectories (Lowe & Moore, 2014).

In the case of abortion, the decision to terminate a pregnancy is seldom made without consulting any social actors within a women's social network. Women may approach partners, family members, friends, community members, healthcare providers and other social contacts to ask for advice and support in the abortion decision. In fact, 95% out of 320 women seeking Post-Abortion Care (PAC) services in Western Kenya, consulted their social network before making the abortion-decision. The man responsible for the pregnancy (64%), a friend of the same sex (31%) and a woman's mother (23%) were the most frequently approached persons to discuss the abortion decision with. In 92% of the cases, women received the advice to terminate their pregnancy (Osur et. al., 2015).

Additionally, in contexts where access to abortion is restricted, interpersonal relationships play a major role in accessing (post-)abortion care. In places where abortion is penalized, information about abortion providers or effective abortifacients is usually spread via word of mouth. Women seeking abortion care can, therefore, employ their interpersonal relationships to identify where, when, how and by whom they can induce an abortion (Rossier, 2017). In Ghana, women that induced an abortion shared that they enlisted the help of friends and family members to obtain misoprostol (Rominski et. al., 2017). In western Kenya, former clients of abortion providers formed an important source of new clients as they referred abortion-seeking women to their previous abortion provider (Osur et. al., 2015). Furthermore, given that abortion can be a costly procedure, money is often raised to pay for the procedure with the help of those that are aware of the woman's situation (Rossier, 2017).

Thus, abortions are a social event in which interpersonal relationships within social networks are of great influence on women's pathways towards an unsafe or safe abortion.

Male partners and (un)safe abortions

Within a woman's social network, especially her male partner proves to be a key actor that influences the occurrence of unintended pregnancies and unsafe abortions. In Kenya, culturally defined gender roles position men as the primary decision-maker within sexual relationships. Sexual initiation, contraceptive use, abortion decision-making, prevention, and treatment of sexually transmitted infections (STIs) and HIV, and sexual coercion are mainly determined by men within any sexual relationship (Onyango et. al., 2010).

When it comes to the decision to terminate an unintended pregnancy, male partners can directly or indirectly influence the outcome. A study carried out in Kimisu, Kenya, found that women pursued an unsafe abortion because their male partner denied financial support to raise the child, denied paternity or ended the relationship as soon as the pregnancy was visible. In some cases, women shared that their male partner demanded the abortion directly as primary decision-maker in the household (Rehnström Loi et al., 2018). A study carried out in Burkina Faso highlighted that some male partners even resort to coercive means to achieve an abortion. Several of the 36 women interviewed were forced by their male partner to ingest abortifacients or undergo an abortion procedure. Other women were pressured into an abortion because their male partner threatened or blackmailed them (Ouedraogo et. al., 2020).

Male partners also play an important role in accessing (post-) abortion care. A study carried out in Uganda concluded that men play a critical role in women's access to safe abortions or PAC because they control most of the financial resources. Even though abortion is illegal in Uganda except to save the life of the mother, money can facilitate women's access to relatively safer abortion methods and PAC. Without men's financial support women may have to rely on more unsafe methods of abortion and if they experience complications they may delay care-seeking or may not obtain care at all (Moore et. al., 2011). A study carried out in Zambia pointed

out that male partners could support women in accessing abortion-care by employing their own social network, which was often bigger than women's social network. Via their social network, male partners were able to obtain information about abortion methods and connect to abortion care providers. Additionally, male partners could accompany women to appointments for the abortion procedure, could arrange transport to access the location of the abortion provider and could offer emotional support during and after the abortion procedure (Freeman et al., 2017).

Male partners can, thus, significantly impact women's abortion trajectories for better or for worse. In case male partners offer support, women may not terminate the pregnancy or are able to seek safer abortion procedures. When male partners deny support or resort to physical and emotional violence to ensure an abortion, women are more at risk for unsafe abortions.

Research topic and relevance

As the studies in the above sections show, male partners play a significant role in women's abortion trajectories whether they are involved directly or indirectly, supportively or unsupportively, consensually or non-consensually. Already during the 1994 International Conference on Population and Development in Cairo, the importance of understanding the role of men in women's sexual and reproductive health was called to the attention of the global community. Almost 3 decades later, these calls have been partially answered by research and programs focusing primarily on the influence of men in contraceptive use and maternity care. However, up until today, men's roles in (unsafe) abortions have received little attention (Freeman et al., 2017).

For this reason, this master's thesis will be dedicated to understanding women's experiences with unsafe abortions in Kilifi County, Kenya, and the ways in which they perceive and experience the involvement of their male partner in their abortion trajectory. From an academic point of view, I hope this will contribute to filling the knowledge gap described above that various authors have pointed out in the literature (see: Freeman et al., 2017; Moore et. al., 2011; Onyango et. al., 2010; Ouedraogo et. al., 2020; Rehnström Loi et al., 2018).

Besides having an academic purpose, this master's thesis also aims to contribute on a practical level. Most reproductive health programs that aim to reduce unsafe abortions in Kenya focus almost exclusively on women. Reproductive health services dealing with contraception, the prevention of unintended pregnancies and unsafe abortion, and safe motherhood view women as their primary clients and are therefore often offered as part of maternal and child health services. These programs fall short in the Kenyan context where men are often primary decision-makers when it comes to sexual and reproductive health (Onyango et. al., 2010). How men are involved in, influence or undermine women's sexual and reproductive health is therefore important to include in interventions that aim to strengthen women's SRHR (Strong, n.d.).

Creating a better understanding of men's roles in women's unsafe abortions might help to inspire programs and interventions that include both women and men as their target audience. Existing programs in Kenya that involve men in women's sexual and reproductive health or as part of a heterosexual couple have already seen more improvements in the utilization of sexual and reproductive health services by both sexes opposed to interventions that adopt an individualistic approach (Onyango et. al., 2010). It is likely that interventions that aim to reduce unsafe abortion in Kenya will have the same results when the inclusion of men is an important cornerstone of the program.

Research questions

To guide this research, the following main research question has been formulated:

How do young women (aged 14-30 years old) in Kilifi County perceive and experience the involvement of their male partner[1] in their pathway towards an (un)safe abortion?

To subdivide the main research question, the following sub-questions have been formulated:

1. *What is the legal, social, economic and medical context in which young women's unintended pregnancies, unsafe abortions and interactions with their male partner take place?*
2. *What is the role of male partners in young women's use of contraceptives, experiences with sexual violence and commercial/transactional sex that resulted in an unintended pregnancy?*
3. *What is the role of male partners in young women's decision to terminate an unintended pregnancy?*
4. *What is the role of male partners in young women's experiences with abortion- and post-abortion treatment*

These sub-questions will be answered in the chapters that make up the result section of this master's thesis. Each of the questions will contribute to a better understanding of young women's abortion experiences in Kilifi County and the involvement of their male partners in their abortion trajectory.

Reading guide

The rest of this master's thesis will be divided in the following chapters:

The second chapter will present the theories and concepts that make up the theoretical framework of this master's thesis. Hereafter, the methodology that explains how this research has been conducted will be outlined. The fourth, fifth and sixth chapter form the results section of this master's thesis in which the findings of this research will be presented. These three chapters are divided by the three themes: unintended pregnancies, abortion decision-making, and (post-)abortion treatment. Each chapter will be introduced by a case study that shares a story of one of the young women that has participated in this research. The last chapter will end this master's thesis with a discussion and conclusion based on the theories and the findings that have been discussed in the previous chapters.

[1] I initially chose the term male partner to refer to young women's casual sex partners, boyfriends, and husbands. However, as the data show, young women also encountered perpetrators of sexual violence or engaged in commercial or transactional relationships with clients/transactional partners, which causes this term to not fully cover young women's experiences. Throughout this master's thesis I will, therefore, refer to perpetrators or clients/transactional partners in cases of sexual violence and commercial/transactional sexual relationships to accurately represent the experiences of all young women that participated in the research project.

Theoretical Framework

Chapter 2: Theories and theoretical concepts

Introduction

To understand young women's experiences with unintended pregnancies and unsafe abortions in Kenya, it is necessary to build a deeper understanding of gendered power inequalities that exist within Kenyan society. The existing power structures within Kenyan society determine women's access to safe abortions as well as women's ability to make autonomous decisions and take actions to protect or improve their sexual and reproductive health. For this reason, this chapter will take a deeper look at the theories and theoretical concepts that are relevant to understand gendered power inequalities and the ways in which they shape women's abortion trajectories.

Firstly, this chapter will give an overview of Braam's and Hessini's (2004) findings on the power dynamics that perpetuating unsafe abortion in Africa. This section will give an understanding about the power dynamics of different institutional structures that individually and together shape women's access to safe abortions. The second section of this chapter will outline Blanc's (2001) theory about gender-based power in sexual relationships and the third section will outline Pratto's and Walker's theory on the four bases of gendered power (2004). These sections will give an understanding of how unequal power and gendered access to different power bases within heterosexual relationships can influence women's sexual and reproductive health outcomes. Lastly, the concept of reproductive navigation by Van der Sijpt (2014) will be explained. This final section will give an understanding of how women can navigate (gendered) power disbalances to give direction to their own reproductive pathways. Together these theories and theoretical concepts will form the theoretical framework of this master's thesis.

Gendered power dynamics perpetuating unsafe abortions in sub-Saharan Africa

Within their study on power dynamics that perpetuate unsafe abortions in sub-Saharan Africa, Braam and Hessini (2004) observe that patriarchal power lies at the core of understanding unsafe abortion. Patriarchy can be understood as a social system in which men hold a dominant power position over women. It consists of those behaviors, ideologies and belief systems that maintain, justify and legitimate male gender privilege and power. Braam and Hessini note that over the course of centuries, patriarchal ideologies have framed the morality, legality, and socio-cultural attitudes towards women's sexuality and reproductivity. This affects the way power plays out within the political, socio-cultural, and economic systems that govern the accessibility, acceptability, and affordability of safe abortions (Braam & Hessini, 2004).

Braam and Hessini (2004) distinguish various institutional structures within patriarchal societies that affect that women's ability to make autonomous decisions and take actions to pursue a safe abortion.

Firstly, legal institutions exert significant power over women's reproductive lives by framing the legality, morality, and accessibility of induced abortions. The restricted legal status of induced abortion in many sub-Saharan African countries reinforces several societal messages concerning abortion, namely: (1) it is a crime to terminate a pregnancy, (2) it is immoral to terminate a pregnancy, (3) access to safe abortions should not be an integral part of

comprehensive reproductive care services, (4) the right to abortion is not a human right, (5) others can make decisions about women's bodies and lives. These messages as well as the (legal) consequences of the laws that embody these messages tremendously affect women's power to decide and act according to their reproductive desires.

Secondly, religious institutions play a powerful role in constructing ideas about women's sexuality and reproductivity. Religious teachings have long portrayed the idealized version of women as chaste, virginal, and caring. This greatly affects social constructs of ''sex'' and norms about women's sexuality. In addition, many religions reinforce the role of women as wives, mothers, and homemakers, making childbearing one of women's main responsibilities. As a result, a woman's body does not merely belong to herself but also to her husband, family, extended family, society, and God. Therefore, a woman's sexual and reproductive decision-making is frequently dominated by the (reproductive) demands of her husband, family, community, and society.

Thirdly, institutionalized economic inequality affects a woman's decision-making about unintended pregnancies as well as her access to safe abortions significantly. Poverty is a key determinant of unsafe abortions in sub-Saharan Africa where many women opt to terminate a pregnancy due to financial constraints. In a system where women are expected to bear children and are economically disadvantaged, women may become trapped in an ongoing cycle of poverty by taking care of multiple children. Alternatively, if a woman decides to (unsafely) terminate a pregnancy, a lack of financial resources may impact women's ability to access safe abortion care and post-abortion care in case of complications. If complications arise and are untreated this may impair women's ability to work and earn money on the short- or long-term furthering the cycle of poverty. Furthermore, in case a woman dies due to an unsafe abortion, her household will lose a crucial source of income which impacts future generations' levels of poverty.

Fourthly, institutionalized discourses and language surrounding abortion is an important factor in maintaining a largely conservative approach to the issue. Historically, the discourse used by anti-choice movements has played a significant role in defining the terms of the debate. Anti-choice movements have focused on terms like life, babies, and families to build a discourse that puts those who advocate for safe abortions morally on the defensive. Additionally, abortion has often been pictured by these movements with images of death, blood, and infertility. This has shifted the power in the debate towards groups that are opposed to facilitating legal, affordable, and accessible induced abortions which makes it harder for women to demand safe abortions based on social justice, public health, and human rights arguments.

The legal, religious, economic and discoursal power structures that Braam and Hessini observe within institutions, impact a woman's sexual and reproductive autonomy within her interpersonal relationships. Asymmetric power relations within interpersonal relationships fostered by the inequalities inherent to the legal, religious, economic and discoursal power structures have granted men exceeding decision-making power. As a result, men are often the primary decision-makers about whether and when to have children and how many to have. When a woman experiences an unintended pregnancy, her decision to pursue an abortion is heavily dependent upon the response of her male partner towards the pregnancy, the extend of her financial dependency on him, legal and cultural norms about attachment to her male partner and her concerns about the survival other children and family members. In this context, unsafe abortion may be the result of an unbalanced decision-making process within women's interpersonal relationships or a woman's last attempt to gain back some of the decision-making power in relation to her body despite the potential risks to her life and health (Braam and Hessini, 2004).

Gender-based power in sexual relationships

Within her theory on gender-based power in sexual relationships, Blanc (2001) dives deeper in the asymmetric power relations within interpersonal relationships that affects women's capacity to make decisions and take action to protect or improve their sexual and reproductive health. Within heterosexual relationships, power is frequently unbalanced. In general, female partners often have less ability to exert power within decision-making processes than their male counterparts (Blanc, 2001). Power within sexual relationships can be defined as ''the relative ability of one partner to act independently, to dominate decision-making or to engage in behavior against the other partner's wishes, or to control a partner's actions'' (Blanc, 2001, p. 189). What is important is not the absolute power of either partner in a couple, but the relative power each partner holds compared to each other (Blanc, 2001).

Gendered power inequalities within sexual relationships are rooted in the social meanings given to the biological differences between men and women or, in other words, gender (Blanc, 2001). Gender can be defined as: ''the widely shared expectations and norms within a society about appropriate male and female behaviors, characteristics, and roles, which ascribe to men and women differential access to power, including productive resources and decision-making authority'' (Varga, 2001, p. 180). Gender norms are at the base of the behaviors, characteristics and roles that are established as appropriate for both sexes within society. Gender norms are the norms in society that determine what a man and a woman are supposed to be, how they are supposed to look, how they are supposed to think and how they are supposed to act. Within society, gender norms inform the roles that men and women ought to fulfil. Gender roles encompass the range of behaviors, attitudes and characteristics that are considered as acceptable, appropriate, or desirable for a person in any situation based on their sex. Blanc (2001) as well as Braam and Hessini (2004) observe that these different gender roles give men and women different access to power in society and these gendered power inequalities frequently become institutionalized in different structures of society, including sexual relationships. Blanc (2001) aims to capture the relationships between the power dynamics in society, the power dynamics within sexual relationships and the effects on women's sexual and reproductive health in the framework below.

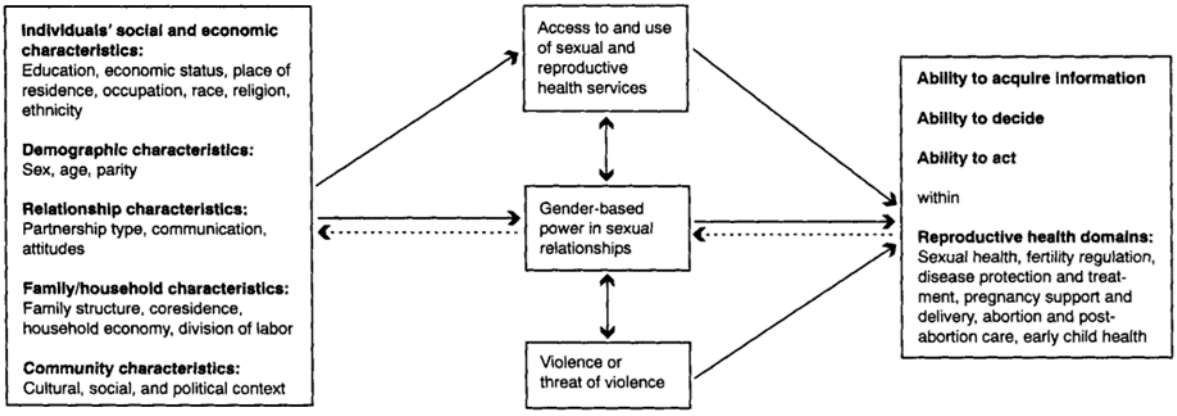

Figure 1 Framework for the relationship between power in sexual relationships and sexual and reproductive health (Blanc, 2001, p. 191)

Starting at the left of the framework, individuals' contexts (social and economic characteristics, demographic characteristics, relationship characteristics, household characteristics and community characteristics) are hypothesized to influence the balance of power within the relationship and the extent to which individuals have access to sexual and reproductive health services (Blanc, 2001).

In the middle, the balance of power is linked to sexual and reproductive health outcomes in three ways: (1) directly, (2) through its relationship with violence between partners and (3) through its influence on the use of health services. For example, direct effects of power imbalances within sexual relationships include women's ability to negotiate contraceptive use to prevent unintended pregnancies and STD's. Power imbalances can also influence women's access to sexual and reproductive health services, which, in turn, can affect women's sexual and reproductive health outcomes. For example, in contexts where women's mobility depends heavily on men, access to health services may be limited. Lastly, power imbalances are linked to (domestic) violence in sexual relationships which can cause various negative sexual and reproductive health outcomes for women (Blanc, 2001).

At the right side of the framework, the balance of power is linked to the ability of partners to acquire information about their sexual and reproductive health, the ability to make decisions about their sexual and reproductive health and the ability to take action to protect or improve their sexual and reproductive health. Sexual and reproductive health are defined broadly in this framework and include amongst other things: fertility regulation, protection and treatment of diseases, pregnancy support and delivery, abortion and Post-Abortion Care and early child health (Blanc, 2001).

The interplay between the various components of the framework determines women's power position and women's ability to protect and improve their sexual and reproductive health.

The four bases of gendered power

The balance of power within interpersonal relationships and its effects on sexual and reproductive health can further be studied by exploring the different sources of power that partners can exploit to achieve one's desired outcomes. In addition to Blanc's (2001) framework, Pratto and Walker (2004) identified four gendered bases of power that individuals can draw upon to achieve their intended outcomes within relationships. The extent to which individuals can derive power from the four bases of gendered power is not equally divided in society. In line with Blanc's findings, access to the power bases is divided according to the gender structure in society wherein the ability to exert power is biased towards male individuals. All bases are interconnected and can reinforce each other. Power associated with one power base, can help to obtain power within another base (Pratto & Walker, 2004).

The first base of gendered power is force. Force is a significant aspect of power struggles within relationships between men and women. Men's use of physical and psychological violence against women is a major source of gender inequality. Force includes: physical and emotional abuse, rape, assault, sexual harassment, and many other forms of violence. Not only the actual exercise of force, but also the threat of violence indirectly limits women's power. Even though many heterosexual relationships are free of violence, a women might feel compelled to stay in a relationship with a man who does not abuse her, because she fears another man might. As a result, her current partner has more power vis-à-vis her than he would have if other men were not violent (Pratto & Walker, 2004). Force and the threat of force are inextricably related to women's negative sexual and reproductive health outcomes. Violence is detrimental to women's sexual and reproductive health and past experiences with violence are predictive of future sexual risk behavior in women (Rosenthal & Levy, 2010).

The second base of gendered power is resource control. Resource control refers to access to socio-economic resources such as: well-paying jobs, (higher) education, (access to) health care, institutional influence, and prestige (Rosenthal). Especially, favoritism of men over women in a variety of occupations and economic sectors lead to women's diminished power over

resources (Pratto & Walker, 2004). Inequalities in resource control can lead to the social-economic dependency of women on men within interpersonal relationships. Socio-economic dependency on men makes it difficult for women to negotiate, for example, condom use and monogamy within a relationship to protect their sexual and reproductive health (Rosenthal & Levy, 2010). Women's need for economic support is in some instances a reason to engage in (risky) sexual relationships with men. Women's sexuality then becomes a resource in exchange for the resources that men have (Baumeister & Vohs, 2004).

The third base of gendered power are social obligations. Most of our basic physical needs for sustenance, like sanitary living conditions, and basic social needs, such as belonging and attention, are met through a social system of obligations. Social obligations include responsibilities towards others (such as a partner or children), the provision of care and satisfying other people's needs and desires (Rosenthal & Levy, 2010). Families are a prominent structure of social obligations in which social obligations are divided by gender. Women usually have more obligations in terms of child rearing, care giving and meeting their partner's needs, whereas men generally acquire (financial) resources for physical sustenance. Even though this division of labor seems complementary, the problem is that different obligations do not equal comparable amounts of power. This contributes to power inequality, but differences in obligations also gives different access to other power bases (Pratto & Walker, 2004). Women's level of social obligations within a relationship often reflects women's commitment to the relationship. For example, married women are more likely to engage in unprotected sex even if they suspect a partner of infidelity because of their sense of obligation towards the relationship. Additionally, female sex workers are less likely to use a condom with regular clients or when they perceive the relationship with the client to be more intimate. The commitment to the relationship thus increases the sense of obligation or actual obligations that women experience. In the same relationship, these obligations ore often not reciprocated by men. This limits women's control over their sexual and reproductive health (Rosenthal & Levy, 2010).

The last base of gendered power are consensual ideologies. Consensual ideologies related to gender include: gender norms, gender roles, gender stereotypes and any other cultural or religious beliefs or expectations about men and women (Rosenthal & Levy, 2010). Consensual ideologies legitimize gender inequality within laws, social roles, occupational segregation, religious practices, interpersonal behavior, and public discourse. For example, a subset of men's stereotyped personality traits, such as assertive, rational, non-emotional and competent makes it seem that men are more suitable for leadership roles and legitimizes men's increased access to power resources such as force within these roles (Pratto & Walker, 2004). A noteworthy set of ideologies that influence gendered power are ideologies about women's sexuality and their bodies. Societal beliefs about what constitutes masculinity versus femininity and male versus female sexuality determine what is seen as acceptable sexual behavior for women. In many cultures, gender ideologies prescribe that women should not be in control over their own sexuality. Women are supposed to be passive acceptors of sex, should not have sex with multiple partners, should not have more knowledge about sex than men, should not be outspoken about their sexual needs and desires are only a few of the norms that persist among many groups. This decreases women's power to negotiate safe and pleasurable sex (Rosenthal & Levy, 2010).

Reproductive navigation

Within a context of gendered power inequalities as studied by Braam and Hessini (2004), Blanc (2001), and Pratto and Walker (2004), it is important to note that women are not merely passive actors (Van der Sijpt, 2014).

For long, feminist have celebrated the termination of unwanted pregnancies as the ultimate freedom of choice. From this perspective, abortions are a manifestation of women's autonomy and empowerment. However, according to Erica van der Sijpt (2014), understanding abortion in terms of autonomous choice results in at least three misrepresentations of women's reproductive decisions and actions.

