SOCIO-CULTURAL AND ECONOMIC FACTORS INFLENCING UNSAFE ABORTION IN MIGORI SUBCOUNTY, MIGORI COUNTY, KENYA

BY

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DECLARATION

By the Candidate

This thesis is my original work and has not been presented for examination in any institution.

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DEDICATION

This work is dedicated with greatest love and affection to my family, friends and teachers for their love, support and encouragement. Most importantly I dedicate it to God for giving everything, life, knowledge, wisdom and ability to do the study. May God rest in eternal peace the soul of my father who died before he could share with me this great achievement.

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ABSTRACT

Abortion is highly restricted in Kenya, but remains a controversial and common phenomenon which contributes to a major public health problem. Indeed (unsafe) abortion is a public health problem, putting many women at severe risk of serious health disability or even death. Studies in Kenya reveal that abortion occurs at significant levels. In Kenya, over 300,000 spontaneous and induced abortions occur annually, making it a leading cause of reproductive morbidity and mortality. This study was conducted in Migori Sub-County, Migori County Kenya. The study had three objectives: to describe traditional knowledge, attitudes, beliefs and behaviour about sexual relations, having children and contraceptive use in Migori Sub-County; to examine the changes that have taken place historically, which have influenced the knowledge, attitudes, beliefs and practices regarding sexuality, having children and abortion; to establish the social, cultural and economic factors that influence unsafe abortion among the Luo of Migori Sub-County. The study used the anomie theory and the theory of redefinition of the situation which argues that despite the socio-economic crisis the Luo of Migori Sub-County find themselves in, the crisis brings change and change brings about disorganization in society which will make them begin to search for new beliefs, status, norms to bring about stability. A cross-sectional and descriptive research design was used in the study. The data was collected using interview schedule, key informant interviews, focus group discussions and life histories. Respondents were identified using multi-stage and purposive sampling techniques. The target population was females who had procured abortion and males whose spouses and/or girlfriends had aborted. There were ten cases, four focus group discussions and 215 respondents. The quantitative data was analysed using descriptive statistics while the qualitative data was transcribed and analysed by thematic content analysis. The study revealed that the majority of respondents had sexual relations before marriage; female respondents experienced sexual relations two years earlier that their male counterparts; mass media and westernization have greatly interfered with the traditional beliefs and practices; the increase in illicit sexual relationships among married partners in search for favours (money) especially females. The study recommends that any reproductive health program have to focus on the socio-economic contexts within which abortion occurs if the problem is to be pragmatically addressed. Further research may focus on individual and community knowledge, attitudes and practices that relate to socio-cultural factors aimed at reducing incidences of abortion.

LIST OF ACRONYMS AND ABBREVIATIONS

WHO – World Health Organization

MDG – Millennium Development Goals

KNH – Kenyatta National Hospital

IPAS – International Pregnancy Advisory Services

PIWH - Pacific Institute for Women's Health

KAP - Knowledge, Attitude and Practice survey approach

TFR – Total Fertility Rate

KDHS – Kenya Demographic and Health Survey

MICS – Multiple Indicator Cluster Survey

ASFR – Age-specific Fertility Rates

LAM – Lactational Amenorrhoea Method

IUDs – intrauterine devices

NCPD – National Council for Population and Development

DNA – Deoxyribonucleic Acid

STIs – Sexually Transmitted Infections

FGD – Focus Group Discussion

KMET – Kisumu Medical Education Trust

FP – Family Planning

PTSD – Post-traumatic Stress Disorder

PAS – Post-abortion Syndrome

UNFP – United Nations Population Fund

PAC – Post-abortion Care

IEC – Information Education and Communication

WAS – World Association of Social Health

PEV – Post-election Violence

GBV – Gender-based Violence

GBSV – Gender-based Sexual Violence

KNCHR – Kenya National Commission on Human Rights

DEFINITION OF TERMS

According to Uganda College of Gynaecology the words abortion and miscarriage are used alternatively. “Abortion (miscarriage) is defined as the loss of products of conception before twenty-eight weeks of pregnancy. This may be due to intentional abortion; spontaneous abortion or the cause may not be known in the majority of parents” (UCG 2003).