Firstly, the individualist underpinnings of this perspective tend to overlook the interaction between women's reproductive agency and social others. Women are often studied as individual agents who (have the right to) make rational, free, and informed decisions or actions to achieve their desired reproductive outcomes. Yet, women's sexual and reproductive health does not exist in a social vacuum. As Van der Sijpt points out: ''Reproductive decision-making is a socially contingent affair, embedded in different forms of sociality and power relationships" (Van der Sijpt, 2014, p. 287). Power dynamics embedded in women's relationships with relevant others, such as parents, siblings, partners, in-laws, co-wives and other villagers, affect women's choices and actions about their reproductive health and can thus not be dismissed while studying women's reproductive behaviors (Van der Sijpt, 2014).

Secondly, discourses focusing on women's autonomy and empowerment often consider that fertility can and should be rationally calculated and controlled. This perspective on fertility is highly problematic in the field of sexuality and reproduction. Sexual acts are often spontaneous, reproductive outcomes unanticipated or uncertain and reproductive desires can be contested, multiple and changing. Moreover, reproductive agency is inherently influenced by the physical body. Bodies do not only enable but can also constrain women's reproductive desires. Bodies can be unpredictable and manipulation of the body to achieve desired outcomes has its limits (Van der Sijpt, 2014).

Thirdly, a focus on autonomy has the tendency to only consider explicit moments of decision-making and action. Agency is, however, at play in many gradations and many situations over women's whole life course. This is true even in moments where no explicit decisions or actions are taken and even in cases where women seem to comply with dominant structures or discard the situation at hand as a 'non-event'. In the field of sexuality and reproduction, agency can be expressed in overt and covert decisions or actions as well as in non-decision or non-action. Studying solely explicit events of sexual and reproductive decision-making and action leaves out the many other ways in which women's agency can be practiced (Van der Sijpt, 2014).

Building upon these critiques, Van der Sijpt (2014) offers the concept of reproductive navigation. Reproductive navigation is defined as all the ways in which individuals give direction to their own reproductive trajectories (Van der Sijpt, 2014).

Reproductive navigation emphasizes the interaction between an individual's actions and complex social circumstances, which are both always in constant motion. As Van der Sijpt notes that: ''socialities and physicalities are always implicated in reproductive issues around the world, even if they take different forms and shapes in different localities" (Van der Sijpt, 2014, p.288). Furthermore, reproductive navigation allows for the ambivalence and ambiguity of women's fertility intentions. It acknowledges that in many cases sexual and reproductive events are not deliberately planned nor do outcomes of these events necessarily reflect women's reproductive desires. Lastly, in her work on fertility interruptions, Van der Sijpt is less interested in questioning whether pregnancy interruption can be related to autonomous

action or structural constrains - a question that focuses on the amount of control and restriction. Instead, she focusses on all the kinds of agency women display within their specific social setting and the kind of obstacles they encounter in directing their sexual and reproductive lives. Therefore, reproductive navigation allows for the study of less explicit manifestations of agency like seemingly 'passive' actions of endurance or subtle manipulation of the body (Van der Sijpt, 2014). Thus, in a context of gendered power inequalities, reproductive navigation allows to study both the effect of gender inequality on women's sexual and reproductive health as well as the way in which women navigate power imbalances to exert power over their sexual and reproductive health.

Conclusion

This chapter has taken a deeper look at the theories and theoretical concepts that are relevant to understand gendered power inequalities and the ways in which they shape women's abortion trajectories. Firstly, Braam and Hessini (2004) have found that within patriarchal sub-Saharan societies legal, religious, economic and discoursal power structures impact accessibility, acceptability, and affordability of safe abortions. This affects women's autonomy to pursue and access a safe abortion when she wishes to terminate her pregnancy. Secondly, Blanc (2001) has found that many heterosexual relationships are characterized by an unequal balance of power in which male partners usually hold more power to act independently, to dominate decision-making or to engage in behavior against their female partner's wishes, or to control their female partner's actions. The unbalanced power within sexual relationships greatly affects the ability of women to acquire information, to decide and to act within sexual and reproductive health domains. Thirdly, Pratto and Walker (2004) identified four gendered bases of power that individuals can draw upon to achieve their intended outcomes, namely: force, resource control, social obligations and consensual ideologies. Within society the ability to draw upon and exert power within these power bases is biased towards male individuals, which strongly affects women's ability to make decisions and take action to protect and improve their sexual and reproductive health. Lastly, Van der Sijpt (2011) offers the concept of reproductive navigation to understand interactions between an individual's actions and complex social circumstances, which are both always in constant motion. Within a context of power inequality reproductive navigation allows to study all the kinds of agency women display within their specific social setting and the kind of obstacles they encounter in directing their sexual and reproductive lives. Taken together these theories and theoretical concepts help to understand gendered power inequalities and the ways in which they shape women's abortion trajectories.

Methodology

Chapter 3: Research methodology

Introduction

This chapter will present the methodology of the research to explain how the data were collected, analyzed and interpreted to give an answer to the research questions of this master's thesis. The data that have been used in this master's thesis were gathered during a larger research project set up by Rutgers and the African Population and Health Research Centre (APHRC) in Kenya and Benin. Therefore, this chapter will start off with an introduction of the ''She Makes Her Safe Choice'' program and the ''Lived experiences, social determinants, and pathways to unsafe abortion of young women in Kenya and Benin'' research project. Following this, a section will be dedicated to the research area in Kenya. Hereafter, the research setting and the agreements that have been made between Rutgers, APHRC and myself for the duration of my involvement in the research project will be outlined. Thereafter, the data management and the ethical considerations to keep the participants and data safe will be discussed. The next two sections will describe the data collection and research methods and the last section of this chapter will discuss the data analysis.

She makes her safe choice program and research project

The data that have been used for this master's thesis were collected as part of a larger ethnographic study set up by Rutgers and the African Population and Health Research Centre (APHRC). This research project looked into the lived experiences, social determinants and pathways to unsafe abortion of young women in Kenya and Benin. The key objective of the research project was to deepen the understanding of the experiences of young women facing unintended pregnancies and the way they navigate abortion decision making in their specific social, cultural, and legal contexts, in order to better understand the barriers and opportunities to access safe abortion information, methods and care. The research project was carried out within the context of the ''She makes her safe choice'' program. This program was established by Rutgers and her partner organizations (Including APHRC) [2] in 2019. Currently, the program has been implemented in Benin, Burkina Faso, Cameroon, Ethiopia, Kenya, and Togo. With the program, Rutgers and her partners aim to improve the access to information about sexual and reproductive health and rights (SRHR), contraceptives, safe abortion methods, and sexual and reproductive health services in order to reduce the number of unsafe abortions and maternal deaths stemming from unsafe abortions in these countries (Rutgers International, n.d.).

The research project ''Lived experiences, social determinants, and pathways to unsafe abortion of young women in Kenya and Benin'' makes use of a qualitative research design. A qualitative research design is very suitable if you want to understand, explore, discover, and clarify different situations, feelings, perceptions, attitudes, values, beliefs, and experiences of an individual or a group of people (Kumar, 2014). Within the qualitative design, the research project makes use of ethnographic research methods which are particularly suitable to study a sensitive issue like abortion. When applied to a sensitive issue such as abortion, ethnographic research methods can reveal the imponderable and invisible factors that affect young women's

[2] Partner organizations: DKT Kenya, Shujaaz Inc., Ipas Africa Alliance, Reproductive Health Network Kenya, DKT Ethiopia, Triggerise Ethiopia, Family Guidance Association of Ethiopia, DKT WomanCare Global, Women First Digital, DKT Francophone West and Central Africa, Ipas francophone region, Association Beninoise pour la Promotion de la Famille, Movement Action des Jeunes Benin &African Population and Health Research Centre

abortion experiences. In a context of social inequality and vulnerability, ethnographic research methods can be used because it can capture those issues that are hardly measurable in a statistical survey (Fassin, 2000). With the collected data, case studies were constructed for each of the young women that participated in the research project. Case studies are useful to document complex phenomena in detail while considering the social setting and how individuals give meaning to their daily live (Kumar, 2014). Case studies are applicable when 1) the focus of the research is to answer ‘’how’’ and ‘’why’’ questions, 2) the researcher cannot manipulate the behavior of the participants involved in the research, 3) there is a need to cover contextual conditions that are relevant to the phenomenon that is researched, 4) the boundaries between the context and the phenomenon are not clear. These conditions apply to abortion as a complex issue where practices are often hidden and influenced by personal and contextual factors (Baxter & Jack, 2008).

Study Area: Kilifi County, Kenya

In Kenya, Kilifi County was selected as the research area. Kilifi county, is one of the 47 counties in Kenya and is located at the coast directly above Mombasa. The county is divided into 9 sub-counties: Kilifi North, Kilifi South, Ganze, Malindi, Magarini, Kaloleni and Rabai. Kilifi county counts a population of approximately 1.4 million people of which the majority belong to the Mijikendas ethnic group. The Mijikendas is a group of nine related ethnic communities (the Rabai, Chonyi, Ribe, Jibana, Duruma, Digo, Kambe, Kauma, Giriama, Pokomo and Bajuni) who mainly speak Kiswahili in addition to other local languages. The main economic activities in the county include fishing, agriculture, livestock farming, tourism, mining, and manufacturing (Kenya County Guide, 2021).

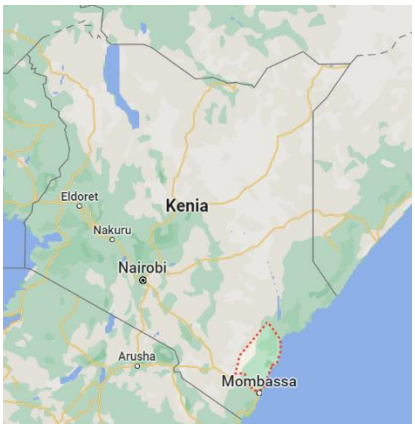

Figure 2: Map of Kenya

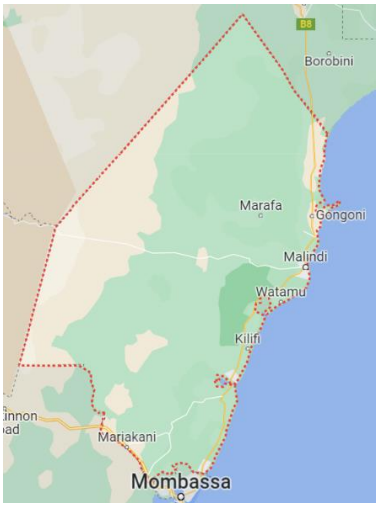

Figure 3: Map of Kilifi County

In terms of sexual and reproductive health, findings show that Kilifi County is a key area to study within Kenya. Kilifi County shows high rates of teenage pregnancies, non-use of contraceptives and sexual risk behaviors that contribute to a high rate of unintended pregnancies that may end in an unsafe abortion. Firstly, Kilifi County is one of the counties in Kenya with a higher rate of teenage pregnancies than the national average. The Kenya Demographic and Health Survey of 2014 found that 22% of the 15–19-year-old adolescent girls were pregnant with their first child or had given birth to their first child compared to the national average of 18%. The high rate of teenage pregnancies can be linked to the deeply rooted cultural practice of early sexual debuts of adolescent girls in Kilifi County. Ochieng (2016) found that material poverty, retrogressive cultural practices and unsafe school and community environments expose school going girls in Kilifi County to early sex and various forms of sexual abuse, including inappropriate touching by peers in the classroom and defilement by fathers at home as well as strangers on the way to and from school. For many school going girls this results in unintended pregnancies, which for several girls ended in an abortion. Secondly, Kilifi County presents a significantly lower uptake of modern contraceptive methods compared to the rest of Kenya. In 2014, the uptake of

modern contraceptives was 33% in Kilifi County compared to the national average of 53%. For long, a high unmet need of contraceptives in Kenya has been linked to an increase in unintended pregnancies that may end up in an unsafe abortion (Mumah et al., 2014). Especially, social norms are influential in determining contraceptive uptake within Kilifi County. Within Kilifi County, social norms that condemn the use of contraceptives before marriage, cause young and unmarried women to face significant stigma that prevents them from taking up contraceptives (Lahari et. al., 2023). Consequently, in their social network study, Lahari et. al. (2023) found that unmarried women with people in their social network that disapprove of contraceptive use before marriage were less likely to use contraceptives while women with fellow women in their social network that use contraceptives were more likely to use contraceptives themselves. Thirdly, Kilifi County has a high prevalence of sexual risk behaviors among adolescents and young people that increase the likelihood of unintended pregnancies and unsafe abortions. Ssewanyana et al., (2018) found that sexual risk behaviors such as early sexual debut, multiple sexual partnerships, unprotected sex, intimate partner violence, and sexual exploitation through early marriage and transactional sex are common in Kilifi County. In the coastal area of Kenya, the prevalence of sexual risk behavior can be linked to the negative impact of the tourism industry (e.g. sex tourism), poverty that leads to commercial/transactional sex and the occurrence of social events that were found to be occasions during which many adolescents might either engage in sexual risk behavior or face a risk of sexual exploitation (Ssewanyana et al., 2018).

Setting of the thesis

This master's thesis was carried out under supervision of Prof.dr.ir. Han van Dijk within the Sociology of Development and Change (SDC) chair group at Wageningen University and Research (WUR). Besides the supervision from Han van Dijk, I received guidance and support from the research team at Rutgers and APHRC. The research team, under guidance of Dr. Ramatou Ouedraogo (APHRC) as the principal investigator and Mr. Camilo Antillon (Rutgers) as Co-principal investigator, consists of four co-investigators from both Rutgers and APHRC: Dr. Jonna Both (Rutgers), Dr. Martin Bangha (APHRC), Mr. Kenneth Juma (APHRC) and Ms. Grace Kimemia (APHRC). Additionally, four research assistants were part of the team: Anne Achieng, Shilla Dama, Mercy Kadzo and Jane Sirima. In June and October, two more team members joined to assist with the workload: Shelmith Wanjiru and Gladys Akinyi Omondi.

At the start of my master's thesis, I met several times with Dr. Jonna Both to determine my role within the research project. We agreed that I would participate in the weekly meetings, coding, data analysis and report writing for the research project. Additionally, we determined that I would join in processing the Kenyan data, since these were all in English while the data from Benin were in French. At the beginning of May 2021, I officially joined the team based on an internship contract with Rutgers until December 2021. During and after my time at Rutgers I was allowed to access all the data that were collected during the research project. I was free to make use all the data that were available while adhering to the data management guidelines and ethical guidelines of Rutgers and APHRC that are discussed in the next section.

While I was not able to visit Kilifi County myself or meet up with any of the team members in the Netherlands during the research project due to the COVID-19 epidemic, the weekly meetings with the team and the open communication within the team made me feel very welcome and involved with each of the team members. Within the team, time and space was created to share everyone's daily activities, challenges and successes, personal struggles and accomplishments, which created close bonds between the team members. This created a very pleasant and collaborative environment to further our research efforts. Additionally, it allowed

me to gain a deeper insight into the field activities as the research assistants regularly shared detailed descriptions of the field setting and their experiences during the data collection. Furthermore, it enabled me to introduce new topics of research and give directions on questions that could be asked during the fieldwork to gain more information for my master's thesis research.

Besides this master's thesis, the data from the research project were presented in several other research products. A research report [3]was created to present the Kenyan data at the end of the research project. This research report presents the findings from the observations made in the healthcare facilities and communities, the data from all the young women participating in the research project and their family, friends and partners that were interviewed, the data from gathered from the key informants and the data yielded from the focus group discussions. Additionally, the findings were bundled in several thematic unpublished manuscripts and published peer-reviewed articles on distinguishable themes that emerged within the data.

Data management and ethics

During the research project, a strict data management policy was upheld to protect the research participants. Each member of the research team had a responsibility to protect confidential, restricted, and/or sensitive data from unwarranted disclosure, loss, or damage to avoid adversely affecting the research participants.

Since abortion is a sensitive topic in Kenya, the data that were gathered were anonymized as soon as they were collected. The research assistants invented new names for the research participants and eliminated all details that could be traced back to the participant. After the data were anonymized, the research assistants uploaded them to a shared drive which only the other members of the research team could access. Part of the research team (including myself) checked the quality of the data before they were admitted to the coding software for the data analysis.

The cleaned, processed, and anonymized research data will be stored for as long as is necessary within the secure database of the APHRC. External users that want to access the data will need to obtain permission after consultation with the concerned Principal Investigator and Program Leader. The data will not be shared with the WUR, but, if needed, can be accessed after permission has been granted by Rutgers and APHRC. In consultation with Rutgers and APHRC it might be decided that this master's thesis will not be published in the online catalogue of the WUR.

To protect the participants during the research project, the following ethical principles were upheld:

- Informed consent: informed consent was obtained from all of the participants prior to their participation in the research project. All the study participants were adequately informed about the aims, methods, anticipated benefits and potential risks of the study before participating and were informed of their right to withdraw from the study at any time. The research assistants also informed participants that they do not have to talk about anything they do not want to talk about. For minors participating in the study a waiver was organized so that parental consent was not necessary. Requesting parental consent for minors to take part in this study could put them at risk and violate their privacy as many young women seek abortion services in secret.

[3] The research report is available for download at: https://aphrc.org/publication/lived-experiences-and-pathways-to-abortion-in-kilifi-county-kenya-2/

- Voluntariness: Participants were informed that participation in the research project is completely voluntary and that they may stop their collaboration at any point if they desire to discontinue their participation.
- Privacy and confidentiality: Confidentiality was ensured for all the research participants. Interviews took place at a location that they preferred and offered privacy. Raw data were anonymized and no identifying information of the participants will be retained in the digital version of the data. Informed consent forms will be saved for seven years, after which they will be destroyed.
- Counselling: Since sharing the intimate details of an abortion experience might cause the participants to relive certain traumatic experiences again, all participants were informed that a dedicated counselor will be available. To offer this Rutgers and APHRC partnered with a local NGO that offers online and clinic-based counseling and psychological support. Participants were be provided with their hotline numbers and the dedicated counselor's contact information.
- COVID-19: The health of the research participants, research assistants and the community were in all cases prioritized over gathering data.

Data collection and research methods

During the research project, the data collection took place from January 2021 to July 2021 in Kilifi County, Kenya. Two sub counties of Kilifi County, North Kilifi and Kaloleni, were selected to represent an urbanized and a rural context within the research project. Four research assistants[4] were positioned in the areas of Kilifi town, Gotani, Matsangoni and Mariakani to collect data. All the research assistants had a background in anthropology or sociology and were acquainted with ethnographic research. The data were collected in four public health care facilities, four private healthcare facilities and the local communities that are served by these selected facilities. For the selection of the public health care facilities, the Post-abortion Care (PAC) records of the region were consulted to identify two public referral hospitals and two primary level public health facilities that recorded a high number of admitted PAC cases (African Population and Health Research Center, Rutgers, and the Kilifi County Department of Health, 2021).

Before entering the field, the research assistants participated in a 5-day training workshop. In the workshop, the research assistants were introduced to the research project, the study objectives, the research design, research ethics and ethnographic research methods. By means of role-play, various components of the data collection were practiced. Halfway through the data collection phase, the research assistants received a second training workshop to refresh the knowledge and skills they obtained in the first workshop (African Population and Health Research Center, Rutgers, and the Kilifi County Department of Health, 2021).

In the healthcare facilities, the research assistants were introduced to the specific wards and individuals that provide PAC services by the heads of the selected facilities. The research assistants entered the healthcare facilities during a national medical staff strike in the middle of the COVID-19 pandemic, which influenced the PAC service provision. The strike emerged because of the limited access to personal protection equipment by the medical staff to protect themselves while treating COVID-19 patients. During the strike, only emergency cases were treated in the healthcare facilities. Post-abortion complications and incomplete abortions were not considered as emergency cases and were therefore referred to private healthcare facilities.

[4] To learn more about the four research assistants see: https://rutgers.international/stories/with-the-right-information-we-can-save-a-generation/

Two weeks into the data collection, the strike ended after taking place for three months and PAC service provision was resumed (African Population and Health Research Center, Rutgers, and the Kilifi County Department of Health, 2021).

In the communities, the research assistants were welcomed by the local chiefs and village elders. They connected the research assistants to local Community Health Volunteers (CHVs) and youth advocates, which were asked to aid in the identification of potential participants for the research project within the communities. Due to the stigma surrounding abortion, the research was introduced under a broader thematic topic (adolescents sexual and reproductive health) to safeguard the confidentiality and privacy of the young women that agreed to share their abortion experiences. Nevertheless, many of the CHVs and youth advocates were hesitant to be involved in the research. However, a few of them agreed to support the research assistants in identifying and reaching out to potential participants (African Population and Health Research Center, Rutgers, and the Kilifi County Department of Health, 2021).

During the fieldwork phase, weekly debrief-meetings were held on Mondays with the research assistants and the rest of the team in Kenya, Benin, and the Netherlands. During the meetings, the research assistants shared their experiences in the field that week, which provided the researchers that were located outside of Kilifi County (Kenya) and Atlantique (Benin) with an insight into the field. The research assistants occasionally encountered distressing situations in the field as they met young women that were the victim of sexual and gender-based violence (SGBV), witnessed abuse in the healthcare facilities and observed painful Manual Vacuum Aspiration (MVA) procedures. The weekly debrief-meetings served as a safe space for the research assistants to share their struggles and receive guidance from the rest of the team. Additionally, the research assistants were provided with professional counselling and one-on-one support from the senior researcher to cope with stressful and highly emotional encounters (African Population and Health Research Center, Rutgers, and the Kilifi County Department of Health, 2021).

Research methods

To collect the data, the research assistants made use of several research methods in the field.

Firstly, the research assistants made use of participant observation in the healthcare facilities and community. Within the healthcare facilities, the research assistants observed the everyday activities in the wards that dealt with PAC, antenatal care, postnatal care, inpatient and outpatient services and emergency treatment. Here they engaged with providers and young women that came in for PAC treatment. Rapport and trust were built with the staff members and healthcare providers by participating in various activities in the facility. The research assistants aided in record keeping, restocking supplies, giving direction to patients in the hospital and they were present during (Manual Vacuum Aspiration) MVA procedures. During the MVA procedures, the research assistants would hand the provider equipment, hold a flashlight to enable the provider to see the cervix and comfort the patients when they experienced pain (African Population and Health Research Center, Rutgers, and the Kilifi County Department of Health, 2021).

In the communities, the research assistants started off by observing key areas within the community, like markets, hair salons and restaurants, to get a feeling for the community. Additionally, the research assistants joined community meetings and events to engage with community members and to learn about the cultural practices of the community. During their time in the community, the research assistants regularly met with the local CHVs and youth advocates. The local CHVs and youth advocates facilitated the contact with young women who

had experienced an abortion and wanted to participate in the research. While observing the community and following up with the participants, the research assistants took up different roles. They acted as a mentor, counsellor, and confidante to the young women they met. Young women often asked the research assistants for help when they had questions about puberty, sexuality, reproductivity and access to healthcare (African Population and Health Research Center, Rutgers, and the Kilifi County Department of Health, 2021).

Secondly, the research assistants carried out in-depth interviews (IDI). In total 54 young women were interviewed at least once about their abortion experience. Additionally, 51 IDIs were carried out with relatives and partners of women that had an abortion. Furthermore, 29 Key Informant Interviews (KII) were conducted with actors active in the SRHR field and abortion and post-abortion service provision.

By means of convenience sampling, the research assistants were able to identify 37 potential participants in the healthcare facilities where they were stationed. 16 of the 37 potential participants consented to be followed up for an interview. In the community, the research assistants were introduced to participants by the local CHVs and youth advocates. By means of snowball sampling, additional participants were identified among the friends, siblings, and peers of the participants. In total, 38 young women in the community agreed to participate in an IDI.

After obtaining formal consent, the research assistants contacted the young women for their first interview. The first interview followed a semi-structural design and focused on the sociodemographic characteristics of the participant, her education, her relationships, her pregnancy, and abortion experience. After conducting the first interview, it was transcribed and used to draft questions for the follow up interview. Most of the interviews were carried out in Kiswahili or other local languages and were translated in English. Especially, the younger participants needed some time before they were comfortable to talk openly about sexual matters. By carrying out multiple interviews, the research assistants were able to build trust and gradually uncovered the stories of the participants (African Population and Health Research Center, Rutgers, and the Kilifi County Department of Health, 2021).

Table 1: Characteristics of young women participating in the research project

		Frequency (N=54)
Age (in years)	14-17	8
	18-24	41
	25-30	5
Highest Level of Education	Primary School	18
	High School	28
	College/University	7
	No Formal Education	1
Area of Residence	Urban	12
	Peri-urban	16
	Rural	26
Marital Status	Married/Cohabiting	3
	Separated	4
	Unmarried	47
Occupation	Student	19
	Employed/Informal labor	19
	Unemployed	12
	Sex worker	4

Besides the IDIs with the young women participating in the research, the research assistants carried out 51 IDIs with relatives (33) and male partners of women that had previously experienced an abortion (18). The relatives included mothers, fathers, aunts, uncles, sisters, friends, grand-mothers, and grand-fathers. Before these relatives were invited for an IDI, consent was obtained from the main research participant. The IDIs with the relatives focused on issues like the relationship between the relative and the main research participant, how they assisted in the decision-making process and abortion care seeking and the rationale that underlay their involvement. The IDIs with partners focused on contraception, the type of relationship they had with their (previous) partner when she fell pregnant, their reaction to the pregnancy, their role in the decision-making and care seeking as well as their perspectives on the abortion of their partner. Four of the partners were in a relationship with one of the main research participants at the time of the interview. Others were recruited via the local CHVs or healthcare providers (African Population and Health Research Center, Rutgers, and the Kilifi County Department of Health, 2021).

Additionally, 29 key informants were selected for a Key Informant Interview (KII) based on their activity in the SRHR field and their knowledge or experience with abortion and post-abortion care provision. Several key informants were purposefully sampled, while others became involved in the research after being identified through snowball sampling. The interviews with the key informants focused on their expertise in SRHR, abortion care and post-abortion care provision. This included their rationale for providing care, challenges they encountered in providing care, policies and guidelines, training and equipment in healthcare facilities, abortion and post-abortion services in the country, contraceptive counselling and their perspectives on unintended pregnancies and abortions (African Population and Health Research Center, Rutgers, and the Kilifi County Department of Health, 2021).

Table 2: Characteristics of Key Informants		Frequency (N=31
Role/position	CHV	4
	Community leader	1
	Healthcare provider (public/private)	11
	Pharmacist/drug vendor	6
	Traditional birth attendant	3
	Policy maker	4
	Teacher	1
	Prosecutor	1
Sex	Male	17
	Female	14

Lastly, 12 Focus Group Discussions (FDGs) were carried out in the communities of the two sub counties. Four of the FDGs included mixed groups of young men and women (18-24), four FDGs included mothers (30-55) with adolescent children and four FDGS included fathers (30-55) with adolescent children. To protect the young women that lived in the community and participated in the research, the research topic for the FDGs was formulated more broadly. Within the FDGs, the participants discussed the social and cultural dynamics regarding abortion, puberty and the transition to adulthood, perceptions towards unplanned pregnancies and abortions, parent-adolescent communication, sexual education, and reproductive decision-making. The FDGs were carried out in Kiswahili and Kigiriama and were later

transcribed in English (African Population and Health Research Center, Rutgers, and the Kilifi County Department of Health, 2021).

Data analysis

From May onwards, the data analysis of the observation notes, IDIs, KIIs and FDGs started. All the interviews and FDGs were audio recorded with the permission of the participants. These files were transcribed verbatim and translated into English if needed. On Wednesday, a weekly meeting was held with the team members that were involved in the data analysis, including myself. In May and June, we used these meetings to reflect upon the findings from the field shared on Monday, to draft the coding scheme, to get familiar with the coding software (Dedoose) and to identify interesting themes for the research report. For the development of the coding scheme both a deductive and inductive approach was used. We drafted the coding scheme departing from the theory outlined in the initial research proposal. While getting familiar with the data, the coding scheme was revised and expanded based on the themes emerging in the data. After checking the quality of the data, the files were uploaded in Dedoose. At the end of June, we started coding and used the weekly meeting on Wednesday to compare findings, adjust the coding scheme, share our reflections upon the findings and to receive feedback on our coded sections. The weekly meetings served as an important opportunity to ensure the consistency and quality of the coding approach between the different team members.

For my master's thesis, I selected several categories of data to inform my results and conclusions. Since my master's thesis aims to understand the perceptions and experiences of young women with unsafe abortion and the involvement of their male partner in their abortion, the observation notes of the research assistants and IDIs of the 54 young women that participated in the research form the backbone of my master's thesis. I analyzed the observation notes and IDIs in their totality for each participant to get an understanding of their complete abortion trajectory and the context in which this took place. Additionally, I selected several codes that corresponded to my research questions. These codes yielded excerpts of sections from the observation notes, IDIs, KIIs and FDGs that were assigned to that specific code. The excerpts provided an enormous database of ''snapshots'' and quotes that enabled me to study a specific theme in the coding scheme. Furthermore, I made use of the written case studies of the young women involved in the research. These case studies helped me to understand the complexity of young women's abortion experiences. Lastly, to complement the data gathered within the research project, I collected peer-reviewed articles to discuss my findings.

Conclusion

This chapter has outlined the methodology that has been used to answer the research questions within this research. The first section discusses the ''She makes her safe choice'' program and the 'Lived experiences, social determinants, and pathways to unsafe abortion of young women in Kenya and Benin'' research project within which this master's thesis research was conducted. The second section presents the background information in the research area: Kilifi County. Kilifi County is located on the coastal region of Kenya and is a key area to study unsafe abortion due to the high rates of teenage pregnancies, non-use of contraceptives and sexual risk behaviors that contribute to a high rate of unintended pregnancies that may end in an unsafe abortion. The third section outlines the setting of this master's thesis which was carried out under the supervision of Prof.dr.ir. Han van Dijk at the SDC chair group at the WUR and

with guidance of the research team from Rutgers and APHRC. Based on an internship contact I joined the research team in May 2021 and participated in the weekly meetings, coding, data analysis and report writing for the research project. The fourth section describes the data management and ethical guidelines that ensured the safety of the participants and data within the research project. The data yielded within the research project are anonymized and stored within a secured database at APHRC. During the research project all researchers made sure to adhere to the ethical principles of informed consent, voluntariness, privacy and confidentiality. Additionally, counselling was offered to the participants of the research project and the COVID-19 regulations were followed during the data collection. The fifth section discusses the data collection. January 2021 to July 2021, four research assistants were placed in the areas of Kilifi town, Gotani, Matsangoni and Mariakani to collect data within public and private healthcare facilities and the surrounding communities. During the data collection, the research assistants made use of participants observation, IDIs and FDGs to collect data. The last section outlines the data analysis, in which the research team made use of a coding scheme to code the transcribed observation notes, IDIs and FDGs. For my master's thesis, I selected various categories of data and codes to analyze to answer my research questions.

Results

The story of Naima

Growing up, life was difficult. My mother left us with our grandmother after she gave birth to my younger sister. For a while, my father raised us together with my grandmother, but that didn't last long. When he came to marry a new wife, his wife said she didn't want us…. So, he left with his new wife and never came back. Now it's just the three of us. Me, my younger sister, and my grandmother.

We had very little. We used to live in a mud house with a roof made from grass. There was not enough money to pay the school fees for me and my sister, so I dropped out when I was in form 2. I decided to look for work, so that I could provide for my family.

I started the job that I'm doing now when I was 17 years old. A friend of mine told me about this work and took me to Mombasa. She used to work there and told me there would be many customers who would want me. She was right. That day many customers wanted me because I was young and new. They were already used to the (sex) workers that were always there. I made a lot of money that day and came back home. That is when I decided to continue working as a sex worker.

The money is the only good part about this job. I bought an iron sheet for the roof, which was a great achievement. Also, I can pay the school fees for my younger sister. Nowadays she is completing the fourth form of high school already. She has been going to school because of this job.

I fell pregnant in December last year. I lost my appetite and anytime I would eat something I got nauseous. My periods are irregular and I could miss them sometimes for up to 6 months, but I started suspecting being pregnant because of the nausea. I went to the pharmacy and bought a pregnancy test. It came out positive. I thought about either raising the child or doing an abortion. Sometimes I would think about raising the child, but my capacity to raise the child was little. I would be making the child suffer.

At that time, I had a customer that was like a boyfriend. In most cases, I use condoms with my customers. When I meet with a customer, we agree on the price first. After we agree, I ask him if he has come with his own condom. I also carry condoms myself, but sometimes customers think that we have manipulated our condoms. Therefore, we ask them first to use theirs. After that we go and I am the one who puts on the condom for him so I am sure he has it. With frequent customers we do not use condoms, they are more like boyfriends. I suspected that one of them was the father, but I couldn't tell him. How do you tell a customer that you carry his child, yet he knows you sleep with many other men? He won't accept it. So, I didn't even tell them.

It was not my first abortion. About two years ago, I fell pregnant and used some medicine that my friend bought me (misoprostol) to terminate the pregnancy. This time, I decided to do the same. I paid my friend 5000 shillings and he got me the medicine. When I took it, I started cramping, it was very painful. I bled for three days and at that time my friend told me to go to the hospital. I went to the hospital to get an MVA. It's a private hospital. I couldn't go to the district hospital, because they will ask you too many questions there.

I felt bad about the abortion. I was thinking maybe I could have just raised the baby, but looking back there is already someone I need to take care of: my sister. It wasn't easy to make the decision, but in the end, I didn't want the child to suffer the way we suffered when our mother and father left.

Chapter 4: Unintended pregnancies

Introduction

At the start of young women's pathways towards an unsafe abortion, they usually experience an unintended pregnancy. In 2014, 35% of the pregnancies that occurred were reported by Kenyan women of reproductive age as either unwanted or mistimed (Kenya National Bureau of Statistics, 2014). Due to the restrictive abortion law in Kenya, it is hard to determine the precise number of unintended pregnancies that end up in abortions each year in Kenya (Hussain, 2012). However, in 2012, it was estimated that 41% of all unintended pregnancies that year ended up in an unsafe abortion (Mohamed et al., 2015).

Multiple studies have investigated the driving factors of unintended pregnancies in Kenya and other sub-Saharan African countries. Limited knowledge about contraceptives, limited use of contraceptives, limited access to family planning services, contraceptive failure, coerced contraceptive decision-making, sexual and gender-based violence, and various socio-economic determinants like socio-economic status, educational status, occupational status, residency, and age have been found to affect the prevalence of unintended pregnancies in this region (Ali et al., 2016 & Ameyaw et al., 2019).

This chapter will explore the domains that contributed to young women's unintended pregnancies in Kilifi County and the role male partners played in these domains. Within the data, three domains showed up repeatedly in young women's stories: contraceptive non-use, sexual violence, and transactional sex. Each of the following sections will discuss one of these domains making use of the fieldwork data from the research project and peer-reviewed literature to gain a full understanding of young women's experiences with unintended pregnancies in Kilifi County.

Unintended Pregnancy

Unintended pregnancy is commonly defined as a pregnancy that is either unplanned, mistimed or unwanted. Consequently, intended pregnancies are considered as planned, well-timed and wanted. Yet, dividing between unintended and intended pregnancies in this binary way is rather limiting. When women are indifferent about the pregnancy or when the pregnancy occurs later in life than the woman wanted, the pregnancy is still considered intended (Rehnström Loi, 2020). Moreover, perceptions and fertility aspirations can shift during the pregnancy. Life circumstances can change within a short span of time, making pregnancies that were ''intended'' at the moment of conception ''unintended'' as the pregnancy progresses (Mumah et al., 2014). Therefore, this chapter will consider all pregnancies that are or become unplanned, mistimed, or unwanted before and during the pregnancy as unintended pregnancies.

Contraceptive non-use

One of the most prominent reasons for unintended pregnancies within the research project was contraceptive non-use. Unintended pregnancies are strongly related to the unmet need for contraception in Kenya (Mumah et al., 2014). According to the most recent estimates (2014), 42% of women in Kenya have an unmet need for contraception. Women are considered to have an unmet need for contraception when they are currently not using any contraceptive method but do wish to postpone their next birth or limit their childbearing altogether (Kenya National

Bureau of Statistics, 2014). The unmet need for contraceptives in Kenya is highest among adolescents (15-19) and young women (20-29) (Population Reference Bureau, 2014). Additionally, women in rural areas, women with no education and women that fall within the lowest wealth quintile are more at risk for having an unmet need for contraception (Kenya National Bureau of Statistics, 2014).

Women with an unmet need for contraception report various reasons for not using contraceptives. In a comparison between Demographic and Health Surveys of 52 countries, Sedgh et al. (2016) found that many women did not use modern methods of contraception currently because of having concerns about the side effects of contraceptives, having infrequent sex or no sexual intercourse at all, not having resumed menstruation after birth and/or breast-feeding, being opposed to contraception or because of having someone close to them being opposed to their contraceptive use.

Young women participating in the research project offered similar reasons as for why they were not using contraceptives. However, they also gave insight into other factors that influenced their contraceptive non-use. Stigma and limited knowledge about contraceptives affected many young women's non-use of contraceptives besides the (anticipated) side effects and their partner's disapproval of contraception. Taken together, these four factors caused major barriers for young women to access and use contraceptives to prevent an unintended pregnancy.

Side effects

One of the reasons why young women did not use contraceptives at the moment that they fell pregnant was their experience with side effects while using such methods in the past. Young women cited experiencing stomach aches, irregular menstruations, breakthrough bleedings, headaches and weight gain or loss as side effects that caused them to discontinue their previous method of contraception. These side effects were mainly caused by hormonal contraceptive methods, like the pill, the injection, the implant, and the Intrauterine Device (IUD), which can cause several side effects related to the artificial hormones that they contain[5]. Some young women also noted that they were not keen on using condoms, since the ''oil'' (lubricant) of the condom caused them stomach aches.

Another issue regarding the side effects of modern contraceptives was the misinformation and myths that circulated in the community about the potential adverse effects that modern contraceptive methods could cause. These caused young women to fear that using contraceptives could lead to infertility, disease, or birth defects. Therefore, they abstained from using modern contraceptive methods altogether.

I had a discussion with a friend who had already had the injections, but for me I was afraid, I thought it might interfere with my reproductive system. […] I heard that with the use of the family planning methods you might have a baby born with some abnormities. (Mercy, 18 years old, primary school student, 16-07-2021)

Ochako et al. (2015) found the same relation between myths and misconceptions about modern contraceptive methods and the non-use of contraceptives in the Nyanza, Coast, and Central regions of Kenya. Adolescent girls and young women rely heavily on their social network to access information about the use of modern contraceptive methods. Their peers and partners form an important source of information to learn about the true and fictional side-effects of modern contraceptive methods. Without prior or adequate information about modern

[5] For an elaborate overview of side effects of hormonal contraceptive methods see: Sabatini R., Cagiano R. & Rabe, T. (2011). Adverse Effects of Hormonal Contraception. Journal of Reproductive Medicine and *Endocrinology, 8*(1), 130-156.

contraceptives from other sources, it becomes difficult for young women to distinguish which information is correct. Therefore, misinformation about the presumed harmful side effects of modern contraceptive methods in these regions caused adolescent girls and young women to shun the use of modern contraceptive methods which led to a higher risk of unintended pregnancies.

Contraceptive knowledge

A second reason for contraceptive non-use that young women offered was the level of knowledge they possessed about contraception. Even though most young women that participated in the research project had heard of various contraceptive methods, the amount and quality of information they possessed about contraception varied. Some young women had received detailed information about the types of contraceptives that are available, how to use them and how to access them. However, a large share of the young women reported that they knew nothing or very little about contraception before they fell pregnant. In such cases, they had been told about the existence of contraceptives, but had received too little information on how they are supposed to be used and where they are available.

I did not have knowledge of anything. I did not know people are supposed to use protection. [….] He (boyfriend) was just telling me that we need to be using protection, but I wasn't understanding. Even though I have gone to school and I have been told about contraceptives, you know there is practical and there is theory. When you have experience you know, but when you don't, it is hard to understand. (Faith, 16 years old, primary school student, 23-06-2021)

In an evaluation of Comprehensive Sexual Education (CSE) curricula in 60 secondary schools in Kenya, Sidze et al. (2017) found that key topics such as reproduction, STI's, abortion, access to condoms and sexual health services, adequate information about contraceptive use and sexual violence were often excluded from the curriculum in favor of promoting abstinence. Indeed, many adolescent students indicated that they wished for more information on contraceptives, including how to use and access them. However, a large share of the teachers responsible for teaching the CSE classes indicated they felt uncomfortable about discussing sexual matters with student due to religious and cultural beliefs. Some opposed to the inclusion of information about contraceptives because they perceived this would encourage students to engage in sexual relationships. Consequently, some of the messages conveyed in the classroom about sex and sexuality were fear-inducing and judgmental, emphasizing that sex is dangerous and immoral. The implementation of Comprehensive Sexual Education in schools, thus, remains a challenge. With schools being a primary source of sexual education, it is important to improve the contents of the school curriculum in order to help adolescents live healthy sexual and reproductive lives (Sidze et al., 2017).

Apart from the school curriculum, young women received information about contraception from their family members, peers, doctors, Community Health Volunteers (CHV's), Non-Governmental Organizations (NGO's) and their local church. This variety of information sources would sometimes bring forward conflicting or confusing messages about sexuality and contraception. Whereas some sources promoted the use of contraceptives and safe sex, other sources encouraged abstinence, questioned the morality of sex before marriage and warned against the potential side effects of contraceptives. This left young women questioning whether contraceptives were the right choice for them. Additionally, some young women wondered if contraceptives were even meant for them as it was often referred to as 'family planning' yet they did not want to start with planning a family. Altogether, the limited and conflicting information young women received influenced their uptake of contraceptives.

There was the urge to have sex, but we first had to discuss on what to do to prevent a pregnancy. He suggested to use family planning, but I declined since I had no family. Therefore, we mostly use the withdrawal method and a condom. (Kabibi, 22 years old, college student, 28-04-2021)

Stigma

For many young women, stigma proved to be an important factor that prevented them from accessing and using contraceptives. They noted that within their community, the use of contraceptives is deemed inappropriate and shameful for young and unmarried women. Young and unmarried women that are known to use contraceptives are seen as promiscuous, unfaithful, ''slutty'' or believed to be prostitutes.

Participant FDG youths: Those who use family planning and are not married have different names that they can be called. They can be called "vicheche" (zorilles) or prostitutes or "vipikipiki" (motorbikes).

Interviewer: Why motor bike?

Participant FDG youths: You know the motor bike anyone can climb on it, that's where they get those names.

(FDG youths, participant, 29-06-2021)

To avoid such stigmatization, young women would not visit family planning services or seek contraceptive counselling in healthcare facilities as they were afraid that they might be seen by friends, family, or community members. Young women that did enter family planning services or contraceptive counselling could also experience stigmatizing attitudes from healthcare providers that offered these services and were denied care based on their age of marital status. This would prevent them from obtaining their preferred contraceptive method or any contraceptive method at all.

There are health care providers who are old and who are judgmental. They see you and say that you are a young person and you have not given birth yet. So, they tell you to go back and wait for your time. (Key informant interview, representative community center, 10-06-2021)

Håkansson et al. (2018) confirm that the personal beliefs of healthcare providers often clash with the human rights of young and unmarried women that seek contraceptive services. 32% of the healthcare workers questioned about their beliefs on contraception indicated that young women that use contraceptives are promiscuous. 39 % believed that young women that use contraceptives will encourage other women to engage in a promiscuous lifestyle. 36% believed that contraceptives should only be available for married women and 32% found that adolescent girls (15-19) are too young to make the decision whether they should use contraception. These stigmatizing beliefs among healthcare providers can form an additional barrier for young women to access contraceptives

One modern method of contraception that was more frequently used among the young women despite the persisting stigma on contraception, was the emergency contraceptive pill. Some young women exclusively relied on the emergency contraceptive pill as their method of contraception and used it frequently. Even though emergency contraceptive pills were not intended for regular use when they were developed, they have been found to be used as a regular method of contraception in various sub-Saharan countries (Both, 2013). A study carried out by Keesbury et al. (2011) in the Nairobi, Coast, Rift Valley, Nyanza, and Western regions of Kenya found that the majority (58%) of emergency contraceptive buyers had bought emergency contraceptives twice or more in the preceding month. In Ethiopia, emergency contraceptive pills were considered as more discreet method of contraception. Emergency

contraceptive pills only have to be taken once and young women can therefore quickly dispose of the box and pill strip to keep their use hidden. Additionally, emergency contraceptive pills can be bought by male partners in drug stores and pharmacies in cases where young women are too scared to buy emergency contraceptive pills themselves (Both, 2015). This might explain the use of emergency contraceptive pills by young women in Kilifi County as a strategic way to avoid stigma.

Male partners and contraceptive non-use

Besides side-effects, limited knowledge on contraceptives and stigma, male partners played an important role in young women's non-use of contraceptives. When it comes to contraceptive use, male partners are generally the primary decision-makers in sexual relationships in Kenya to determine whether to use contraceptives, which methods of contraception to use and when to use contraceptives (Harrington et al., 2016). In many of their sexual relationships, young women indicated that the use of contraceptives had to be discussed with and approved by their male partners. Some young women stated explicitly that they first had to ask permission from their male partner if they wanted to start using a contraceptive.

Elvinah: I just want to use the family planning, but I must consult my boyfriend and see his view.

Interviewer: Are you now using any family planning method?

Elvinah: I'm not using any method

Interviewer: Why are you not using family planning?

Elvinah: I want to talk to my boyfriend first, because I cannot do anything without involving him.

(Elvinah, 29 years old, unemployed, 07-06-2021)

Many young women indicated that their main method of contraception before falling pregnant were condoms. Yet, the use and availability of condoms was often dependent upon their male partner. The willingness of male partners to use condoms is an important factor to prevent unintended pregnancies. However, in many cases male partners were not in favor of using condoms (regularly), which left young women vulnerable to unprotected sex if they were not able to convince their partner to use a condom.