The school further classified abortion into eight forms namely, threatened, inevitable, complete, incomplete, septic, missed, molar and habitual abortion (UCG 2003).

Threatened abortion is where there is little vaginal bleeding and there may be no lower abdominal pain. Pregnancy may still continue; uterus is of size and of expected dates of pregnancy and cervix closed.

Inevitable abortion is where the process is irreversible, contractions (pain similar to labour pains) and bleeding is seen and cervix may proceed to open, thus forcing the foetus out.

Complete abortion is a situation where all the uterine contents are passed out, and is usually characterized by little bleeding, closed cervix, empty uterus and reduced size.

Incomplete abortion is where uterine contents are not completely passed out, bleeding sometimes is there with clots from the vagina (may be severe), severe lower abdominal cramps and products of conception may be felt in the cervical canal.

Septic abortion is as a result of untreated incomplete abortion and thus results in infection. This kind of abortion is usually criminal, that is why the victims do not present themselves to hospitals to secure complete evacuation. They only visit hospitals when they develop fever, offensive vaginal discharge, lower abdominal pain and tenderness on palpating abdomen.

Missed abortion is where the foetus dies and the contents of the uterus are not expelled in time. Later, one may notice dark blood drops (spotting) from the vagina and uterus becoming smaller than expected dates.

Molar abortion is a situation where there is abnormal placenta, no foetus, vaginal bleeding and passing of red material like ripe coffee berries, and the uterus is much bigger than expected. Usually mother feels no foetal movements even after five months. Later the placenta is cast out as deciduous cast.

Fistula (or vaginal fistula) is a medical condition in which a fistula (hole) develops either between the rectum and vagina or between the bladder and vagina after severe or failed child birth when adequate medical care is not available.

Parity – The state or condition of being equal, especially regarding status or pay or the number of times a woman has not been pregnant or the number of times she has given birth to a foetus with a gestational age of 24 weeks or more, regardless of whether the child was born alive or was still born.

Total fertility rate sometimes called the fertility rate, period total fertility rate (PTFR) or total period fertility rate (TPFR) of a population is the average number of children that would be born to a woman over her lifetime if she were to experience the exact current age-specific fertility rates (ASFRs) through her lifetime and if she were to survive from birth through the end of her reproductive life

Total fertility rate represents the number of children that would be born to a woman if she were to live to the end of her childbearing years and bear children in accordance with current age-specific fertility rates.

Emic knowledge and interpretations are those existing within a culture, that is determined by local custom, meaning, and belief and best described by a ‘native’ of the culture.

Cultural relativism is the principle that an individual human’s beliefs and activities should be understood by others in terms of that individual’s own culture.

Abortion is the termination of a pregnancy whether spontaneous or induced by the removal or expulsion from the uterus of a foetus or embryo before viability.

Unsafe abortion refers to termination of a pregnancy by people lacking the necessary skills, or in an environment lacking minimal medical standards, or both (for this study, an unsafe abortion refers to an extremely dangerous life-threatening procedure that is self-induced in unhygienic conditions, or it may refer to a much safer abortion performed by a medical practitioner who does not provide appropriate post-abortion attention.

Incidence of unsafe abortion refers to the number of new abortion cases in a year divided by the number of women of reproductive age (for example, if a population initially comprises 1,000 women or reproductive age and 28 women are treated in a health facility for abortion related complications in 2012, the incidence of unsafe abortion proportion is 28 cases per 1,000 women).

Social factors refer to things that affect someone's lifestyle such as education level, religion, income, marital status, family size, community safety and social support.