Most of the time when you are having sex with your boyfriends, they refuse to use condoms. That is what happened to me personally and that is how I got my first child. (FDG youths, participant, 28-06-2021)

Ngure et al. (2012) found that male partners in Human Immunodeficiency Virus (HIV) -1 serodiscordant couples in Kenya were reluctant to use condoms even though condoms prevent HIV-1 transmission because they claimed condoms reduced sexual pleasure. Most of these male partners reported that they did not feel 'sexually satisfied' when they used a condom. In addition to this, female partners in the same couples indicated they struggled to negotiate condom use as this might lead to arguments, withholding of economic support and verbal or physical abuse.

Some young women navigated their male partner's reluctance to use condoms by withholding sex until their male partner agreed to use a condom. ''No condom, no sex'' served as leverage in the couple's negotiations about condom use.

For several young women, the negotiations about contraceptive use proved to be quite dynamic. Their male partners sometimes encouraged certain methods of contraception while

refusing other methods of contraception. Male partners tended to refuse the use the long-term contraceptive methods such as the contraceptive pill or the IUD, but encouraged the use of emergency pills, withdrawal, or fertility awareness approaches. This meant that young women had to rely on less effective methods of contraception to prevent an unintended pregnancy. Harrington et al. (2016) uncovered that one of the main reasons why Kenyan men refused long-term contraceptive use by their female partners was the belief that such methods lead to infidelity. Out of fear for infidelity by their female partner, male partners therefore restricted the use of those contraceptive methods.

To avoid pregnancy despite their male partner's disapproval and reluctance to use contraceptives, a few young women opted to use contraceptives secretly. Young women that choose to use contraceptives without their partner's knowledge often opted for 3-monthly injections since they were easily concealed.

He said that he does not like them (contraceptives) and that they make a woman cold and come with some complications. But after the abortion incident, I have been thinking about ways to avoid a recurrence of it. Recently I decided to go with my friend to the dispensary to get a three months injection plan which he does not know about and I will not tell it to him. (Naomi, 18 years old, primary school student, 09-06-2021)

Covert contraceptive use can be seen as a practical strategy to navigate power imbalances within relationships (Blanc, 2001). However, even though covert contraceptive use might be seen as a form of autonomous decision-making Harrington et al. (2016) found that many women did not feel empowered by this strategy. On the contrary, women indicated feeling guilty and afraid in case their male partner might uncover their contraceptive use. Therefore, even though covert contraception use is an effective strategy to bypass male partners' influence over contraceptive use, it is often not a long-lasting solution.

Sexual violence

In addition to contraceptive non-use, sexual violence played a key role in the prevalence of unintended pregnancies within the research project. The World Health Organization (WHO) defines sexual violence as: ''Any sexual act, attempt to obtain a sexual act, unwanted sexual comments, or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (World Health Organization, 2011). Sexual violence can lead to unintended pregnancies through the non-use of contraceptives, non-reporting of incidences of sexual violence and a lack of adequate care to address the potential impacts of sexual violence. Perpetrators of rape are, for example, not likely to use condoms which increases the risk of unintended pregnancies significantly. Additionally, stigma often prevents victims of sexual violence to report the incident or even mention it to other people. The lack of reporting incidents of sexual violence diminishes victims' chances to receive the necessary care to avoid unintended pregnancies resulting from sexual violence (Ajayi & Ezegbe, 2020).

The Kenyan Demographic and Health Survey (KDHS) of 2014 shows that 14% of women aged 15-49 have experienced sexual violence at least once in their lifetime (Kenya National Bureau of Statistics, 2014). However, underreporting is a big issue in gathering reliable data on the prevalence of sexual violence (Maternowska et. al., 2009). Perpetrators of sexual violence are often close to the victim, which can make it very complicated for victims or sexual violence to come forward and report the perpetrator. Moreover, in cases where perpetrators are close to the victim, the risk of repeat incidents of sexual violence increases. (Ajayi & Ezegbe, 2020).

Data about the repetition of sexual violence is unfortunately not gathered in the KDHS, but among the women who reported sexual violence in the KDHS, 77.3% indicated that their current or former partner (husband/boyfriend) was the person that committed sexual violence against them (Kenya National Bureau of Statistics, 2014).

The link between sexual violence and unintended pregnancy comes up in various ways in the stories of the young women that participated in the research project. Most of them indicated that they felt pressured to engage in sexual acts with their partner before they fell pregnant. In these cases, young women experienced sexual coercion, which caused them to engage in unprotected sex per their male partners wish. Sexual coercion can be understood as a variety of non-physical means and behaviors such as verbal pressure, lying, manipulation, arguments, and threats to obtain sexual acts without voluntary, expressed consent. Also, the intentional use of alcohol or drugs to impair the victim's judgement or resistance to sexual advances is included under this definition of sexual coercion (DeGue & DiLillo, 2005).

[Abstinence] is a good thing, but it depends upon your boyfriend. Sometimes he will request you to visit and when you refuse to have sex, he will get angry. Other times, he tells you to count your safe days and when you are safe you can visit. However, sometimes he will call you when your days are unsafe and he will insist that you must visit him [to have sex]. (Elvinah, 29 years old, unemployed, 07-06-2021)

Additionally, young women were very vulnerable to sexual violence when there were disparities between age and social status between them and the perpetrator. Authoritative figures, like teachers, community leaders and religious leaders, can abuse their position to exploit young women.

Elvinah: The male teachers used to have a romantic relationship with the pupils and when you refuse to be in a relationship with him, he ends up awarding you small marks in the examination.

Interviewer: Did it ever happen to you?

Elvinah: Yes, it ever happened to me. I tried to refuse, but when he continued, I told my parent about the situation. She accompanied me to my school, but when the teacher was approached, he denied it. I didn't lose hope despite him awarding me small marks. I encouraged myself that he wouldn't mark the final national examination, rather it will be marked at the examination center.

(Elvinah, 29 years old, unemployed, 07-06-2021)

Within the research project it became apparent that especially adolescent girls and young women were very vulnerable to experiencing sexual violence. Many documented cases of sexual violence, both within the healthcare facilities and in the community, concerned girls below the age of 18. This is in line with the data presented in the 2019 Kenya Violence Against Children and Youth Survey. The survey found that 15.6 % of young women (18-24 years old) experienced sexual violence before age 18 with 62.6% reporting multiple incidents of sexual violence begore age 18. Additionally, 13.5% of girls (aged 13-17) experienced sexual violence in the past 12 months. Furthermore, among girls (aged 13-17) who ever had sex, 33.7% indicated that their first sexual experience was pressured or physically forced. The most likely perpetrators of sexual violence against young women participating in the survey were spouses/boyfriends, classmates/schoolmates, male family members, neighbors, or friends (Ministry of Labor and Social Protection Kenya: Department of Children's services, 2020)

Where I am from, there is an old man who only had 9 daughters. God blessed with him with girls alone. He said, "There is no way any man will enjoy my girls before I can experience

them." So, every girl passed through him. He broke their virginity before they left for their own marriages. Since he raised them, he enjoyed them before a man who has not even raised them will." (FDG mothers, participant, 23-06-2021)

Since the start of the COVID-19 pandemic, many organizations and researchers have raised the alarm that the number of sexual violence cases has increased drastically. Due to the lockdown, curfew and the closure of schools, minors were more likely to be attacked during daytime in a private location by someone they knew in comparison to statistics gathered before the pandemic (Rockowitz et. al., 2021). In line with these findings, research carried out in 12 secondary schools in rural Western Kenya found that girls in the COVID-19 cohort who experienced school interruption due to COVID-19 containments measurements were twice more likely to fall pregnant before graduating compared to the cohort that graduated in November 2019 pre-pandemic. Additionally, girls in the COVID-19 cohort were more likely to be sexually active and less likely to report their sexual encounters as desired (Zulaika et. al., 2022). The COVID-19 pandemic thus has had detrimental effects on girls' experiences with sexual violence and unintended pregnancies.

We had closed schools; my mother would leave me at my grandmother's during the day when she goes do casual jobs in the market. Then my aunt's boy started calling me in to his room. The first day he asked me if I have ever done (sex). I told him I have never. He told me he would teach me, but I refused and went outside to play. Then another day he called me and told me that when he touches my breast, they will grow big. He asked me to remove my sweater and he touched me and told me not to tell anyone it is our secret. Then later in the evening he called me and removed my underwear and then he had sex with me. (Public facility observation notes Jane, patient admitted for PAC, 2021-06-21)

Five young women participating in the research project directly fell pregnant after experiencing defilement and/or rape. Four underage girls, aged 14, 15, 16 and 18 were violated by an adult male perpetrator, which classifies these cases as defilement under Kenyan law. According to Kenyan law, sexual intercourse with a child under the age of 18 years old, regardless whether the child consents, is considered defilement and therefore punishable with imprisonment for at least 15 years (National Council for Law Reporting, 2006). All four girls fell pregnant unintendedly and ended up having an unsafe abortion. In the last case, a young woman (20) was repeatedly abused and raped by her father. She fell pregnant and was forced by her father to undergo an abortion. She was introduced to one of the research assistants by a local CHV after she had run away from her home and was staying at a village elder's house. Her father had tied her up and severely burned her along her inner thighs, vulva, and lower back.

Rehema's mother explains: He (my husband) left me sleeping and went to the children's room and told Rehema to come. She asked him where are we going? What is happening where we are going? He was holding a knife and a panga and was threatening her. He told her sleep here and Rehema laid down and he did what he wanted to do to her. After that he told her don't say, don't talk to anyone. (Interview mother Rehema, 14-06-2021)

At the time of the research project, her father was arrested and the case was pending in court. Yet, throughout the research project, it became clear that the father will likely be released without persecution.

I hear that my father will be released. They (family members) are selling a cow so that they can release him. […] My father told me that that if he will be released that he will finish me. I never even go home, why should I? My mother and siblings can come to visit me if they want to see me. (Rehema, 20 years old, unemployed, 12-04-2021)

In many cases of sexual violence, legal persecution of perpetrators is halted before or after perpetrators get arrested. Many perpetrators or families of perpetrators bribe the authorities to avoid jail. Furthermore, cases of sexual violence are often settled between families of the victim and the perpetrator by means of (financial) compensation or forced marriage (Munala et. al., 2020).

Transactional sex

Lastly commercial and transactional sex was an important factor that contributed to young women's unintended pregnancies within the research project. For most young women that participated in the research project, economic hardship was a feature of their daily lives. Many of them grew up in households where income was not secure or fluctuated during the seasons. Most of their parents and caretakers made a living by doing casual labor, seasonal labor and menial jobs or were unemployed. Consequently, 19 out of the 54 young women dropped out of school to work and contribute to the household income. The most common jobs included washing clothes or fetching water for other families, casual farm work, weaving palm leaves, selling cashew nuts, housekeeping, waitressing, and braiding hair. On average these jobs earned them between 100 and 300 Kenyan Shillings (1-3 USD) a day which was essential to pay for rent, food, sanitary products, and clothes.

I went to school up to form two, then I dropped out. We are two in our family and at that time we couldn't afford school fees for both me and my little sister, so I had to drop out of school for her to finish her studies. So, I started working here so that I can get to provide for my family. (Monica, 23 years old, sex worker, 19-05-2021)

Within the research project, several young women engaged in commercial and transactional sexual relationships to navigate the economic challenges that they faced. Even though the terms ''commercial sex work'' and ''transactional sex'' overlap, they are often distinguished in the literature. Commercial sex work is usually seen as a formal occupation in which commercial sex workers exchange sexual services for pre-negotiated monetary or material compensations. Transactional sex is commonly understood as a noncommercial relationship that is motivated by the implicit assumption that sex will be exchanged for material support or other benefits. Transactional sex typically lacks formality and can also occur in ongoing relationships (Zamudio-Haas et. al, 2020; Stoebenau et. al., 2016). Four of the research participants engaged in commercial sex work to generate their daily income. Several other young women engaged in transactional sex to complement their primary income or gather an income while going to school.

It is not like I do it (transactional sex) every day. Sometimes I work as a waitress in a small café in Kilifi town and during those times I always have enough money for my upkeep so I see no need to go around chasing men. (Jane, 23 years old, sex worker, 29-05-2021)

Munala et. al. (2023) identified several reasons why young women would engage in transactional sexual relationships. The first and foremost reason for engaging in transactional sex were material/basic needs. Money, clothes, food, and other gifts were common incentives for young women to engage in transactional sex. An additional reason were school-related influences. School going girls indicated that transactional sex partners paid for their school fees and that sexual relations with teachers may result in special treatment and better grades. Parental influences were found to as another reason to engage in transactional sex. In cases where parents experienced poverty, young women could be indirectly or directly pressured to engage in transactional sex to contribute to the household income. Additionally, a lack of parental guidance and neglect could make young women more vulnerable to be persuaded to

engage in transactional sex. A further reason that was found to contribute to transactional sex was peer pressure. Schoolgirls explained that when their peers engaged in transactional sex it could feel as the norm and wanting to fit in, they would seek out potential partners for a transactional relationship. The last reason why young women engaged in transactional sex was their vulnerability to perpetrators. Men with high positions, like teachers, police officers and doctors, hold more power and have easier access to young women that are vulnerable to be pressured into transactional sexual relationships.

For young women that engaged in commercial or transactional sexual relationships during the research project, basic material needs were the most prominent reason to enter a transactional relationship. Multiple young women started relationships with male partners that they had no interest in because they could provide them with money, menstrual pads, food, clothes, and other items that they needed in their daily lives.

Interviewer: You told me you had started a relationship with him because you were suffering, and let me ask you, were you the one who asked to be in a relationship or was he seducing you?

Miriam: He was seducing me.

Interviewer: When he was seducing you, did you agree to date him directly or when you saw the problems?

Miriam: At first, I stayed distant and then when I saw that my problems are getting bigger, I had no choice but to accept him.

I: So, if the problems were not there, you wouldn't have accepted him?

P: I wouldn't have accepted him.

(Miriam, 20 years old, unemployed, 15-07-2021)

Young women in Kilifi County mostly mentioned the direct and indirect pressure from their family as a reason to engage in transactional sex. Especially when households lacked basic resources, young women could be encouraged to engage in transactional sex to support their own or their family's (basic) needs. Even community members and healthcare providers recognized that young women coming from poor backgrounds could experience immense pressure to contribute to the household income by any means necessary.

The mother takes that money and uses it without asking the child where the money came from. Later, when she (the mother) hears the child is pregnant. [She asks] "Where did you get the pregnancy?" [….] That has happened. A child in 6th grade, experienced something like that. When she was asked, she said it is because of the problems they have at home, there is no food. The child was sleeping with someone and given money; she brought the money to the mother so they can buy flour. Just like that, until the child got pregnant and gave birth. Right now, the baby is grown. (FDG mothers, participant, 23-06-2021)

Even though commercial and transactional sexual relationships can give young women access to (financial) resources, they can pose serious risks and consequences for young women's sexual and reproductive health. In Kenya, commercial and transactional sex has long been linked to the pervasiveness of unintended pregnancies, unsafe abortions, and the spread of HIV and other STI's (Dunkle et. al., 2004; Robinson & Yeh, 2011). Additionally, women engaging in commercial and transactional sex have a higher risk for experiencing gender-based violence (Munala et. al., 2023), stigma and social exclusion (Fielding-Miller et. al., 2016).

[I don't like] the discrimination that comes with being a prostitute. You know I am a sex worker; I sell to people per shot, but when people go home and tell my grandmother I am a prostitute, it is bad. [….] When people know you are a prostitute, they do not want to associate with you. So that is the thing I don't like about it." (Monica, 23 years old, sex worker, 19-05-2021)

Underlying power imbalances that characterize many commercial and transactional sexual relationships make it hard for young women to negotiate safe sex and make them more vulnerable to violence and abuse. Disparities in wealth, age and social status can make it difficult for women to negotiate the use of condoms and the time, place, and circumstances under which the transaction takes place (Zamudio-Haas et. al., 2020). Additionally, pressing need for (financial) resources can make women more likely to engage in risky sexual acts that are better compensated. A study carried out by Robinson and Yeh (2011) in Busia, Kenya, found that women that engaged in commercial and transactional sex were more likely to supply risky, better compensated sex to cope with unexpected health shocks. Particularly, when another household member fell ill, women were more likely to engage in sex without a condom to earn more money to pay for treatment.

Even though young women participating in the research project were aware of some of the risks related to commercial and transactional sexual relationships, it appeared that the nature of the relationship mitigated young women's perceptions of risk. If the relationship was more serious or more frequent, young women would more often have sex without a condom. For example, commercial sex workers were more likely to engage in unprotected sex with regular clients. Occasionally, both parties would go for a HIV test before having unprotected sex, yet this was not always a prerequisite.

Most of the time, I would use a condom, but sometimes I go without when the client has offered good money or you have built trust in them and mostly it is with those that are constantly seeking services from me. (Jane, 23 years old, sex worker, 29-05-2021)

Conclusion

Unintended pregnancies are a leading cause of unsafe abortions in Kenya. This chapter explored the domains that contributed to young women's unintended pregnancies in Kilifi County and the role male partners played in these domains.

Three domains that contributed to young women's unintended pregnancies showed up repeatedly in young women's stories: contraceptive non-use, sexual violence, and transactional sex. According to young women, side effects, their level of knowledge about contraception, stigma and the disapproval of their male partner were important factors that caused them to abstain from using contraceptives. For multiple young women, contraceptive non-use led to their unintended pregnancy. In addition to contraceptive non-use, sexual violence was a reoccurring theme in young women's stories about their unintended pregnancies in Kilifi County. Within the research project, multiple young women experienced physical or non-physical force to engage in sexual acts which caused them to fall pregnant unintendedly. Several young women fell pregnant unintendedly after experiencing (multiple accounts) of sexual violence. Lastly, various young women in Kilifi County experienced unintended pregnancies within commercial or transactional sexual relationships. Within commercial and transactional sexual relationships, young women encountered difficulties to negotiate safe sex as there was often a disparity in wealth, age and social status between young women and their male transactional partner/clients. For multiple young women this resulted in an unintended pregnancy.

The story of Zahra

I met my ex-boyfriend when I was still in primary school. I was 17 at the time and he was 21. To be honest, in the beginning I wasn't very interested in starting a relationship with him. But you know how it goes. There is a lot of peer pressure in high school and this guy was handsome, so we started dating. We stayed together until we saw each other's bodies (had sex). That is when I accidentally fell pregnant.

A month after we had sex, I did not have my period. I was very worried and didn't understand why I did not bleed. I discussed it with my friends at school who told me: "If you did 'it'(sex), you can be pregnant." They advised me to take a pregnancy test, so that is what I did. I took a test and it was positive. After I took the test, I called my boyfriend. I told him about the pregnancy test and he started questioning me. He said: "What are you saying? You don't have your period, why? When was the last time I saw you?". The way he responded was very hurtful and it made me feel like I was really stupid.

I bought another pregnancy test and two days later I called him again. I told him that I was really pregnant. He still didn't believe me. He told me: "Look, it is over between me and you. You should search for the one who made you pregnant. I don't want to be mentioned in your household. Do what you want to do with the pregnancy. You will figure it out yourself and solve that issue, but for now I am not ready to be a father." It made me feel so bad. I felt so alone.

I knew an abortion would be an option, even though it is well-known that you may give your goodbyes to the world (die) when you plan to do an abortion. Besides, in high school we were taught that abortion was a crime. However, I still considered it because my boyfriend refused to raise the child with me. I wanted to keep the child, but what would I tell the child when he was older? At some point, he would want to know his dad. What would I say then? My parents were another issue. My mom may have killed me if she knew I was pregnant. I knew it was dangerous, but I had to look for a way to terminate the pregnancy.

I decided to ask my friend in the village. She is a bit older than me and might know what I should do. She told me: "Because the pregnancy is very young, you can use shubiri (traditional medicine)". I went to her house and she boiled the shubiri for me. After I drank the brew, my stomach stated aching. It ached so badly! My friend told me not to shout, because other people would hear me and would want to know what was happening. I was in pain, but what could I do? I preserved, until at last, I started bleeding. The blood came out in big cloths, like pieces of liver. I was very scared. Although I committed a sin, I prayed to God to help me. I stayed at my friend's house until the bleeding stopped.

After I went home, the bleeding and stomach cramps started again. I went back to my friend's house and she told me that I should go to the hospital. I didn't want to go to the hospital. How would I face the doctor there and tell him what I had done? I didn't have the courage. My friend gave me some pads to wear for the bleeding, but after 2 more weeks the blood was still flowing and my stomach was in a lot of pain. I went to my friend again and she went to the hospital on my behalf. She came back with some pills (most likely misoprostol). After I took them, I finally felt some relief.

In the end, even though I survived, it affected me a lot. I fell behind in school and dropped out. I couldn't focus on my studies; I was constantly thinking about the abortion and the pain. I still wonder why he (boyfriend) dumped me. What was my mistake or where did I go wrong? Why did he do that? Now, I don't want any other relationship. If this is what relationships lead to, I don't want them again.

Chapter 5: Abortion decision-making

Introduction

On their pathway towards an abortion, young women move through a period of decision-making in which they evaluate if they want to proceed with their unintended pregnancy or pursue an abortion. This period is characterized by multiple processes and transitions that influence the eventual abortion decision. For many young women, the decision-making process starts when they become aware of the pregnancy and ends when the final decision is made. In between, young women may reflect upon their emotions about the unintended pregnancy, share the pregnancy news with other actors and weigh different factors that influence their choice to pursue an abortion. Male partners can become actively or passively involved in the decision-making process. Their actions, lack of action or anticipated actions can influence the abortion decision significantly.

This chapter will describe the abortion decision-making process that young women in Kilifi County go through before undergoing an abortion. The chapter will be divided in sections that will discuss the pregnancy recognition, young women's feelings about their unintended pregnancy, sharing the pregnancy news, factors contributing to the abortion decision and the influence of their male partners on the abortion decision. Even though it might appear that these events succeed each other in a consecutive way, it is important to note that decision-making is not a linear process. Young women can go back and forth between the different stages of making the decision and their initial insights, feelings and thoughts can change throughout this process.

Pregnancy recognition

Most young women started to suspect that they could be pregnant based on various physical symptoms that they recognized as signs of a pregnancy. Many young women indicated they missed their menstrual period for one or two months, which was often the first sign of pregnancy that they recognized. In addition, they described that they felt nauseous, fatigued, dizzy and experienced stomach aches, headaches, tender breasts, or a changed appetite. For many young women, a combination of these symptoms would strengthen their suspicions about a potential pregnancy.

However, some young women did not recognize the initial physical symptoms of a pregnancy. In these cases, they could describe the symptoms to a trusted actor in their social network who would point out that they might be pregnant. In this way, male partners could become involved in the pregnancy recognition. Young women would describe their symptoms to their male partner as they believed they might be ill. Some male partners would recognize the symptoms their partner experienced and were the first ones to recognize that she was pregnant.

To confirm the pregnancy, young women usually would take a pregnancy test. The costs of a pregnancy test ranged from 50 to 100 KSh per test. In those cases where young women shared their suspicions about the pregnancy with their male partner, their male partner could be a source of financial support and information to buy and carry out the pregnancy test. Male partners could provide the money to cover the costs of a pregnancy test or were, in several occasions, the ones who went to the pharmacy to buy a pregnancy test themselves. For some young women buying a pregnancy test was a difficult affair because they feared they would be recognized by shop owners, community members or friends who might spread they rumor that they were pregnant. In those cases, male partners could be very helpful by going to the

pharmacy and buying a pregnancy test on young women's behalf. Occasionally, male partners were also a source of information and explained their female partner how to use a pregnancy test if she had no prior experience with taking a pregnancy test before.

Interviewer: Did you do a pregnancy test?

Mercy: Yes,

Interviewer: How did you test?

Mercy: My boyfriend brought me the test kit and explained how to use it.

Interviewer: Had you told him that you might be pregnant?

Mercy: yes, I told him that I had missed my period

(Mercy, 18 years old, primary school student, 16-07-2021)

In a few cases, neither the young woman nor her male partner would recognize the pregnancy symptoms. In those cases, when a girl or young woman would describe the physical symptoms she experienced to her male partner, he would either refer her to the hospital or take her there himself. In the medical health center, the healthcare provider would be the one to recognize the pregnancy symptoms and run a pregnancy test.

When my mates were going to church, I felt sick, so I decided to buy malaria drugs from the chemist. But after finishing the dose I was still feeling sick. So, the boy was looking for me because I wasn't visiting him. I told him I am not well. He told me he would take me to a clinic near his home where he has a friend. They tested malaria and it was negative so they tested pregnancy. They used my urine and a strip and they tested it and it came out positive. (Brenda, 18 years old, high school student, 05-05-2021)

Initial feelings about the pregnancy

When young women confirmed that they were pregnant, they experienced a wide range of emotions. Some of them reported feeling happy and excited, especially when they expected a positive reaction and support from their male partner to raise the child. However, many young women described that they ''felt bad'' about the pregnancy. They expressed feeling stressed, sad, shocked, and worried about the implications of the pregnancy on their future and the reaction of their family, friends, and male partners towards their pregnancy. Unmarried young women could also experience shame. Premarital pregnancies are highly stigmatized in Kenyan society and they were scared to bring shame upon themselves or their family if their pregnancy would be discovered.

"After I tested, I freaked out and started crying. I cried. People feel happy, but I cried. I was shocked because I was not expecting it. If I would go home, what was I going to tell my parents?" (Chemu, 23 years old, college student, 05-07-2021)

Taken together, the emotions young women experienced could be fluctuating and ambivalent. Young women could, for example, feel happy but worried at the same time when they fell pregnant. Moreover, their feelings about the pregnancy could change suddenly in response to changes in their circumstances or environment. This frequently left young women feeling confused and uncertain about the future of their pregnancy.

I was wondering how it will be. If I keep the pregnancy, how will it be? Will I go to my boyfriend? He is studying and it's not like we are prepared for this. I was also thinking on the

other hand, if I remove it my life may end there. My boyfriend will find another wife, so will I do this or that? You get me? You find yourself tearing up, but there is no solution. You have to think of what to do. (Kabibi, 22 years old, college student, 13-07-2021)

Sharing the news

After confirming the pregnancy, many young women opted to share the pregnancy news with their male partner. Some male partners were directly informed after the pregnancy was confirmed, while other male partners were in the dark about the pregnancy for a couple of days or even weeks. This often depended on the reaction young women expected from their male partners when they shared the news. When young women expected a positive reaction from their male partner, they often involved him as soon as they suspected being pregnant or confirmed the pregnancy.

When they (nurses) told me about the results [of the pregnancy test] it was stressful. But at that time, I knew someone would support me, so I felt okay about that. When I went back home, I called him (boyfriend), but he turned against me. That made me really confused. (Lucy, 24 years old, manual laborer, 28-04-2021)

In other cases, young women anticipated a negative reaction from their male partner and were more reluctant to share the pregnancy news. Some young women postponed sharing the news for a while, while others opted to tell their male partner about their pregnancy via a phone call or by enlisting the help of a friend to share the news on their behalf.

I shared what I was going through with my best friend. She told me that crying was not a solution and that I should tell the person involved so that we can decide on what to do. I did not know where to start, I was scared he couldn't understand me because I had taken pills [emergency contraceptive pill] and he was certain nothing would happen. Therefore, I requested her to tell him on my behalf because I didn't know how to tell to him. (Kabibi, 22 years old, college student, 28-04-2021)

Several young women made the decision to not inform their male partner at all about the pregnancy. In some cases, they did share the news with other actors in their social network to seek advice and support, but a few young women kept the pregnancy a secret from everyone until they made their abortion decision or even until after the abortion itself. Fear was the main reason to keep the pregnancy hidden. Young women shared that they were scared for verbal or physical abuse from their parents, siblings, other family members, male partners, friends, and community members if they would reveal their pregnancy. These young women made the decision to procure an abortion on their own, but were influenced in their decision-making by the anticipated reactions of actors within their social environment.

Factors influencing the abortion decision

During the decision-making process, young women considered various factors that influenced their abortion decision. Young women frequently cited education, stigma, forced marriages, economic circumstances, and the reaction of their male partner towards the pregnancy as factors that influenced their abortion decision.

Education

For many young women being able to continue their education was an important factor to consider an abortion. They shared that they were worried about dropping out of school if they gave birth because combining childcare with their education would be difficult.

I was considering to give birth and then to go back to school. But then I asked myself, if I keep the pregnancy now, where will I go? And how will it be when I come back and start all over again. So, I felt it would be hard for me to go back to school and I might even drop out. (Crystal, 17 years old, high school student, 06-06-2021)

Additionally, several young women were afraid to receive negative reactions from their teachers and classmates if they showed up at school while being pregnant. Therefore, they would skip school to hide their pregnancy and considered an abortion to be able to go to school again without being shamed. Others young women indicated that they would have been forced to drop out of school because their parents, siblings or other family members would not continue to pay their school fees if they were pregnant. Discontinuing paying school fees was a warning that parents and caretakers often gave their daughters in order to encourage them to abstain from engaging in sexual relationships. To avoid losing their school fees, these young women considered an abortion.

Stigma

Stigma was a persistent factor that influenced young women's abortion decisions. Young women dreaded the reactions of actors within their communities towards their pregnancy. They explained it was expected of women to be married before getting pregnant in their community. Therefore, unmarried women are often blamed and shamed when it is discovered that they are pregnant. The shame of a premarital pregnancy does not only affect the woman herself, but also extends further to her family. With this knowledge, young women often felt the pressure to hide their pregnancy or to terminate the pregnancy before it became known within their community that they were pregnant.

I said there is no way I can go. So, the best way is to just terminate. I had fear of, let's call it stigma. (….) How will society take me? I will bring shame on my mother. Things like those are what was in my head. Now all I wanted was an abortion, the sooner the better." (Faith, 24 years old, business owner, 25-02-2021)

Forced marriages

Since premarital pregnancies are unacceptable in the community, young women are often pressured to marry the father of the child to reduce the shame that falls upon them and their families. The willingness of the young woman to marry is not considered within the decision of both families to agree to the marriage. The possibility of a forced marriage was therefore for many young women an important factor that influenced their abortion decision. Young women mentioned not being "ready" to marry, being too young to marry or finding the father of the child not a suitable partner for a marriage. Additionally, they feared that a marriage would stand in the way of reaching their own goals and dreams in life. For these reasons, they favored an abortion above marriage.

If I was forced to raise the child, I would have been married. I wouldn't have been allowed to stay at [my parental] home with that pregnancy. I wouldn't be able to go back to school. There is no way I could be helped, apart from getting married. But I didn't want to get married. I wanted to achieve the goals I had set for myself; at least two or three, so that I can see how life goes." (Sophy, 22 years old, shop attendant, 11-05-2021)

Economic circumstances

Frequently, young women cited their economic circumstances as a factor that influenced their decision to terminate their pregnancy. If young women were still in school, they were often dependent upon their family for financial support. In these cases, they often did not want to add an extra burden on their families by giving birth to an additional member of the family that needed to be taken care of. Even in cases where young women were employed, they often did not earn enough income at their current job to support raising a child. Additionally, young women indicated that they would have to stop working in order to give birth and raise the child. Without paid maternity leave or child support, this would result in a loss of income. Some young women were responsible for the family income and had financial responsibilities towards their parents, siblings, and child(ren). In those cases, young women indicated that they would not be able to carry the costs for an additional member of the family. Financial constraints were, therefore, an important factor that young women considered in their abortion decision.

I couldn't raise another child alone. There was no way I could burden my mother with another child. and my kind of work doesn't give me a lot of money to take care of another child and I am paying my siblings school fees too. (Jennifer, 27 years old, sex worker, 27-07-2021)

Reaction of the male partner

Even though the above-mentioned factors were important reasons for young women to desire an abortion, the lack of (financial) support from their male partner to raise the child was often fundamental to the abortion decision. Upon receiving the pregnancy news, a share of the male partners denied paternity. They refused to take responsibility for the pregnancy and declined to take part in the abortion decision.

Some male partners reacted angrily upon hearing the pregnancy news and were verbally abusive towards their female partner. This scared several young women away from continuing the conversation about whether to keep or to terminate the pregnancy. Other male partners simply received the news and proceeded to disregard any further requests to talk about the pregnancy. They ignored phone calls and messages or, in some cases, disappeared altogether after receiving the pregnancy news. When male partners were not willing to participate in the abortion decision, young women often delayed the decision-making in the hope that they were able to convince their male partner to communicate with them in the future. When male partners remained absent, most young women considered an abortion.

Whenever I called him, he would not receive me and he had blacklisted me. I had to call him using some else's phone, which he would receive, but when he heard my voice, he cuts it off. That delayed me, so I had to make the decision later. (Nana, 24 years old, bartended, 15-07-2021)

In multiple cases, male partners accused their female partner of cheating after they were informed about the pregnancy. They questioned being responsible for the pregnancy and refused to believe that they were the father. In those cases, young women were often sent away to find support elsewhere.

Several young women were unaware that their male partner was already married while they were in a relationship. Upon sharing the news, their male partner would reveal that he already had another family and was not interested in supporting an extramarital child.

When I told him I was pregnant, he said he can't have another child. He has a wife, that was the first time he told me he has a wife and a family. [….] He used to say he was single, that he

had separated from his former wife. He said that if I keep the baby, I will have to raise it myself. (Jennifer, 27 years old, sex worker, 12-07-2021)

When male partners denied paternity, many young women feared that they did not have the (financial) means to raise the child as a single parent and considered an abortion.

Negotiations

When male partners actively participated in the discussions to decide whether to pursue an abortion, multiple scenarios could occur depending on partners' individual abortion desires. Abortion desires could either be concordant or discordant, which influenced how easy partners could come to an agreement. When abortion desires were discordant, partners could employ various strategies within their own range of power to achieve their desired outcome.

Concordant abortion desires

In several cases, the abortion desires of both partners aligned. In these cases, young women and their male partners jointly made the decision to terminate the unintended pregnancy. This proved to be the easiest decision-making process for both partners. Even if the exact motivations to terminate the pregnancy could differ between partners, they were often complementary and no conflict occurred. When abortion desires were concordant, male partners often took on a supportive role in the abortion decision-making and the rest of the abortion trajectory.

I told my boyfriend, he was so shocked, but he didn't deny it. We had to plan what we will do. We decided together to terminate the pregnancy. That is what we had to do. It's not like we liked it very much. (Nita, 21 years old, unemployed, 07-07-2021)

Discordant abortion desires

In most cases, the abortion desires of both partners did not align. When the abortion desires of both partners were in discordance, the decision-making process proved to be complicated.

In several cases, partners were able to convince each other to pursue their abortion desires. By communicating directly about the subject, partners could outline their arguments in favor and against an abortion to each other. Continuing one's education or financial hardship were often considered as good reasons to pursue an abortion. Discordant abortion desires could lead to friction and tension between both partners. However, several couples were able to reach a consensus without long lasting conflict.

I had to abort due to the wedding plans, there is no way a wedding was to happen when I am pregnant. (…) He was ok with my decision, since I had explained to him the situation at home. (…) He told me to give birth, but I told him there was no way I could give birth since I had explained my situation. He was harsh but he listened to me. (Elvinah, 29 years old, unemployed, 07-06-2021)

In multiple cases, partners were not able to convince each other and relied on different strategies to achieve their desired outcomes. It was common for male partners to use emotional blackmail to pressure their female partner into procuring an abortion. Young women disclosed that their male partner would threaten to end the relationship if they kept the pregnancy. In order to preserve their relationship and to avoid becoming a single mother, young women would opt to terminate the pregnancy. In several cases, male partners threatened with violence or self-harm if the young woman would not agree to pursue an abortion. These young women expressed they made the abortion decision out of fear for their own wellbeing or the wellbeing of their partner.

I told him I had not seen my period since we last met. First, he didn't say anything. He was just quiet. Then he said he wanted to hang himself. I told him he should not hang himself. He said that if I don't want him to hang himself, I should end the pregnancy. (Daisy, 17 years old, primary school student, 01-05-2021)

When young women themselves desired an abortion, but could not convince their male partner to agree with them, they could opt to pursue an abortion without their male partner's knowledge. A few young women terminated their pregnancy secretly and only informed their male partners about the abortion after it had already taken place. Like covert contraceptive use, secret abortions were a way for young women to achieve their fertility desires despite the dominance of their male partner in the decision-making process.

I called the guy and told him. He was shocked, I was crying and I didn't even want to look at him. He was against terminating it, but I wanted to terminate it. So, I knew, this one, I'll handle it alone. I didn't tell him [about the abortion] until I came out of the hospital. (Chemu, 23 years old, college student, 05-07-2021)

Conclusion

During the decision-making process young women move through various phases in which they make the decision to terminate their unintended pregnancy. This chapter explored how young women discover their pregnancy, reflect upon their emotions, share the news with their male partner, consider the factors that influence their abortion decision and negotiate the abortion decision with their male partner.

Young women often discovered being pregnant after missing their period and experiencing various physical signs like nausea and headaches. Male partners could play a role in the pregnancy recognition by recognizing the pregnancy symptoms and by acting as a source of financial support and information to confirm the pregnancy. Young women felt multiple emotions when they discovered the pregnancy. Several of them were happy. Yet, most felt sad, uncertain, stressed, or shocked. Emotions could be ambiguous and change throughout the decision-making process, which could leave young women feeling confused and uncertain. The pregnancy news was often shared with the male partner. Whether to inform the male partner and how to inform him was highly dependent upon his anticipated reaction towards the pregnancy news. Young women considered several factors like education, stigma, forced marriages and economic circumstances. Even though all these factors were influential in the abortion decision, the reaction of the male partner proved to be fundamental to the final decision. When male partners denied to offer (financial) support to raise the child, many young women considered an abortion to be the best option. When male partners were actively involved in the abortion decision, the abortion desires between both partners could be concordant or discordant. In cases of concordant abortion desires, the decision-making process was easy and male partners would often play a supportive role in the abortion trajectory. When the abortion desires of both partners were in discordance, the decision-making process proved to be complicated. To achieve their abortion desires, both partners could employ various strategies. Partners could try to convince each other with rational arguments and reach a consensus or act within their own range of power to realize their plans for an abortion.

The story of Tisha

I met this guy who is a boda-boda (motorbike) rider at a disco Matanga, which is organized when someone dies in the community. They put on music and they go round to collect money to help the family. We started dating. We had fun. He is a guy that couldn't stand you up. If he tells you that we would meet on this day and this time, he would be there. Then last year on 25th December, it was Christmas, we went out to a guest house. It was my first time and we had agreed. At the guest house we used Trust (brand of condoms). I wanted to prevent any chance of getting pregnant and getting HIV. We stayed the night and I went home the following day.

When January came, I wasn't feeling like usual. I missed my period, I felt sleepy all the time, food was tasteless, so I started to suspect myself. I bought a pregnancy test at the local market and found out I was pregnant. I told my boyfriend and he said: "If you are pregnant, I don't know the pregnancy, I only know you." I didn't know what to say. Then he said that the only way he can help me is to help me remove it. I wanted to raise the child, but how could I take care of it? I only do small jobs and I live with my stepmother. So, I had to accept it. I asked him how I could remove it. I don't have money to go to hospital. Moreover, it is a crime. How would I have explained it to the doctors? I would be arrested.

My boyfriend told me he knows an old lady who removes pregnancies the traditional way. He said that she is even more of an expert than the doctors in the hospital. So, we went by motorbike to the place and found the kinyanya kizee (derogatory term for old lady). The old lady asked me how long I had been pregnant. Since it was February by then, I told her it was about two and a half months. Then she boiled things, leaves and roots of trees. She would wait for it to cool down then give it to me to drink. She told me that it was the drug to remove pregnancies. She said: "There is getting well and dying, now it is for you to decide, whether you decide to get well or to die, but you decide on your own. There are pregnancies that come out well and there are pregnancies that do not come out well." That is what she explains to you, she doesn't even hide the risk.

I drank the tea throughout the day. It was a lot, maybe even 5 liters. I stayed in a dark room. The place looked very bad. There were other patients, but the room was divided into three. There was one woman with a big pregnancy, like 8 or 9 months. She gave birth safely and then the old lady brought a bucket of water. The mother and father put the baby inside the water until it died. The other woman, I don't know how many months old her pregnancy was. It came out in pieces. There was no other door, so she had to pass us by. She dug a hole and buried it inside.

At night my stomach started hurting. It was very painful, like someone was cutting me from side to side. I told my boyfriend not to leave me because if I die there, he would be the one to tell my people at home the news. We stayed there until deep in the night. At 1 am, that is when I started bleeding. I was given a bucket and I sat on it until chunks came out. I slept there and, in the morning, the old lady told me that I could leave. I bled for a couple of days more, just like a normal period.

Right now, when you look at my body it hasn't gotten back to where it used to be. I have lost a lot of weight. I also think about a lot of things. I feel guilty and don't feel any joy. My friends try to counsel me but I don't believe them. They tell me if I get pregnant again, I should go to hospital to get an abortion, but I don't want to abort again. Even if I get pregnant now, I will give birth and raise the child. It is better to be called 'Mama' than to be called 'Mother of deceased'.

Chapter 6: Abortion and post-abortion care

Introduction

Once young women come to the decision to terminate their unintended pregnancy, they start their journey to seek and access an abortion. Like the abortion decision, seeking and accessing abortion care is not a linearly process for most young women. Young women can go back and forth between searching information, weighting the benefits of different abortion methods, procedures and providers, and barriers they encounter to access the abortion treatment of their choice before they found treatment.

This chapter will outline young women's experiences with searching, accessing, and undergoing an abortion and post-abortion care. The first section of this chapter will be dedicated to young women's level of knowledge and search for information about abortion. The second section will discuss young women's decisions on the method they selected to terminate their pregnancy. The third section will focus on young women's experiences while undergoing their abortion, including the emotions, pain, and stigma they endured. The fourth section will describe young women's complications after their abortion and the post-abortion care they received to mitigate the physical and psychological consequences of their abortion. Throughout these sections, it will be highlighted how male partners actively or inactively influenced these processes.

Information about abortion

Before falling pregnant, young women in Kilifi County had varying levels of knowledge about abortion. Some young women knew very little about abortion before they fell pregnant, while others had specific knowledge about certain abortion methods before they found themselves in need of such information. For many young women, their most important source of information about abortion was their social network. Most young women had learned about abortion though their friends, classmates, family members and community members. Especially, local gossip was an important medium of collecting information. In day-to-day conversations, young women picked up the stories about women in their community that had terminated a pregnancy and the methods, procedures, and providers they had accessed to procure an abortion. Additionally, several young women noted that they were taught about abortion in school during biology classes or sexual education classes. However, the information provided in these classes was frequently focused on the legality of abortion and the risks associated with unsafe abortions. In a few cases, young women were aware of NGOs like Marie Stopes International that offer comprehensive abortion care in the region.

In rural areas, young women were mainly knowledgeable about traditional methods of abortion. They mentioned local herbs and plants like tea leaves, aloe vera and neem leaves that can be boiled and drank in large quantities to induce an abortion. Additionally, young women in rural areas frequently named ingesting a high dose of *shubiri*, which is a traditional medicine to heal various ailments, as a popular method to terminate a pregnancy. Furthermore, young women spoke of boiling Coca Cola, drinking highly concentrated juice or energy drinks or taking a high dose of over-the-counter medicine as ways to procure an abortion. Lastly, some young women had heard about local healers that could be approached for massages and crude procedures to induce an abortion.

I knew there was tree called majaji with fruits. When the fruits are still young, you can boil them. When you take them, they can terminate a pregnancy. Such things I heard from people

and it is what I used. Although I didn't have any experience, I just tried it. […] I knew of shubiri and there is another tree called mkilifi (neem tree) […]. You can take the barks or leaves and boil them. (Sophy, 22 years old, shop attendant, 09-05-2021)

In urban areas, young women were more often aware of medical and surgical methods of abortion before they fell pregnant. Some young women knew about abortion pills that could be bought at local pharmacies or drug vendors. Several young women also knew about providers in private clinics and public healthcare facilities that offered clandestine medical and surgical abortion procedures.

There are some doctors who remove pregnancies. Now that place is like a hospital, but when someone goes there and they want their pregnancy removed, they close the door so that it can't be known what is going on in there. They have other equipment that they use which can remove the pregnancy especially if it is bigger. (Amira, 23 years old, unemployed/seasonal laborer, 01-07-2021)

Once young women fell pregnant, they took advantage of their prior knowledge to reach out to friends, family members, community members, healthcare providers and online resources to gather more information about a suitable way to terminate their unintended pregnancy. Some young women shared it was easy for them to approach people in their social network, while other found it extremely difficult to broach the subject with others. Stigma, fear of legal prosecution and cultural norms about women's sexuality and reproductivity prevented young women to talk about their desire to procure an abortion freely. Therefore, most young women would only reach out to social actors that they trusted most. When male partners were involved, they could be a valuable source of social connections to seek and access information about abortion. Male partners could approach male friends, male family members and male healthcare providers more easily than young women to gather information.

He (boyfriend) told me there are three methods of termination. He told me there is his friend who is a doctor. He said he will call him and tell him (about our situation) before I talked to him. He said that there is a method where you use some medicine. When you take it, it causes the fetus to kuyeyusha (melt) and then it becomes blood and you bleed. There is another one where you put the tablet down there (in the vaginal canal) and it works the same way. There is another one, you use a metal, it looks like a machine, and it grinds. When it grinds, it (the fetus) becomes blood and gets out with the metal. The doctor told him the methods of taking the pills or placing the tablet down there may cause death but when you use a metal, the doctor removes the blood right there and then. He cleans you up and you're done although its expensive. (Nita, 21 years old, unemployed, 09-07-2021)

In some cases, young women would seek information from people in their social circle that they were not necessarily close with, but that they considered to be more knowledgeable because of their age, occupation, social status, and previous abortion experiences.