Economic factors according to this study, include employment status and income level which might make women and girls engage in illicit sex that leads to unsafe abortion.

Traditional knowledge refers to the knowledge the Luo of Migori Sub-County have on sexuality and abortion and thus did not exist since there is no single word for abortion.

Traditional attitudes – According to the Luo of Migori Sub-County abortion is equated to murder and they would not inform their social environment because of stigma. They have negative attitudes towards abortion.

Traditional behaviour – These are changing societal norms towards women's roles and actual, emotional acceptance of them for one-self, specifically as the norms that relate sexuality and abortion since such behaviour are still regarded by the Luo of Migori Sub-County as deviant behaviour. For example, girls who were married as virgins made their parents get a lot of bride wealth and honour.

Cultural factors – Culture encompasses the set of beliefs, moral values, traditions, languages and rules of behaviour which according to the Luo of Migori Sub-County did not accept abortion. This is because children were viewed as a source of wealth and

strength. Abortion is associated with spilling of blood/ death thus denying them wealth and strength. There was no single word for abortion in their language. Cultural customs prohibit premarital sexual behaviour which may lead to unwanted pregnancies and abortion.

Traditional beliefs – The Luo of Migori Sub-County had several beliefs which were aimed at preventing abortion for example nobody was allowed to cross the legs of a pregnant woman for fear of falling on her; if a pregnant woman was not supposed to eat eggs; if a girl became pregnant she was supposed to disclose the father of the child during labour pains in order for the child to be born alive and lessen the pain; there was also the belief that if you do not use herbs during pregnancy, you might not carry the child to term and many more beliefs.

Change – The Luo of Migori Sub-County have experienced changes in their traditional system on how to handle sexuality and pregnancy due to lack of infrastructure such as '*simba'* and *'siwindhe'* which were used to teach young girls and boys on sexuality. Changes have also occurred in the uptake of modern medicine instead of herbs which prevented abortion. The value system has gone through changes including intermarriages with non-Luo.

Luo normative system – The Luo of Migori Sub-County had sets of norms which served to main practical functions which was used to evaluate human actions and guide people's behaviour. This was done through the beliefs systems, language and culture on sexuality and abortion.

CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 Introduction

Abortion is the termination of a pregnancy by the removal or expulsion of the foetus before it has attained viability hence causing its death (WHO, 1970). Abortion can occur either spontaneously due to complications with pregnancy or it can be deliberately induced. Circumstances in which spontaneous abortion can take place may be due to illness, use of certain medicines, exposure to certain physical conditions such as accidents and beating. Abortion can be induced to preserve the life of the pregnant woman, for example in the case of ectopic pregnancy whereby fertilization takes place in the fallopian tube. This is referred to as therapeutic abortion. However, in Kenya this must be certified as necessary, ideally by three medical practitioners if the law is followed as prescribed.

According to the Constitution of Kenya, Chapter 4 part 2, under the Right to Life, Section 26: 1-4. It states that, "Every person has the right to life, the life of a person begins at conception, a person shall not be deprived of life intentionally, except to the extent authorized by this constitution or other written law. Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law." An induced abortion for any other reason (not medical) is termed as elective and is proscribed by the law in Kenya. In general, the term abortion most commonly refers to induced abortion, while spontaneous abortions are referred to as miscarriages. Most

miscarriages occur early in the pregnancy such that the woman may or may not be aware that she was pregnant.

This chapter has provided the background to the study, the problem statement, and the objectives of the study, the rationale, and research hypotheses.

1.2 Background to the Study

Abortion is not a recent phenomenon (Kegode, 2010). Throughout human history, abortion has been practiced for one reason or another. For instance, in ancient Greece and Rome, abortion was a legal form of birth control without social stigma (Richmond-Abbott, 1992).

It has been induced by various methods, including the use of herbal abortifacients, sharpened tools, physical trauma, the use of some medical drugs such as quinine among others, and other traditional methods.