I knew through my other friend but not my close friend. She is a friend that I see in the community and greet her. However, I just opted to ask her. Maybe she knew. She was a bit older than me, so she knew more. I had to follow her and ask her. I told her to keep it as a secret as no one at home knew. I wanted it to be her secret. (Zahra, 20 years old, unemployed, 10-07-2021)

While seeking information on abortion, young women also learned about the (deadly) consequences of (unsafe) abortions. Frequently, young women shared the stories of fellow women in their community who had been hospitalized or died due to the complications of an unsafe abortion.

I had a friend with whom I went to school. When she knew she was pregnant, she wanted to remove it. So, she used shubiri and it didn't come out. She looked for other methods and she was told to boil tea leaves and she drank but it didn't come out. So, she was taken to a hospital where she did the abortion. She said they used metal. So, she stayed and she started bleeding heavily and she became sick. She was taken to a health center and was admitted but she did not survive. (Brenda, 18 years old, high school student, 26-06-2021)

Based on these stories, young women could opt to avoid certain abortion methods or obtain extra information to avoid the consequences they had heard about.

Selecting an abortion method

Guided by the information young women acquired, they sought a suitable abortion method to terminate their unintended pregnancy. Seeking and accessing an abortion is a complex and stressful process for many women in Kenya. The contradictions between the Kenyan constitution and penal code create an ambiguous legal environment in which women, abortion- and healthcare providers, and law enforcers generally consider abortion to be illegal in all cases except when a woman's physical wellbeing is threatened by carrying the pregnancy to term.

Due to this legal environment, seeking an abortion could be a timely endeavor. It could take young women from a couple of days up to a couple of weeks find a suitable abortion method and access a provider that could supply this method. During this time, several factors influenced young women's selection of an abortion method and access to this method. Their choices and opportunities were influenced by their social network, their financial status, stigma, and the perceived effectiveness of various abortion methods

Social network

Frequently, young women enabled the help of their social network to select and access an abortion method to terminate their unintended pregnancy. Close family members, friends, male partners, and acquaintances could supply abortion methods or bring young women in contact with abortion providers. Even though abortion is a highly stigmatized issue, abortion methods and providers are well-kept public secret within most communities. Most people know something or someone that can help with terminating an unintended pregnancy. A chain reaction of social interactions, whereby a young woman reaches out to a trusted actor in her social network who in turn can reach out to a trusted actor in their network, can lead young women to a suitable abortion method and provider. This chain of events often determines which abortion method and provider young women use.

I talked to my cousin and she told me if the one responsible has denied it, you must remove it because you won't be able to stay like that with your children. I asked her what will I do and she told me let me direct you to my friend. She gave me her friend's number. When I went to her (cousin's friend) she told me she has this doctor, she will take me to him. (Mila, 25 years old, hairdresser, 14-07-2021)

In many cases, male partners were absent when young women selected and accessed abortion methods and providers. However, when male partners were present, they could help young women in their search for an abortion. Male partners often had a larger social network than young women which could increase young women's opportunities to access various methods of abortion and abortion providers.

The one who got me pregnant went to the doctor and explained to him till he was done then he came to tell me what the doctor had said and told me to go see him (the doctor) the

following day. He had talked to the doctor and I had been instructed to visit the following day at 6:00 p.m. and I agreed to it. (Mapenzi, 16 years old, primary school student, 24-06-2021)

Financial costs

In most cases, financial costs were a determining factor that influenced young women's selection of an abortion method and provider. Many young women had little financial resources and were therefore dependent on affordable abortion methods or the financial support of their male partner, family members or friends to access an abortion. If young women struggled to accumulate the financial resources to afford an abortion, they often had to delay the abortion procedure until they had gathered the money or fall back on cheaper methods.

When male partners were absent and young women were not able or willing to source money from other actors in their social network, they often opted to ingest a high dose of traditional herbs, plants, and medicine to terminate their unintended pregnancy. Traditional herbs, plants, and medicine like *shubiri*, neem, aloe vera, and tea leaves costed as little as 10Ksh and could easily be sourced from local shops. Additionally, since these herbs, plants and traditional medicine are used to treat various ailments, like stomach cramps or nausea, they are often kept in stock in young women's households or are grown in their household's garden and could therefore be used without spending money. In total, 21 out of the 54 young women made use of traditional herbs, plants, and medicine (to attempt) to terminate their unintended pregnancy.

[I decided to use the herbs] since it was my own doing and I did not have money to buy the medicine or go to a hospital. Also, I did not know of any place I could go to. So, I decided to use the readily available means which I would hear people talk of. (Kiri, 15 years old, unemployed, 08-05-2021)

32 out of the 54 young women made use of medical abortion methods (misoprostol or a combination of misoprostol and mifepristone) to terminate their unintended pregnancy. Medical abortion methods were significantly more expensive than the use of traditional herbs, plants, and medicine. While some young women paid roughly 1000 KSh for a couple of tablets, others paid 3000 KSh up to 4000 KSh depending on the place and the provider they approached for care. Most young women did not have this amount of money readily available and reached out to trusted family members, friends, and acquaintances to accumulate the money. When male partners were present, they often supplied the money for a medical abortion or arranged the medical abortion on young women's behalf.

I decided to talk to my best friend so she could help us since she had been in the same situation before. She advised me on what to do, how she accessed the drugs, where her boyfriend had purchased them for her. I requested her to help me since I didn't dare to go to a chemist to purchase it. She inquired from her boyfriend how he got the drugs. We were given the price and my boyfriend paid and the delivery was done. I took the drugs at night. (Kabibi, 22 years old, college student, 28-04-2021)

Young women that reached out to healthcare providers in healthcare facilities often paid the most money to obtain a medical abortion. In addition to misoprostol and mifepristone, healthcare providers could offer a combination treatment with an MVA procedure to ensure a pregnancy termination at a later gestational age. Generally, based on the money that young women could supply, healthcare providers decided which method and amount of care they would offer.

We went to [the hospital] and explained [my situation]. They said that I can terminate [the pregnancy], but it depends on my money. [the doctor said:] "If you give me little money, I

will give you a drug and you go endure and it can come out or not. If there is more money that you can give me, a lot of money, it can come out without a problem and then I completely clean you." (Elvinah, 29 years old, unemployed, 13-07-2021)

Very few young women opted for surgical abortion methods. Surgical abortion methods (incl. crude surgical methods) at private and public healthcare facilities or traditional providers were the most expensive way to terminate an unintended pregnancy. Only 4 out of the 54 young women opted for a surgical abortion due to the gestational age of their unintended pregnancy or after failing multiple times to ensure an abortion with other methods.

Stigma and safety

Besides the financial costs of abortion methods, stigma played an important role in young women's selection of an abortion method and provider. Many young women differentiated between the ''medical safety'' of a certain abortion method and the ''social safety'' of accessing and using that method. Abortion methods that were considered as more discreet were often labeled by young women as more ''socially safe''. More so than their physical wellbeing, secrecy was of the utmost importance to most young women seeking abortion care. They worried about their family, friends, neighbors, community members and the local authorities finding out about their plans or attempts to procure an abortion. Therefore, young women often opted for abortion methods that were easily kept hidden or concealed. Methods like traditional medicine and the self-administration of misoprostol and mifepristone were popular among young women because these methods could often be accessed without having to disclose why they needed them and for whom they were intended. Besides this, traditional medicine, misoprostol, and mifepristone could easily by sourced by male partners, friends, and family members on behalf of young women so that they could avoid being scrutinized.

I was scared that there would be someone who would go and tell it to other people if I would tell them something. That's when I decided to stay alone. […] I wanted it to be a secret, even though it ended up not being a secret because I had to look for another person to ask for the drugs. However, I told that person that the drugs weren't for me, but that I was buying them for someone else. (Naima, 23 years old, sex worker, 06-07-2021)

Especially, herbs and traditional medicine were mentioned by young women as extremely ''socially safe'' since they could be prepared and ingested in a private environment without the involvement of other social actors. Moreover, since most herbs and traditional medicine are multipurpose and can be used for treating various ailments like nausea and influenza, young women noted that it would not raise any suspicion even if they were discovered ingesting the medicine.

While I was boiling the aloe vera, everyone had gone home except for my younger sister. She is the one who asked me why I was boiling the aloe vera. So, I told her I had a flu, that is why I am boiling aloe vera. (Ruth, 17 years old, high school student, 20-03-2021)

Even though young women were often aware of healthcare providers that offered medical or surgical abortions clandestinely, they avoided searching care in healthcare facilities. Young women remarked that the social risks were often too high when seeking care at a healthcare facility. They feared people discovering their abortion attempt and were afraid to be reported to the local authorities by patients, visitors, and other staff at the healthcare facility.

Depending on the information young women had, the medical safety of abortion methods was often a subjective issue. Young women that made use of traditional medicine sometimes believed them to be safer than a medical or surgical abortion since traditional medicine were often used at home every day and therefore considered to be unharmful.

I didn't have too many worries because the few stories I heard… I never heard of anyone who died from taking shubiri when aborting. So even though the worry was there, it wasn't too much. (Sophy, 22 years old, shop attendant, 11-05-2021)

Whether young women chose for an abortion method that they considered more ''socially safe'' or more ''medically safe'', surviving an abortion was often regarded by young women as a case of luck. Young women remarked that abortion methods could have different outcomes for everyone. For some it might be safe while for others it might be unsafe depending on the strength of your body, good fortune, or God.

I knew when you do abortion it's either you die during the process or have complications where you are not able to give birth later in life, only by the grace of God you will be safe after doing abortion. (Kabibi, 22 years old, college student, 28-04-2021)

Perceived effectiveness and multiple methods

A lack of information as well as the uncertainty around the effectiveness of different abortion methods caused a few young women to mix multiple abortion methods to ensure a successful abortion on their first attempt. They decided to mix traditional medicine with other substances, such as concentrated juice and generic medicine, to brew a strong concoction to increase their chances of a successful abortion.

I used a mixture. I went to the chemist and bought some small pills. I then went and added some drugs that I have for hormonal balance. I then swallowed some Panadol. I don't know if you know shubiri, I also used that. So, I don't know if they all worked together or not. (Tunda, 20 years old, hair dresser, 24-05-2021)

Undergoing the abortion

Setting of the abortion

Depending on the method of choice, young women underwent their abortions at different locations. When young women self-administered traditional or medical abortion methods, they often chose to undergo the abortion at their own home. Out of fear for stigma, negative reactions and abuse from male partners, family members and community members, young women often secluded themselves and self-administered the abortion methods at night to hide their abortion attempt.

I drank those things at night so that people wouldn't know. I would stay until people have finished eating food and act like I want to use the jiko (stove), I would boil it and put it in a cup. The time I go to sleep is when I would drink it… (Sophy, 22 years old, shop attendant, 25-07-2021)

When young women sought abortion care from a (traditional) healthcare provider, they visited the home, clinic, or workplace of the provider for the abortion. It was common for clandestine abortion providers to request that young women visited them at night to receive medical or surgical abortion procedures. Providers of abortion can be prosecuted per Kenyan law and therefore preferred operating during the nightly hours when there were fewer people around.

Young women were very selective with involving other actors during their abortion. Trusted family members, friends and male partners were often the closest actors that could assist young women with preparing traditional and medical abortifacients or accompanied them to abortion providers.

My Aunt is like my confidant. She knew that I had a boyfriend. So, when I told her, she told me to go to her place and that she can help me. She told me to come with 6000 shillings. I told my boyfriend and he sent her the money directly. So, when I arrived there, she gave me a drug that I took, it was only one tablet. After taking it, I started bleeding and having a lot of cramps, it was so painful. […] I bled for that day and the following day. Then at night, I was taken to the hospital. There was a nurse there who cleaned me. It was very painful but she cleaned me fast and I went back home. My aunt had prepared everything. (Sharon, 24 years old, college student, 23-04-2021)

Many male partners did not partake in the abortion process. However, several male partners were present while young women underwent the abortion. In some instances, male partners had arranged for an appointment at an abortion provider and accompanied their female partner to undergo the procedure to offer emotional support. In other cases, they were present when young women ingested traditional medicine or abortion pills and could assist them with managing the bleeding and pain.

Young women had varying experiences with clandestine abortion providers. Some were attentive to young women's needs, while other providers did not show much care for the pain and emotional distress that young women experienced during their abortion. Also, the hygienic standards of provider's workplaces varied greatly. While young women noted that it is important that surgical abortions are carried out under sanitary conditions to prevent infections, the pressure to terminate their pregnancy overshadowed young women's concerns about the hygienic conditions of the place where they underwent the abortion.

It was a doctor who procures abortions at his home. My boyfriend had already spoken to him, so I went alone. The place looked bad. When you see the scissors, other things, you get frightened. But now what will you do…It is just that you have to do it…you wonder how you will tell your mom [about the pregnancy]. You decide that "Kufa gari, kufa makanga" ("Die driver, die conductor": a saying that means to be prepared for the worst). (Tatu, 18 years old, unemployed, 16-06-2021)

Emotions and pain

During the abortion, many young women experienced intense stress, anxiety, loneliness, and pain. They worried about the possible complications that could arise from their abortion attempts and spend the hours while undergoing the abortion fearing falling ill or dying. At the same time, young women were apprehensive about seeking help if complications arose because that would mean they had to disclose their abortion attempt to other people.

I was thinking that if I started bleeding heavily, I wouldn't know what to do. It could force me to call people to help me and I didn't know what to tell them. That is how I questioned myself, but it was by good luck that I didn't have difficulties during the process. I had deep thoughts. What if I became unconscious? I wasn't at peace. (Kabibi, 22 years old, college student, 28-04-2021)

While undergoing the abortion many young women also had the fear that their abortion attempt might not be successful. They mulled over the consequences that giving birth would have on their life and feared the possibilities of becoming a single mother, being forced to marry, being unable to financially support the child, being stigmatized, being cast away from home and not being able to continue school.

Despite their best efforts to seek information about the method of their choice, young women were often not prepared for or aware of the pain that they could experience during their abortion. Some described the pain as the ''cutting" or ''slicing" of a knife through the stomach. Other young women mentioned the pain was worse than childbirth. The pain was often

accompanied by (heavy) blood loss and cramps which remined some young women of their menstrual period.

I started having stomach pains. When the pain was too much, I couldn't take it anymore. I moved from the bed and slept on the floor. The cold was helping with the pain. It got to a point I thought I would die. I could feel the blood coming out. So, I decided to wake up my sister and tell her. I told her the problem and she was scared so she went and called her mother. When they came, I was on the floor turning because of the pain. It was like cramps during periods but it was more painful. I got to a point where I couldn't take the pain. (Brenda, 18 years old, high school student, 05-05-2021)

Young women that underwent a surgical abortion could experience excruciating pain when they were not (properly) administered pain medication or anesthetics. While some young women did receive pain killers or anesthesia. However, a few of them experienced a surgical abortion without any pain management.

I was seeing that I'm going to just die. I was feeling a lot of pain because there is no numbing injection. You feel the thing being pulled. That means: you feel it completely. It is not like giving birth at all. Giving birth is easier. (Tatu, 18 years old, unemployed, 16-06-2021)

To manage the pain, young women took painkillers like Panadol or Indocin. Male partners that were involved in the abortion process could support young women by providing pain killers or money to buy painkillers. Other young women took warm baths or were massaged by friends and family members to relieve the pain.

Multiple abortion attempts

Several young women experienced one or more failed abortions and went through multiple abortion attempts to terminate their unintended pregnancy successfully. A couple of young women were unsuccessful to terminate their pregnancy at their first attempt because either the method or the dose was insufficient. These young women used the same method multiple times to ensure a successful abortion or switched methods until they accomplished to terminate their unintended pregnancy. In cases where young women had little financial resources, they often started with the most affordable abortion methods, such as local herbs, plants and traditional medicine, which often failed. Consequently, they often had to look for other, more expensive, methods or had to repeat the abortion method multiple times to ensure an abortion.

I tried jaji (nutmeg) first, but it wasn't successful. For the second attempt I boiled mkilifi (neem). Day one I boiled it and felt my stomach aching for a while before it stopped. Day two I tried it again and added a lot more peels to make it bitter. I drank it but I didn't see any success. Then I remembered there is shubiri. So, I thought where would I get it, but then I remembered my sister…there is a cousin who has a chest problem. I went to her place, took it and boiled it that day. That's when I felt my stomach aching and I knew it was ready. (Neema, 23 years old, housekeeper, 06-06-2021)

Forced abortions

Four young women experienced a forced abortion. Forced abortions were an extremely traumatic experience for young women. They felt intensely sad, hurt, confused, and scared during the abortion which was induced by their male partner without their consent.

Two young woman ingested abortifacients without being aware of it. They did not recognize their pregnancy symptoms and believed they suffered from a flu. When they complained to their male partner about having a flu, their male partners recognized the pregnancy symptoms and offered the abortifacients under the pretense that they were painkillers. In both cases, the

young women started bleeding and panicked. They were rushed to the hospital where they found out they were experiencing an abortion.

In another case, a 16-year-old student was dating an older male partner when she fell pregnant. When she confessed to her male partner that she had missed her period the previous month, he told her to meet him later so that he could buy her some ''medication''. When they met, he gave her a glass of milk and forced her to swallow a couple of pills that he informed her would abort her pregnancy.

In the last case, a young girl was violently abducted on her way to school. One man and woman, presumably family members of the man that made her pregnant, grabbed her and transported her on a motorbike to a remote area. They held her down and forced her to swallow several abortion pills and inserted some abortifacient medication in her vaginal canal. They left her when she started bleeding. Her mom found her and rushed her to the hospital.

I thought they might want to kill me. They just held me down and gave me the medicines. I was struggling, I didn't want to take it. They put them in water and then some they put 'down there' (vagina). They held my legs apart and then inserted the medicine. (Lisa, 14 years old, primary school student, 17-07-2021)

Medical complications and post-abortion care

Complications

Complications were a common part of young women's abortion experiences. Frequently young women experienced moderate to severe complications that caused them to seek post-abortion care.

Before undergoing their abortion, most young women were informed by friends, family members and abortion providers to expect some bleeding and pain after undergoing the traditional, medical, or surgical abortion procedure. Therefore, many young women did not immediately recognize that they were experiencing (severe) complications. When the bleeding and pain were excessive and prolonged or when other symptoms arose like dizziness, fainting, weight loss or debility, young women became alarmed and started looking for post-abortion care.

I started bleeding heavily and it didn't feel like a normal menses. There were big things coming out. I panicked suddenly. I went home and got a pad, but the blood was too much. I was changing pads almost every thirty minutes. I asked the guy who gave me the drug what was happening. He told me that the pregnancy is coming out, I should just relax, but I was unsettled, I was losing a lot of blood and I thought I would die. (Chemu, 23 years old, college student, 14-03-2021)

Some young women experienced such severe complications that they were not able to seek care themselves. They lost too much blood or developed an infection that caused them to lose mobility or consciousness. In those cases, male partners, friends, and family members rushed them to the hospital to receive emergency treatment.

When I started bleeding again, the blood was coming out with large clots. They were very large and I bled a lot. I fainted. My sister took me back to the hospital where they had cleaned me. I did a scan and they said there are things inside that they want to remove but they told me to go to Kilifi hospital to be cleaned here. They said my blood is also low. (Crystal, 17 years old, high school student, 11-05-2021)

In multiple cases, fear of stigma and legal prosecution caused young women to postpone seeking post-abortion care. In these cases, young women tried to manage the complications with over-the-counter medicines or traditional medicine. Only when the complications became unbearable or other people discovered their complications, would they seek care. Alternatively, some young women opted to seek care at private hospitals to minimize the chances of stigma or legal prosecution.

This right side (points at right side of the abdomen) was hurting too badly. […] I didn't want to seek help because if I went to the government hospital, they would have known what the problem was and I didn't want that. […] That's why I went to a private hospital. In a private hospital it's your money that speaks. It's money that speaks, that's it. (Saumu, 21 years old, waitress, 29-06-2021)

In a few cases, young women's complications were not interpreted as a medical issue but as religious or spiritual signs of punishment or bad luck after terminating their unintended pregnancy. Some young women and the actors they approached for help considered the complications to result from breaking the social norms around sexual interactions or as a punishment from God for procuring an abortion. When complications were interpreted as religious or spiritual signs, young women would delay seeking care at a healthcare facility and instead visit pastors of spiritual priests to receive prayers or rituals to get healed.

I was taken to a pastor: a woman who used to be a Muslim but she is now a Christian. She prayed for me and took coconut oil and put it in water and gave it to me to drink. She took a bible and she rotated it on my head 3 times to remove the bad luck. (Juliet, 19 years old, secondary school student, 09-07-2021)

Diagnosis

Out of the 54 young women that participated in the research project, 15 accessed PAC in public and private healthcare facilities to treat the complications that they experienced after their abortion.

When young women entered the healthcare facility they were usually admitted to the emergency or maternity ward. They presented symptoms of menorrhagia, sepsis, or infections to the reproductive system. Before care was offered, young women were first examined to determine a diagnosis. Many young women received a pelvic exam in which healthcare providers checked the vaginal canal and the cervix. If the cervix was opened it could indicate an incomplete abortion and young women would be send for an ultrasound and a pregnancy test to see if their abortion failed or if any pregnancy tissue was not properly expelled out of the uterus. When the pregnancy test was positive or the ultrasound showed remaining tissue in the uterus, young women would be diagnosed an incomplete abortion. If the pregnancy test was negative, young women would be checked for other conditions, such as uterine fibroids, that could explain the pain and bleeding.

I explained to him (doctor) everything. Then he sent me to ultrasound. After that, I was sent to the casualty ward. He (doctor) saw it (product of conception) was still there. I was shocked. (Chemu, 23 years old, college student, 05-07-2021)

For some young women, it was difficult to access an ultrasound. Ultrasound were often costly and not every healthcare facility possessed the ultrasound equipment, especially in the rural areas. This often delayed the diagnosis process as young women had to gather the necessary money to pay for the ultrasound examination or had to travel to healthcare facilities in urban areas to receive an ultrasound.

As part of the diagnosis, healthcare providers often tried to determine whether the abortion was induced or spontaneous (miscarriage). However, the research assistants regularly

observed during their observations in the healthcare facilities that this was hard to verify. Fearing stigma, maltreatment and legal prosecution, young women would often not immediately confess that they induced an abortion. Many came to the hospital and told the healthcare personnel during their intake that they spontaneously started bleeding. Some providers would question the young women thoroughly and, sometimes, rudely. Others would make assumptions based on young women's age and marital status. Many providers believed that older and married women were more likely to experience a spontaneous abortion, while younger and unmarried were more likely to induce an abortion. If male partners accompanied young women to the healthcare facility, providers often assumed that they were dealing with a spontaneous abortion.

Treatment

Once young women were diagnosed, they were sent for treatment. The waiting time before receiving treatment varied greatly per patient. Some young women received treatment immediately while others had to wait for hours. This depended heavily on the available staff and equipment. In some cases, there was only one trained healthcare provider for PAC services in the healthcare facility that had to attend multiple patients or was not on duty at that moment. Healthcare facilities were at times so overflowed with patients, that young women had to share beds with other patients in the same ward. In other cases, there was only one (functional) MVA device available which had to be cleaned and sterilized in-between patients.

I stayed in that hospital the whole day. There were no services. After you left me, I was sent to the lab. I stayed at the lab until 4 p.m. Then when I came back from the Lab there was no doctor in the rooms, I was supposed to bring the results back to the doctor and there was no doctor in any of the rooms. (Sophie, 18 years old, unemployed, 14-04-2021)

Additionally, due to the strike at the beginning of the COVID-19 outbreak, many healthcare facilities suspended most treatments besides emergency treatments. Young women that sought PAC would frequently be send away of referred to another healthcare facility if they were not in a life-threatening condition.

When young women were diagnosed with an incomplete abortion, they received an MVA procedure. Many young women referred to this as ''getting cleaned'' or ''having the stomach washed''. During an MVA procedure, the healthcare provider usually takes the following steps:

Firstly, the provider will insert a speculum to make the cervix visible. Secondly, a local anastatic is injected next to the cervix to ease the pain. Thirdly, if needed, the cervix is dilated using a cervical dilator. Fourthly, the manual vacuum aspiration device is inserted through the cervix into the uterus to remove the remaining pregnancy tissue.

They (hospital staff) put me in a room and he asked me what's wrong and I explained my problem to the doctor and he told me to get on the bed. I got on the bed and he (doctor) started kunibofya tumbo (massaging my stomach). He removed a lot of things that were remaining. He then took something and put a pipe inside me and he started cleaning me. He cleaned me and removed the blood. After he finished, he injected me and gave me some drugs. (Furaha, 30 years old, waitress, 26-07-2021)

An MVA procedure could be an extremely painful experience for young women. In most cases young women were not administered (proper) local anesthesia during the MVA procedure. Additionally, when healthcare providers lacked the adequate skills to operate the MVA equipment or when the MVA equipment was outdated, faulty or (partially) broken, young women could suffer tremendous pain.

It (the MVA procedure) was very painful, but I knew I had to be strong so that I could get better. [....] I didn't expect it to take long since the doctor had told me that it would take

around 10-15 minutes. But it took a long time because the MVA kit was faulty. (Khadija, 20 years old, unemployed, 11-03-2021)

Considering the stigma surrounding premarital pregnancy and abortion, young women were very worried about the privacy that healthcare facilities offered. While some healthcare facilities had a designated room for PAC services, other healthcare facilities offered PAC services in the casualty or delivery rooms at the emergency and maternity wards. When this was the case, young women would try to stay quiet during the PAC treatment despite the pain that they were feeling.

If young women had lost too much blood, they were also treated with blood transfusions and IV fluids. Donated blood could be a scarce resource in healthcare facilities. Therefore, patients were often asked to request friends and family members to donate blood in exchange.

So, I went to the big hospital. When I went there, I was told that someone had to donate blood so that I can get blood. I was told to buy blood but I didn't have money. So, my friend, the one who I told you was my cousin, we are very close with her, so she was panicking, she donated blood and my sister donated blood. They were all different blood groups from me but they took the blood and gave me other blood from the bank. (Crystal, 17 years old, high school student, 16-05-2021)

When young women suffered from infections to their reproductive organs or sepsis, they were also administered antibiotics.

Patient-provider interaction

While most young women reported friendly PAC providers, a few described the rude and unfriendly attitudes of the healthcare providers that treated their post-abortion complications. While many providers explained the MVA procedure and involved the young women receiving the treatment in the decision-making, other providers would communicate very limited information about young women's diagnosis and treatment plan. In some cases, young women were just told that their pregnancy was ''spoiled'' and were requested to go a room for the MVA procedure. In a few cases young women were verbally abused by healthcare providers before or during the PAC treatment. Some healthcare providers held a stigmatizing attitude towards young that had induced an abortion. They would scold young women for being sexually active before marriage, falling pregnant outside of wedlock and inducing an abortion.

I was screaming and the other doctor was shouting at me telling me that I should stay still since they were offering the service to me for free and if they stop, I would have to go to a private hospital and pay a lot of money. […] 'huyo daktari sio mchezo hana huruma walahi' (that doctor isn't compassionate). (Irene, 23 years old, business owner, 23-03-2021)

Costs of post-abortion care

Even though PAC services should be provided without charging any fees in public hospitals as determined by the national PAC provision guidelines, many young women had to pay to receive PAC. The research assistants observed that there were no fixed prices for PAC services. The costs depended on the provider and the ability of the patient to negotiate that price. The costs also differed based on the time of the day the services are provided. Young women that sought PAC services at nighttime more often had to pay than young women who sought PAC services during the daytime.

When young women could not afford the PAC, they often had to delay their care. In some instances, young women sought PAC services elsewhere in the hope that services in a different facility or from a different provider would be more affordable. Others waited and returned when they had gathered sufficient funding.

I went to the hospital and told the doctor and explained to him, I wasn't even afraid. He told me I have to be cleaned, but it was very expensive. He told me about 1500 for ultra sound and 6000 for being cleaned. So, in the morning I woke up early and dressed then I went another hospital. (Chemu, 23 years old, college student, 05-07-2021)

Male partners could offer financial support to young women to afford the PAC treatment. Even when male partners were not involved while young women underwent the abortion, some young women reached out to their (ex-) male partners to raise funds for PAC treatment.

Young women could also incur additional costs when they needed supplementary tests that were not available in the healthcare facility that they visited. In those cases, they had to travel to other healthcare facilities to get tests, like ultrasounds, done before they could receive PAC treatment. The costs young women had to spend for travelling and additional tests could raise the bill for treatment tremendously.

When young women were not able to raise money before or shortly after the PAC treatment, they could be detained in the healthcare facility until they paid the bill.

I was supposed to be discharged the same day, but I didn't have the money. They said I should pay 4500 KSh 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 is 7000 KSh but he had 5000 KSh. He talked to them and they accepted. I was discharged and I went home. (Mishi, 19 years old, waitress, 29-06-2021)

Post-abortion contraceptive counselling

As part of post-abortion care provision, young women receive contraceptive counselling to prevent future instances of unintended pregnancies and abortions. During post-abortion contraceptive counselling, young women were informed about the different types of contraceptives, their side-effects, and their benefits. Young women can select the contraceptive of their choice and the healthcare facility will provide them with the contraceptives. In some healthcare facilities, post-abortion contraceptive counselling was offered right after the PAC procedure. In other facilities, young women were asked to make a follow-up appointment two weeks after the PAC procedure. Unfortunately, the research assistants frequently observed that young women did not return for their follow-up appointment and missed the post-abortion contraceptive counselling.

Multiple young women who received post-abortion contraceptive counselling declined to make use of the offered contraception after their PAC procedure. Some declared that they would use abstinence. Others preferred condoms or the withdrawal method as their main form of contraception. Young women also noted the side-effects of hormonal contraceptive methods as reason to decline their use. Several young women that were married or in a relationship mentioned that they first should consult their male partner before they accepted contraceptives.

I was not happy (with the post-abortion contraceptive counselling). Honestly, the words that displeased me were about telling me to use family planning injection. It is not that I didn't want it or not, but I want just wanted to consult my husband first so that I can accept it. (Mary, 21 years old, unemployed, 02-07-2021)

Young women that refused to use contraceptives after their PAC procedure had a higher risk of becoming pregnant again. Kiri (15 years old, unemployed) and Tunda (20 years old, hair dresser) both fell pregnant again during the span of the research project after they had rejected the use of contraceptives during their post-abortion contraceptive counselling session. Both decided to keep the pregnancy.

Conclusion

When young women are in need of (post-)abortion care, they take several steps to search and access abortion methods, procedures and providers to terminate their unintended pregnancy. In this chapter, young women's experiences with knowledge about abortion, selecting abortion methods, undergoing abortion treatment, medical complications and post-abortion care, have been discussed.

Before falling pregnant, young women in Kilifi County had varying levels of knowledge about abortion. Some young women knew very little about abortion before they fell pregnant, while others had specific knowledge about certain abortion methods before they found themselves in need of such information. In rural areas, young women were mainly knowledgeable about traditional methods of abortion while in urban areas young women were more often aware of medical and surgical methods of abortion before they fell pregnant. When male partners were present, they often proved to be a great source of information and social connections that young women could employ to seek information. When young women sought an abortion method, they often reached out to close family members, friends, male partners, and acquaintances that could supply abortion methods or bring young women in contact with abortion providers. Especially, male partners could have a large social network and had the ability to reach out to abortion providers on young women's behalf to arrange an abortion. During their search for an abortion method, most young women were greatly restricted by the financial costs of an abortion, stigma, and the effectiveness of various abortion methods. Depending on the method of choice, young women underwent their abortions either at home or at the location of the abortion provider. Many male partners did not partake in the abortion process. However, several male partners were present while young women underwent the abortion and could offer emotional support. The abortion was for many young women a stressful and painful experience. During the abortion, young women were anxious about the complications and worried about the consequences of a failed abortion. Additionally, young women could experience a lot of pain. Without pain medication, traditional, medical and surgical abortion methods resulted in heavy cramps. After they underwent an abortion, various young women in Kilifi County experienced moderate to severe complications that caused them to seek post-abortion care. Male partners were often not involved in seeking (post-)abortion care, but in a few cases, they brought their female partner to the hospital when she experienced complications and paid for the treatment. Without financial support from male partners of other actors, young women had to delay seeking post-abortion care or had to travel to other healthcare facilities in the hope that treatment would be cheaper there.

Conclusion and Discussion

Chapter 7: Conclusion and discussion

Introduction

In the previous empirical chapters, I have explored how young women in Kilifi County perceive and experience the involvement of their male partner in their journey from an unintended pregnancy to an unsafe abortion.

In this final chapter, I will present and reflect on the main findings that my research has yielded. I will start off by summarizing the answers to my research questions that I have proposed in the introduction of this master's thesis. Thereafter, I will reflect upon three major themes that emerged during the data analysis by making use of the theories and concepts presented by Braam and Hessini (2004), Blanc (2001), Pratto and Walker (2004), and Van der Sijpt (2014). Following this, I will reflect upon strengths and limitations of the methodology and theoretical framework that I have employed for my research. Lastly, I will conclude this chapter by proposing several recommendations for further research and future projects that aim to address unsafe abortions in Kenya.

Main Findings

The legal, socio-cultural, economic and medical domains in which young women experience sex, unintended pregnancies and unsafe abortions

Throughout the introduction and results chapters, I have explored the legal, socio-cultural, economic and medical domains in which young women in Kilifi County experience their unintended pregnancies, unsafe abortions, post-abortion care and interactions with their male partners. Within these domains young women face multiple barriers to protect and improve their sexual and reproductive health.

Firstly, due to the contradictions between the Kenyan constitution and the penal code, young women in Kilifi County faced an ambiguous legal environment in which women, abortion- and healthcare providers, and law enforcers consider abortion to be illegal in all cases except when a woman's physical wellbeing is threatened by carrying the pregnancy to term. As a result, many young women feared legal prosecution if their abortion (attempt) would be discovered and, therefore, went to great lengths to cover up their abortion. They preferred hiding their unintended pregnancies, choosing less safe abortion methods and delaying care to prevent legal authorities from discovering their abortion. In multiple cases, this resulted in severe consequences for young women's sexual and reproductive health.

Secondly, young women in Kilifi County were severely influenced by deeply rooted socio-cultural practices and norms in Kilifi County that affect their sexual and reproductive health. Retrogressive practices and norms like early sexual debut, stigma on premarital sex and contraceptive use, and sexual exploitation through early marriages and transactional sex have for long been linked to the high prevalence of teenage pregnancies, contraceptive non-use and sexual risk behavior in Kilifi County. Another important feature of the social context in which young women experience unintended pregnancies that end in unsafe abortions is the power disparities between male and female partners within couples. As social and cultural norms position men as main decision-makers within the household, young women's ability to make decisions and take actions to protect and improve their sexual and reproductive health could be severely limited by their male partner's decisions and actions. The dominance of male partners within sexual relationships is not only confined to the social domain, but spills over

into the other domains, which increases the barriers young women in Kilifi County face to ensure their sexual and reproductive health and rights.

Thirdly, the economic circumstances in which young women in Kilifi County grew up and lived in influenced their ability to protect and improve their sexual and reproductive health significantly. Many young women that participated in the research project grew up and lived in precarious economic conditions which affected their access to contraceptives, sexual and reproductive health services and comprehensive (post-)abortion care. Additionally, a lack of financial resources also increased young women's financial dependency upon their male partner which increased their risk of unsafe sex, unintended pregnancies and unsafe abortions as male partners were often in charge of buying contraceptives and were an important source of financial support to access safe abortions. To navigate their economic conditions, various young women engaged in commercial of transactional sexual relationships. This, however, often posed additional risks to their sexual and reproductive health.

Lastly, young women in Kilifi County were strongly affected by the COVID-19 pandemic and the subsequent strike that emerged as a result of healthcare workers discontent with the Kenyan Government's COVID regulations. Consequently, young women in Kilifi County struggled to access comprehensive sexual and reproductive healthcare as all services were suspended expect for emergency treatments. For many young women this caused a delay in care when they experienced an unintended pregnancy or unsafe abortion. Additionally, healthcare facilities often struggled with a lack of trained personnel, proper equipment and pain treatment to offer quality (post-)abortion care. This prevented young women in Kilifi County from accessing and experiencing comprehensive care when they experienced sexual or reproductive health issues.

Unintended pregnancies: the role of male partners in contraceptive non-use, sexual violence and transactional sex that resulted in an unintended pregnancy

Within the first chapter of the results section (chapter 4), I have explored the role of male partners in several sexual and reproductive health domains that resulted in young women's unintended pregnancies. Unintended pregnancies are a leading cause of unsafe abortions in Kenya and young women in Kilifi County highlighted three domains – contraceptive non-use, sexual violence and transactional sex - in which men and male partners influenced their behavior and experiences that led to their unintended pregnancy.

Firstly, in most of their sexual relationships, young women indicated that contraceptive use had to be approved by their male partners and that their male partner often had rigid preferences for the contraception methods young women could use and when. Young women shared that their male partners where often reluctant towards the idea of using long-term reversible contraceptive methods, like the contraceptive pill or the IUD, and instead preferred the use of condoms, withdrawal, fertility awareness approaches and emergency contraceptives. With these methods, young women were vulnerable to unintended pregnancies as they were often dependent upon their male partners willingness to use condoms, perform withdrawal and/or respect their ''safe days". To negotiate the use of contraceptives, some young women indicated they sometimes withheld sex until their male partner agreed to use protection. Other young women confided they used contraceptives secretly to avoid an unintended pregnancy despite their male partners disapproval of contraceptives.

Secondly, male partners could have various roles within young women's experiences with sexual violence that led to their unintended pregnancy. In multiple cases, male partners made use of non-physical coercion to pressure their female partner into having (unprotected) sex. In those cases, young women explained they ended up with an unintended pregnancy because it was very hard for them to refuse their male partner's wishes when he was verbally abusive,

made threats or made use of manipulation and blackmail to obtain sex. Additionally, 5 young women fell pregnant unintendedly after experiencing defilement and rape by a male perpetrator. Four underage girls, aged 14, 15, 16 and 18 experienced an unintended pregnancy after they were violated by an adult male perpetrator, which classifies these cases as defilement under Kenyan law. One young woman (20) experienced an unintended pregnancy after she was repeatedly abused and raped by her father.

Lastly, within commercial and transactional sexual relationships, young women in Kilifi County could encounter difficulties to negotiate safe sex with their male partner as there were often disparities in wealth, age and social status between young women and their male transactional partner/client. This gave male transactional partners or clients more influence to decide over the time, place, and circumstances under which the transaction takes place. Additionally, young women were more likely to engage in unprotected sex when male transactional partners or clients could offer more money or when their need for money became more urgent.

Abortion decision-making: the role of male partners in pregnancy recognition, communication and negotiations about pregnancy termination.

The second chapter of the results section (chapter 5) explored the role of male partners in abortion decision-making. Within their stories, young women in Kilifi County outlined how their male partners could play a role in the recognition of their pregnancy, their feelings about the pregnancy, their communication about the pregnancy and their decision to pursue an abortion.

In the early stages of an unintended pregnancy, male partners could play an important role in the recognition of the pregnancy. Several young women did not recognize the pregnancy symptoms they were experiencing and after sharing these symptoms with their male partner, male partners could be the first actors to inform young women that they might be pregnant. Furthermore, male partners often provided the resources to confirm the pregnancy by either providing money for a pregnancy test or by buying a pregnancy test on young women's behalf and offering information on how to use a pregnancy test.

While some male partners played a role in the pregnancy recognition, others were informed of the pregnancy after young women discovered and confirmed the pregnancy. Young women's decision to share the pregnancy news with their male partner was highly dependent upon his anticipated reaction. Some young women opted not to share the pregnancy news with their male partner out of fear for his reaction. Others enlisted the help of friends to share the pregnancy news or told their partner the news over the phone. When young women shared the news that they were pregnant, the reaction of their male partners proved to be extremely influential in their choice for an abortion. Some male partners reacted positively and were willing to support in raising the child. Others reacted shocked or surprised, but were willing to engage in further discussions about the decision whether to pursue an abortion or not. However, a large share of the male partners denied paternity and refused to engage in any further discussions about the pregnancy. Some male partners reacted angrily and were verbally abusive to young women when they shared the pregnancy news. Other male partners simply received the news and proceeded to disregard any further requests to talk about the pregnancy. Various male partners accused their female partner of cheating and sent their female partner away to seek support elsewhere. In several cases, male partners revealed that they were already married and were uninterested in raising the child. When male partners denied paternity and withheld support, they passively influenced young women's decisions for an abortion as young women often did not have the (financial) means to raise the child as a single parent.

Even though a large share of male partners avoided further contact after denying paternity, various male partners were actively involved in the abortion decision-making process. They engaged in several discussions with their female partner about whether or not to terminate the unintended pregnancy. During these discussions the abortion desires between both partners could be concordant or discordant. In cases of concordant abortion desires, the decision-making process proved to be quite straightforward and male partners would often support their female partner in seeking abortion care. However, in most cases the abortion desires of both partners were discordant. This resulted in a complex abortion decision-making process in which both partners could employ various strategies to achieve their desired outcome. In several cases, partners were able to convince each other to pursue their abortion desires by outlining their arguments in favor of an abortion. Particularly, being able to continue one's education or financial hardship proved to be effective arguments convince the other partner to pursue an abortion. In multiple cases, male partners made use of emotional blackmail to pressure their female partner into an abortion. A couple of young women disclosed that their male partner threatened to end the relationship if they kept the pregnancy. Other young women shared that their male partners threatened with violence or self-harm if they would not agree to pursue an abortion. In a few cases, young women decided to navigate discordant abortion desires by secretly procuring an abortion. In these cases, young women often did not inform their male partner about the abortion or only informed him after the abortion already had taken place.

Abortion care(-seeking): The role of male partners in searching, accessing, and undergoing an abortion and post-abortion care

In the third chapter of the results section (chapter 6), I have explored young women's experiences with searching, accessing, and undergoing an abortion and post-abortion care, and the role of their male partner in these processes in Kilifi County. Young women shared that their male partners presence or absence could influence their search for information about abortion, their decisions on which abortion method to use, and their experiences with undergoing the abortion and post-abortion care.

During their search for information about abortion, male proved to be a great resource of information within young women's social network. Male partners could have a larger social network than young women and could approach male friends, male family members and male healthcare providers more easily than young women to gather information.

Once young women gathered the information they needed, they selected a suitable method to terminate their unintended pregnancy. Male partners that were present in this part of young women's journey towards an abortion proved to be a primary source of valuable support to access and afford the abortion methods that young women preferred. Young women shared that their male partners could have more social and financial capital to access different, and often safer, abortion methods and procedures than young women could access on their own. Besides this, when male partners were willing to arrange an abortion on young women's behalf, they could prevent some of the stigma that befalls women when they buy abortion methods or enter facilities that are known to offer abortion care. In cases where male partners were absent, young women were often left with little choice to select an abortion method if other actors in their social network were not able or willing to offer (financial) support. In most of these cases, young women relied on traditional methods to procure an abortion as they were the most affordable and accessible methods available.

When young women underwent their abortion, male partners were involved in diverse ways. In most cases, male partners were absent and young women underwent the abortion on their own or relied on the support of family members and close friends. A lack of support from their male partner, could leave young women feeling very lonely, sad and disappointed. In several

cases, male partners were present while young women underwent the abortion. These male partners could assist young women with managing the bleeding and pain while they underwent an abortion at home or could offer emotional support during a traditional, medical or surgical abortion by an abortion provider. In four cases, young women were forced by their male partner to undergo an abortion. In two cases, one girl and one young woman were administered abortifacients without their knowledge by their male partner. In another case, one girl was forced by her male partner to ingest abortifacients in his presence. In the last case, a young girl was abducted and forcefully administered abortifacients.

After they underwent an abortion, various young women in Kilifi County experienced moderate to severe complications that caused them to seek post-abortion care. Male partners were often not involved in seeking (post-)abortion care, but in a few cases, they brought their female partner to the hospital when she experienced complications and paid for the treatment. Without financial support from male partners of other actors, young women had to delay seeking post-abortion care or had to travel to other healthcare facilities in the hope that treatment would be cheaper there.

Theoretical reflections upon the result: unsafe abortion and gendered power inequalities

Despite Kenya's constitutional grounds for safe and legal abortions, my results shed light on the profound barriers young women face to access safe and legal abortion care in Kilifi County. Against the backdrop of the theorical analyses offered by Braam and Hessini (2004), Blanc (2001), Pratto and Walker (2004) and Van der Sijpt (2014), it becomes evident that gendered power dynamics play a significant role in young women's pathways to unsafe abortion in Kilifi County. Related to the theories discussed in my theoretical framework, I will present three overarching themes that emerged during the data analysis.

Gendered power inequality and access to abortion

When young women in Kilifi County sought abortion care, they faced various barriers on a macro level that limited their access to safe abortions. While sharing their stories, young women frequently mentioned the criminalization of abortion, the high costs of abortion care and the stigma surrounding abortion as important factors that restricted their choices and actions. As Braam and Hessini (2004) observe, these barriers are inherently tied to gendered power inequality that remains pervasive in political, socio-cultural, and economic institutions in sub-Saharan Africa that that govern the accessibility, acceptability, and affordability of safe abortions.

While sharing their stories, young women in Kilifi County named the criminalization of abortion in Kenya as an important factor that influenced their decisions and actions while seeking abortion care. The restricted legal status of abortion in many sub-Saharan African countries, including Kenya, affects women's power to decide over their own bodies tremendously (Braam & Hessini, 2004). While the 2010 constitution of Kenya provides the legal basis for Kenyan women to seek and access safe abortions, the penal code of 2012 criminalizes all forms of pregnancy termination in all cases except for emergency treatment to safe a mother's life. This contradiction creates much confusion and uncertainty amongst women and care providers alike about the legality of abortion care. Women, providers as well as the people that are associated with them are scared to be prosecuted by the legal authorities for inducing an abortion. This legal environment causes young women in Kilifi County to seek abortion services outside of healthcare facilities, which increases the risk of severe complications due to an abortion performed by a person lacking the necessary skills, or in an

environment lacking minimal medical standards, or both. At the same time, it creates a big market for informal abortion clinics and abortifacient provision in Kilifi County in which providers can charge high prices for goods and services. In practice this results in abortion services being inaccessible for many young women in Kilifi County as the risks and costs for seeking comprehensive abortion care are high.