Historically, several herbs were reputed to have abortifacient properties and were used in traditional medicine such as tansy, pennyroyal, black cohosh and silphium (Riddle, 1994). In contemporary medicine, there are medications and surgical procedures which are used to induce abortion. However, the use of these herbs without prescription by a specialist can cause serious harm and have lethal effects. In societies in which elective abortion is proscribed by the law or public opinion, the procedures and instruments used are usually unsafe for the well-being of the pregnant woman. More often than not induced abortion causes trauma on top of the abdomen, leading to serious internal injury to the foetus. Reported methods of unsafe abortion include the use of misoprostol and

insertion of sharp non-surgical implements such as knitting needles, cloth hangers and others.

Among the major public health problems facing developing countries is unsafe abortion, which is a leading cause of reproductive morbidity and mortality (Guttmacher Institute, 2008). In Sub-Saharan Africa, a large proportion of maternal related disabilities and death have their origin in unsafe abortion. Worldwide, it is estimated that 46 million abortions occur in countries where abortion is legal while 20 million occur where the procedure is illegal (Guttmacher Institute, 2008).

According to United Nations Population Fund (UNFP), 515,000 women will die each year from causes related to pregnancy (UNFP, 1999: 2-3). Each year 70,000 will die as a result of unsafe abortion; an unknown number will suffer from infection and other adverse health consequences. An analysis done in August 2013 on unsafe abortion indicated that an estimated 464,690 induced abortions occurred in Kenya in 2012, corresponding to an induced abortion rate of 48 abortions per 1000 women of reproductive age (15-49 years), and an induced abortion ratio of 30 abortions per 100 births in 2012 (ibid). It is also estimated that 157,762 women received care for complications of induced and spontaneous abortions in health facilities in the same year. Of these, 119,912 were experiencing complications of induced abortions. Based on patient-specific data, women who sought abortion-related care were socially, demographically and economically heterogonous. They included educated and uneducated women, urban and rural women, Christians, Muslims and women of “other faiths”, students, unemployed and employed women as well as married, never married and divorced women. In Africa, 4 million abortions occur annually and 13 percent of all

maternal deaths are due to abortion-related complications (WHO 2004; Sledge et al., 2007). In developing countries, unsafe abortion and its related complications is a major leading cause of maternal death. For instance, globally over 500,000 girls and women die annually from complications related to unsafe abortion (Sedge et al., 2007). In East Africa, it is estimated that 14 percent of all pregnancies end up in abortion and nearly one in five maternal deaths are due to unsafe abortion (WHO 2004; Sedge et al., 2007).

In Kenya and elsewhere in the world, there are two main positions in the abortion debate: pro-choice and pro-life propositions (Kegode, 2010). These can further be divided into conservatism, liberalism and feminism. The main gist of the debate centres on whether and when abortion can be legitimate or not. The conservative position strongly opposes abortion for any reason whatsoever. To them abortion is never right because it involves the destruction of human life. The conservative position is influenced by religious, philosophical and cultural convictions, which emphasize that an unborn foetus is human and thus its destruction is tantamount to destroying human life. Kenya's Constitution, for example, points out that life begins at conception thus, the termination of conception is considered as abortion, which is illegal (The Constitution of Kenya 2010, Chapter 4 part 2). However, critics of abortion argue that the issue of abortion should not be reduced to morality alone but should be looked at as a problem that affects men and women in their existential situations with a variety of cases, motives and consequences.

According to Peterson (1998), abortion has been numbered among the liberal causes of modern politics. Abortion is identified with women's rights just as the Civil Rights Movement was identified with equal rights for African Americans and other minorities.