Related to this, the high financial costs of safe abortion care were a significant barrier for young women's access to safe abortion methods and services. As Braam and Hessini (2004) note: ''Poverty in Africa is a key determinant of unsafe abortion, affecting women's decision-making about unintended pregnancies as well as their access to safe care'' (page 46). Within patriarchal economic systems, a gendered division of labor traditionally assigns women the role of homemakers, while men are to be responsible for the household income. This places women in a disadvantaged economic position where a lack of income creates dependency on financial resources from male partners. This limits women's power to make autonomous decisions over their reproductive health (Braam and Hessini, 2004). In line with Braam's and Hessini's analysis, young women in Kilifi County frequently stated a lack of income and a lack of financial support from their male partners as important reasons for desiring an abortion as well as not having the financial resources to afford safer abortion methods and procedures. Young women that lacked financial resources or financial support from male partners often relied on traditional methods or the self-administration of medical abortion methods to procure an abortion. These methods are incredibly risky and caused various young women to be admitted to the hospital with severe complications. More money can directly translate to more safe abortion methods for many young women. Abortion care in private healthcare facilities or informal abortion clinics run by healthcare providers in public hospitals are often the most expensive options, but safer as abortions are provided by trained providers in hygienic environments.

Lastly, stigma was a significant barrier for young women in Kilifi County to access safe abortion care. Stigma impacts young women's journeys towards an unsafe abortion in various ways. It plays a pivotal role in young women's experiences with unintended pregnancies, reasoning for desiring and abortion and abortion experiences. The stigma around abortion that young women in Kilifi County experience is threefold. In the first place, young women experience stigma for using or wanting to use contraceptives to prevent an unintended pregnancy that may result in an unsafe abortion. Young women in Kilifi County explained that within their community young and unmarried women that are known to use contraceptives are seen as promiscuous, unfaithful, ''slutty'' or believed to be prostitutes. Additionally, schools and religious institutions that they visited often promoted abstinence and chastity as appropriate methods of contraception for unmarried women. As Braam and Hessini (2004) note, educational, religious and cultural institutions play a huge role in constructing the norms about women's sexuality and reproductivity. Consequently, these same institutions, have much power to scrutinize reproductive behaviors that they deem unacceptable for women, such as contraceptive use and abortion. To avoid stigmatization, young women in Kilifi County would not visit family planning services to seek contraceptive counselling and in some cases ended up with an unintended pregnancy. Secondly, once young women in Kilifi County fell pregnant, they faced stigma for being sexually active before marriage. Religious and cultural institutions have long portrayed the idealized version of women as chaste and virginal. Premarital sex and resulting unintended pregnancies are therefore highly stigmatized (Braam & Hessini, 2004). Young women indicated that they were extremely scared for the stigma that they would receive if it was discovered that they were pregnant. As a result, they preferred to avoid abortion services provided in healthcare facilities as they were afraid that they might be seen by family, friends and community members. Thirdly, young women in Kilifi County face tremendous stigma for undergoing an abortion. While abortion has not always been an issue of taboo in

sub-Saharan Africa, laws introduced during the colonial era often penalized and criminalized women who sought abortions. This shifted the perspective on abortion as a common practice towards a practice that was deemed immoral (Braam & Hessini, 2004). The stigma that is nowadays tied to abortion, caused various young women in Kilifi County to seek abortion methods and services that could be more easily hidden. Yet, this often meant that they compromising on the safety of these abortion methods. For multiple young women this resulted in severe complications.

Gendered power inequalities within sexual relationships

On their pathways towards an (un)safe abortion, young women in Kilifi County were frequently affected by power imbalances within their relationships with their male partner. While telling their stories, young women indicated how their male partners could exert power to influence their sexual and reproductive decisions. As Blanc (2001) and Pratto and Walker (2004) recognize, gender-based power within sexual relationships is frequently unbalanced and male partners often have more access to power within society to influence decision-making processes about women's sexual and reproductive health. Within young women's relationships with their male partners, they experienced the effects of violence, economic dependency, gendered social obligations and gendered consensual ideologies that affected the balance of power within their relationships and, subsequently, their decisions and actions regarding their sexual and reproductive health.

Young women in Kilifi County outlined various situations in which their male partner made use of force that affected their sexual and reproductive health. A very clear example of the use of force by male partners is sexual violence. In multiple cases, young women experienced defilement and rape, which led to an unintended pregnancy. As Blanc (2001) shows in her framework, violence significantly influences the balance of power in sexual relationships and has a direct link to women's reproductive health outcomes as violence inhibits young women's ability to acquire information, to decide and to act within reproductive health domains. Violence or force does not only refer to physical violence, but also to emotional and psychological force (Pratto and Walker, 2004). In various cases, young women experienced pressure from their male partner to engage in sexual acts or in unprotected sex, which led to an unintended pregnancy. In addition to sexual violence, several young women in Kilifi County experienced forced abortions. In these cases, male partners relied on violence or threats of violence to ensure that their female partner underwent an abortion. As Pratto and Walker (2004) indicate, force is a significant aspect of power struggles within relationships and men's ability to disproportionally draw upon force as a power base can completely overrule women's decision-making power. Young women that underwent a forced abortion were deprived of any way to negotiate or achieve their desired reproductive outcomes.

In addition to violence, young women's decision-making power within their relationship with their male partner was greatly affected by their economic dependence upon their male partner. Resource control (including financial resources) is an important power base within society that men can draw upon to influence women's decisions and actions (Pratto & Walker, 2004. In many cases, young women had less (financial) resources than their male partner and were dependent upon his support to carry their unintended pregnancy to term and raise the child. When male partners demanded an abortion, they could easily threaten to withdraw financial resources or end the relationship which pressured many young women into terminating their unintended pregnancy as they did not have the resources to raise the child as a single mother. Gendered inequalities in resource control also affected the occurrence of unintended pregnancies within sexual relationships in the first place. Due to a lack of financial resources, young women could be dependent upon their male partner to supply contraceptives. When male partners did not have money or did not want to buy condoms, young women were more at risk of experiencing an unintended pregnancy. Additionally, in commercial or transactional

relationships, inequalities in resource control could severely affect young women's ability to negotiate safe sex. Furthermore, when young women were in need of (financial) resources, they were more likely to engage in risky sexual acts (such as unprotected sex) to receive more money or commodities from their male partner in compensation.

Economic dependency is closely related to gendered social obligations that determines the division of labor within the family unit. Within heterosexual relationships, the division of labor (including the responsibilities, provision of care and the obligation to satisfy other people's needs) is often organized such that men are the heads of the household and acquire resources while women are the homemaker and provide care (Pratto and Walker, 2004). As Blanc (2001) shows in her framework, this impacts the balance of power within sexual relationships significantly, since it affects the characteristics that have a direct link to individual's access to sexual and reproductive health services as well as the division of gender-based power between individuals within a sexual relationship. In many cases, where young women fell unintentionally pregnant, this division in social obligations became very clear. Young women felt tremendous pressure to take care of the future child and forsaking their education and employment, while their male partner earned money to support the family. For several young women, the prospect of giving up their education or work to fulfill their social obligations towards the family unit, was an important factor that fueled their choice to pursue an abortion.

Lastly, young women shared the impact of gender norms, gender roles and gender stereotypes that make up society's consensual ideologies about women's sexuality and bodies upon their power within their sexual relationship with their male partner. Young women in Kilifi County noted that it is deemed inappropriate for women to use contraceptives at a young age or before marriage. Within communities, young women that used contraceptives could face significant stigma and harassment. Insults like ''motorbike", ''slut" and ''prostitute" are frequently used to refer to young women that are known to use contraceptives and engage in sexual relationships before marriage. Young women that engaged in sexual relationships, were therefore hesitant to enter contraceptive counselling services to obtain contraceptives to prevent an unintended pregnancy. Male partner, on the other side, enjoyed much more liberty when it came to contraceptive use and sexual relationships. This made young women more dependent upon their male partners for contraception provision and placed them at risk for STIs and STDs if male partners decided to pursue multiple sexual relationships at the same time. Additionally, as Pratto and Walker (2004) note, consensual ideologies legitimize the inequal balance of power between men and women in sexual relationships. They can legitimize men's use of violence within relationships, men's disproportionate resource control and men's role as primary decision-maker within the household. This makes it difficult for women to shift the balance of power within their sexual relationships.

Navigating gendered power inequality

While young women in Kilifi County were affected by gendered power inequalities on their pathway towards an abortion, they shared how they employed various strategies, albeit hidden, to give direction to their own reproductive trajectories. By making use of covert contraceptive use and covert abortions, young women navigated existing power structures and achieved their desired reproductive outcomes in an inexplicit way.

Contraceptive use was a reproductive domain for young women in Kilifi County that social others had much influence over. Influence of their male partner, stigma and limited access to contraceptive services affected young women's ability to obtain contraceptives. Most young women were therefore reliant on condoms, fertility awareness methods and contraceptives supplied by their male partners to prevent an unintended pregnancy. Male partners were an especially important factor in young women's contraceptive use, as they are ascribed the role of primary decision-maker in sexual relationships. Various male partners were strongly

opposed to contraceptive use and refused their female partner to use contraceptives and rejected to make use of contraceptive methods themselves. This left young women in a vulnerable position to experience unintended pregnancies. However, a few young women shared that they visited family planning services to receive birth control pills, an IUD or three-monthly birth control shots despite the disapproval of their male partners. They explained that they did not desire to fall pregnant and kept their contraceptive use hidden from their male partner. As Van der Sijpt (2014) observes, covert decisions and actions can be a way to exert reproductive autonomy, while seemingly adhering to dominant power structures. Young women seemingly complied to the wishes of their male partner, while using contraceptives covertly to prevent an unintended pregnancy. This inexplicit, covert and hidden strategy is an important form of reproductive navigation for young women in Kilifi County to achieve their desired reproductive outcomes within inequal power-relationships.

Similar to covert contraceptive use, young women could also hide their abortion from their male partner when abortion desires were discordant. In a few cases, young women decided to terminate their unintended pregnancy without informing their male partner or informing him after the abortion was completed. In these cases, young women's abortion desires were not in alignment with their male partners abortion desires and they navigated this by undergoing a covert abortion. The young women in these cases, desired to pursue their education, continue their employment or find another, more suitable male partner instead. As Van der Sijpt (2014) outlines, a woman's reproductive decisions are informed by the social status she derives from it. The absence of the status of mother, allows women to pursue other desires such as education, employment or other relationships. To achieve these desires, young women in Kilifi County may opt to pursue an abortion in secret to avoid abuse, stigma and discrimination that comes with defying their male partner's wishes.

Reflections upon the theoretical framework: combining theories to understand young women's experiences with unsafe abortion

While reflecting upon the results through the lens of the theories by Braam and Hessini (2004), Blanc (2001), Pratto and Walker (2004), and Van der Sijpt (2014), it becomes evident that each theory has its strengths and limitations for understanding young women's experiences with unsafe abortion in Kilifi County. In this section I will reflect upon my theoretical framework and propose that the theories that make up my theoretical framework are complementary and can be combined to gain a better understanding about power dynamics that underly unsafe abortions.

Braam's and Hessini's (2004) theoretical understanding of the power dynamics that perpetuate unsafe abortions in sub-Saharan Africa forms the first cornerstone of my theoretical framework. This theory brings an understanding about the effects of patriarchy and its power inequalities that are inherent to institutions that govern the accessibility, acceptability, and affordability of safe abortions, including Kenya. Patriarchal ideologies have long been present in many sub-Saharan Countries and with the formation of nation states during the colonial era have become strongly ingrained in political, legal, economic, religious and cultural institutions at the national level. Braam and Hessini (2004) provide a theoretical analysis of how gendered power inequalities within these institutions affect women's ability to make decisions and take action to protect and improve their reproductive health.

Although, Braam and Hessini (2004) provide a great account of the gendered power dynamics that play out on the macro level in Kenya, it does not provide a detailed understanding of how gendered power inequality plays out at the micro level within sexual relationships in which

young women might experience unintended pregnancies that end up in an (un)safe abortion. Therefore, I selected Blanc's paper on the effect of power in sexual relationships as the second cornerstone of my theoretical framework to be able to study the interactions between young women and their male partners during their pathway towards an (un)safe abortion.

Blanc (2001) observes that power within heterosexual relationships is frequently unbalanced. Since men are mostly ascribed the gendered role of primary decision-makers within society, women typically have less ability to exert power within decision-making processes within their relationships with their male partner. Male partners often make or have a final say in decisions regarding sexual initiation, contraceptive use, abortion decision-making, prevention, and treatment of sexually transmitted infections (STIs) and HIV within sexual relationships. Therefore, Blanc has designed a framework in which gender-based power within relationships is linked to reproductive health outcomes. This framework provides great insight in the links between gender-based power and individual's characteristics, access to reproductive health service and the ability of partners to employ violence to coerce their partner into their desired reproductive outcomes.

Even though the framework of Blanc (2001) lays the groundwork for understanding the effect of gendered power inequalities within interpersonal relationships on sexual and reproductive health outcomes, it has several limitations. Firstly, Blanc's framework only emphasizes the connection between violence and the balance of power between partners in a relationship. This leaves out other important sources of power like economic, social, and religious/cultural sources of power that partners can draw upon to influence decision-making and act autonomously within relationships. In addition to this, Blanc's framework leaves no room to illustrate the interconnectedness between different sources of power in society and the way this affects an individual's power position within a sexual relationship. Therefore, I have complemented Blanc's framework with the theory on the four bases of gendered power by Pratto and Walker's (2004).

Pratto and Walker (2004) propose that besides violence (force) there are three common power sources in societies (resource control, social obligations, and consensual ideologies) that individuals frequently exploit to exert power and achieve one's desired outcomes. These four sources of power are introduced by Pratto and Walker as the four bases of power that individuals can draw upon to achieve their intended outcomes. In line with Blanc's (2001) findings, Pratto and Walker recognize that the extent to which individuals can derive power from the four bases of gendered power is not equally divided in society. Male individuals often are often positioned within society to easier access and employ force, resources, social obligations and consensual ideologies to achieve their sexual and reproductive desires. Additionally, Pratto and Walker (2004) note that all bases of power in society are interconnected and can reinforce each other. Power associated with one power base can help to obtain power within another base. For example, exertion of force can yield more power to control resources. The interconnectedness between power sources explains how partners can dominate on multiple levels and areas of decision-making within sexual relationships.

While all of the theories described above provide a great foundation for understanding the power dynamics young women in Kilifi County encounter while making decisions and taking actions to protect and improve their sexual and reproductive health, these theories mostly explain the structural constraints in which young women operate and are less suitable to study young women's own agency. Therefore, I have introduced the concept of reproductive navigation by Van der Sijpt (2014) as the last cornerstone of my theoretical framework.

Van der Sijpt (2014) offers the concept of reproductive navigation as a new way of understanding women's decisions and actions within the social context in which they take place. Instead of questioning whether pregnancy interruptions are a result of structural

constraints or autonomous choice, Van der Sijpt (2014) offers her concept to study all the ways in which women give direction to their own reproductive trajectories and the barriers that they encounter while doing so. Reproductive navigations include the seemingly passive actions, like non-action or compliance, that are usually overlooked as forms of agency. While studying a particularly sensitive topic as unsafe abortions, reproductive navigation complements the theories above to understand both gendered power inequalities that young women in Kilifi County face as well as the ways in which young women navigate these power imbalances to exert power over their own sexual and reproductive health.

Reflections on the research methodology

While reflecting upon my methodology, I have to acknowledge several limitations within the data sampling, data collection and data analysis that have affected my research.

Firstly, an important limitation of my research is the lack of male perspectives on unsafe abortion. While several male partners were selected for interviews during the recruitment of research participants, I have decided early on during my writing process to exclude their perspectives and experiences with unsafe abortion in relation to the data that were gathered from the female research participants. An important reason for this is that the data yielded from the interviewed male partners was not in proportion to the amount of data yielded from young women that participated in the research project. In total 18 interviews were carried out with young women's current male partners during the research project, compared to 54 young women that participated in the research project and engaged in multiple interviews. Additionally, the male partners were in most cases (14 out of 18) not the male partner with whom young women experienced their unintended pregnancy that resulted in an unsafe abortion and in some cases the male partners that were interviewed had no experience with unsafe abortion at all. For the scope of this research, I was interested in studying unsafe abortions as a reproductive event in the lives of young women in Kilifi County. The combination of a lack of male participants and male partners that were not involved in young women's unintended pregnancies and unsafe abortions, made it very difficult to assemble a representative sample of male partners and proportionally present male partner's perspectives and experiences regarding unsafe abortion vis-à-vis the perspectives and experiences of their female partners. Therefore, I have opted to exclude the interviews with male partners from my data set.

Secondly, the young women selected for the research project are not an accurate representation of the average female population in Kenya. During the recruitment of young women in Kilifi County that have experienced an unsafe abortion, participants for the research project were mainly recruited within public healthcare facilities and via community health volunteers that served in local communities. This resulted in a sample of young women that mainly come from low socio-economic backgrounds. It is likely that these young women are more vulnerable to experience unsafe abortions and complications due to financial constraints, limited education, limited contraception use and, in cases of rural areas, limited proximity to healthcare facilities. Additionally, approximately half of the young women were recruited to participate in the research project after being admitted to a public healthcare facility for experiencing complications after their unsafe abortion. This leaves out a group of women that did undergo unsafe abortions without experiencing (immediate) complications. The perceptions and experiences of young women that participated in the research project are, thus, not fully generalizable to the rest of Kenyan women. Yet, the results of this master's thesis are likely transferable to young women in similar contexts that experience unsafe abortions.

Thirdly, the data collection was affected by the global COVID-19 pandemic that had a severe impact on the Kenyan society. During the data collection, the research assistants were

confronted with the global outbreak of COVID-19 and the implementation of national COVID-19 regulations, which limited them to carry out their research in the field. Additionally, the recruitment of participants in public healthcare facilities was hindered the first couple of weeks by a strike initiated by healthcare personnel in protest of insufficient safety materials and health insurance to treat COVID-19 patients. During this time, many healthcare facilities in Kilifi County closed most of their departments related to sexual and reproductive healthcare except for the emergency ward. Young women seeking care for complications after an unsafe abortion were frequently rejected care unless the condition was life threatening. This impacted the ability of the research assistants to recruit participants and collect data within public healthcare facilities. Furthermore, as new research suggests, COVID-19 also impacted the experiences of young women with unintended pregnancies and unsafe abortions in itself. The COVID-pandemic resulted in an increase in unintended pregnancies, sexual and gender-based violence, unsafe abortions, and maternal and neonatal deaths in Kenya. COVID-19 measures such as curfews and lockdowns in addition to disruptions in public sectors such as transport, health, trade and security limited women's access to critical sexual and reproductive health services (Igonya et al., 2021). The results presented in this master's thesis are therefore to be understood in the broader context of the COVID-19 outbreak in Kenya and the impacts this has had on women's sexual and reproductive health.

Lastly, while doing research it is important to acknowledge my own positionality as a researcher. My own gender, gendered experiences and values about gender have not only sparked my interest for this topic, but also influenced the way I have analyzed the data and presented the findings throughout this master's thesis. From a young age, I have been raised with the idea that women and men hold equal positions in society and grew up in a society in which men and women have equal rights to express, decide and pursue their sexual and reproductive desires. I recognize that this has strongly influenced my own beliefs and norms about sexual and reproductive justice and equity. This affects the way I view the sexual and reproductive health topics that have emerged within the data during my research process. Additionally, while I have fully immersed myself in the stories of the research participants, I have to acknowledge my inability to fully relate their lived experiences to my own lived experiences. I have to recognize that I have never experienced an abortion and while I can strongly emphasize with young women's experiences with abortion in Kilifi County, I cannot say that I know how what it is like to undergo an (unsafe) abortion. Related to this, I also have to take into account the cultural differences between my research participants and myself. The way they view sexual and reproductive health and rights can differ from my own perspectives. While, I have truly done my best to represent the perspectives and experiences of young women in Kilifi County, my own perspectives and experiences might shine through the presentation of young women's stories. Lastly, I have to note that I have not interviewed the research participants myself due to the COVID-19 travel restrictions. As a consequence, also the positionality of the four research assistants have influenced the data collection. I luckily had the opportunity to be closely involved in the research assistants' progress in the field and have gotten to know much about the context of doing the research in the field through their stories, but I realize that this is not the same as being in the field myself.

Recommendations

From my results and research limitations, I would propose the following recommendations to inspire further research and future projects that aim to address unsafe abortions in Kenya:

Firstly, it would be highly valuable to include male partners in new research and projects that address unsafe abortions in Kenya. As my research has shown, male partners play a significant

role in women's unsafe abortions. They can directly or indirectly, consensually or non-consensually, supportively or unsupportively, influence women's decisions and actions within sexual and reproductive health domains (including abortion). While the ''She makes her safe choice" research project involved several male partners, it would be interesting to repeat the research with more male participants or to set up a new research project that specifically looks at men's experiences with unsafe abortions. This could give us more insight in the factors that affect men's involvement in unintended pregnancies and unsafe abortions. Furthermore, interventions that aim to address unsafe abortions in Kenya, would do well broaden their target population to include men/male partners. Up until today, many interventions that address the prevention of unintended pregnancies and unsafe abortions view women as their primary audience. Yet, unsafe abortions are a social affair that include many actors. With male partners being one of the most influential actors in women's sexual and reproductive lives, it becomes essential to set up interventions that address both female and male partners that consider an abortion.

Secondly, research and interventions that address unsafe abortions in Kenya may benefit from paying careful attention to power relationships that underlie unintended pregnancies and unsafe abortions. As various authors (see: Freeman et al., 2017; Moore et. al., 2011; Onyango et. al., 2010; Ouedraogo et. al., 2020 & Rehnström Loi et al., 2018) and my research suggest: unintended pregnancies and unsafe abortions do not exist in a social vacuum. They are social contingent affairs that are embedded in various gendered power dynamics that play out on the macro and micro levels of society. Therefore, it is important that more research will be done into the causes, mechanisms and effects of gendered power inequality that affect women's sexual and reproductive health. Additionally, interventions that aim to reduce the number of unsafe abortions may reach their full potential if they incorporate strategies that aim to mitigate the effects of unequal gender-based power on women's sexual and reproductive health. This may be done by creating awareness, offering (financial) support to access safe abortion services and promoting gender equality amongst the communities in which they operate.

Lastly, it is necessary to initiate and promote efforts to shift the public narrative of unsafe abortion as a women's issue towards a narrative of unsafe abortion as a societal issue in which all sexes and genders are involved. For too long, unsafe abortions have been deprioritized as an issue that only affects a part of the population. Yet, unsafe abortions have far-stretching consequences for society as a whole since it affects the direct costs of the public healthcare system, a loss of productivity, generational poverty, costs of law enforcement and the persistence of stigma and gender inequality within society. Therefore, it is crucial to shift the narrative and talk about abortion as an issue that affects all.

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