But is abortion really a liberal cause? A careful examination of the history of the abortion rights movement would shock even the most ardent defenders of a woman's right to choose. The founders of the movement were in fact racists who despised the poor and who were searching for a way to prevent coloured races from reproducing. Rather than defending the rights of the poorest of the poor, which is the tradition of liberalism, the founders advocated for abortion as a means of eliminating the poor; especially Blacks, Jews, Slavs, and Italians. And rather than desiring to help the poor through welfare programs, they wanted to eliminate all charities and government aid. Today, most liberals would be shocked to know of this racist heritage. Not only is the founding of the abortion rights movement anti-liberal, but it may have been an attempt to promote racial genocide.

Abortion has, therefore, continued in Africa despite the ban due to the disintegration of kinship based normative system which has enabled girls especially those in schools, to get exposed to unprotected premarital sex, increased adultery due to the liberalization of the sex code and the fact that women are no longer the inhibited faithful housewives. People in positions of control such as priests, teachers and employers may also be taking advantage of women under their control. This has led to promiscuous relationships without responsibility and some of the resulting pregnancies end up in abortion in spite of the fact that it is illegal (*The Daily Nation* 23rd July, 2008; 3).

Globally, there are regional variations in the permissibility and prevalence of abortion. In many Western Societies, there are more liberal attitudes/perspectives with regard to the legitimization of abortion compared to African societies. In some Western Countries such as France, Romania and Poland, abortion has become accepted as a birth control method, even though there are a variety of other methods that exist. In Greece, even with stiff

opposition of the Greek Orthodox Church, abortion remains a popular form of birth control. In Africa, there is still strong opposition to abortion hence in many countries it is illegal. In many societies the sanctity of human life is greatly respected/upheld. Children are highly valued in many African societies (Ocholla-Ayayo, 1980) hence, abortion is abhorred. However, despite this strong negative attitude toward abortion in Africa, the reality is that it occurs and its incidence is increasing due to increase in liberal sex attitudes and socio-economic changes in the society.

Women seeking to terminate their pregnancies in most cases resort to unsafe methods, especially where and when access to abortion in hospitals is prohibited and expensive. The World Health Organization defines unsafe abortion as '… a procedure carried out by persons lacking necessary skills or in an environment that does not conform to minimal medical standard or both. (WHO, 2004).

Unsafe abortions are sometimes referred to as 'back alley/street' abortions because they are performed by persons without medical training, a professional health provider operating in sub-standard conditions due to legal prohibition or the woman herself. Unsafe abortion in many cases is also procured by the use of crude, unsanitary instruments without regard to health consequences. So, it is not just a matter of lacking skills alone. As a result, unsafe abortion is a public health concern because of its higher incidence and severity of its associated complications such as haemorrhage, incomplete abortion and damage to internal body organs. This study therefore, sought to examine socio-cultural and economic factors influencing increasing incidences of unsafe abortion in Migori Sub-County

1.3 Problem Statement

Abortion is an age-old practice that has major impact on public health in different human societies, though with varying impacts (Kegode, 2010). The problem can be perceived from several perspectives. First, it manifests itself in the form of severe health complications, risks involved, cost of post-abortion care and fatality. Secondly, the occurrence of abortion has raised questions regarding its moral legitimacy, because it hinges on destruction of human life. Thirdly, induced abortion has social, psychological, biological and moral reverberations.

In spite of the above negative implications of abortion, unsafe abortion is still performed by pregnant women in most communities. The decision to perform an abortion is influenced by several a number of factors. In particular, this study sought to establish how the problem of abortion threatens the Luo normative system. It takes the position that the breakdown of the traditional Luo normative system has contributed to the increased incidence of unsafe abortion. It highlights the what, how and when of induced abortion in order to capture the nature and experience of abortion in relation to socio-cultural and economic conditions in the society.

The study employs ethnographic, constructionist and definition of situation approaches to provide deeper understanding of the problem of abortion in the contemporary Luo society in Migori Sub-County, Nyanza Province, Kenya. Thus, the focus on socio-cultural and economic factors that influence unsafe abortion practices among the Luo community in Migori Sub-County. To enhance this, the study investigated the influence of traditional knowledge, attitudes, beliefs and behaviour about sexual relations, having children and

contraceptive use in Migori Sub-County on our knowledge of abortion. In addition to that, this study interrogated the changes that have taken place historically altering the knowledge, attitudes, beliefs and practices regarding sexuality and abortion. By so doing, the study centres on the socio-cultural factors that influence unsafe abortion among the Luo community in Migori Sub-County.

1.4 Objectives of the Study

1.4.1 General objective

The general objective of the study was to examine socio-cultural and economic factors that influence unsafe abortion among members of the Luo Community in Migori Sub-County, Migori County, Kenya.

1.4.2 Specific objectives

i. To describe traditional knowledge, attitudes, beliefs and behaviour about sexual relations, having children and contraceptive use in Migori Sub-County.
ii. To examine the changes that have taken place historically, which have influenced the knowledge, attitudes, beliefs and practices regarding sexuality, having children and abortion.
iii. To establish the economic factors that influence unsafe abortion among the Luo of Migori Sub-County.

1.5 Hypotheses

i. Socio-cultural institutions, beliefs and practices pre-empted abortion in traditional Luo society as reflected in Migori Sub-County.

ii. The breakdown of traditional normative order due partly to socio-cultural, economic and moral changes is probably the single most important factor leading to the relative prevalence of abortion in the county.

iii. Educated women with some resources are more likely than the uneducated to abort.

1.6 Justification of the Study

The study on abortion in Migori Sub-County is important because of its incidence and dilapidating effects it has on social, psychological and health. Thus, it is imperative to study and understand the socio-cultural and economic context within which unsafe abortion occurs in view of designing effective interventions of reducing, high levels of unsafe abortion. The study provides ethnographic data on Luo community perspectives on abortion. The study provides information that policy makers, planners and implementers can use in tackling the problem of unsafe abortion. The Luo did not have one word for abortion meaning it was not there or rare in the past since a word exists only if there is use for it. However, there were traditional mechanisms that functioned to reduce the incidence of induced ‘abortion’ that can be vital in teaching the issue in the contemporary society. It provides data on sexual and contraceptive behaviour/practices and the cultural logic behind these practices at present.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

While it is not possible to provide a complete review of all studies that have been conducted on all issues of unsafe abortion, an attempt has been made to focus on issues of concern to the study. This section provides a review of studies on abortion in traditional and contemporary Africa, parts of the world and Kenya in particular. It also highlights studies on sexual behaviour.

2.2 Abortion in Pre-colonial Africa

Some studies suggest that some ancient and traditional societies tolerated induced abortion although on rare occasions. The ancient Egyptians are reported to have been the first community in Africa to discover techniques of procuring abortion (ibid). Deverieux (1976) suggests that in some African communities, abortion was used as a birth control method and unwanted pregnancies resulting from rape, incest and illicit sex were terminated before the first cry a baby makes at birth. This was out of the belief that the first cry the baby makes at birth is what makes it human and social.

Among the Akan people of Ghana, induced abortion was allowed if the pregnancy was from rape or illicit sex. The Akan people view a foetus as having no human attributes (ibid). To them human life begins at birth. Among the Samburu of Kenya uncircumcised girls who conceived out of wedlock were forced to terminate their pregnancies because

conception out of marriage reduced a girl's chance of marriage and the size of the herd paid as bride-wealth.

Several studies, however, show that in the majority of pre-colonial African societies, abortion was abhorred and highly stigmatized (Ocholla-Ayayo, 1976; Ndeti, 1978; Parkin, 1978). In many communities, children were highly valued as symbols of social status, completeness in one's marital status, wealth, source of labour and social security (Ocholla-Ayayo, 1994). In the Luo community a woman's social status depended on the number of children (especially sons) that she bore. Such a woman was respected by her husband and kinsmen (Muange, 1999). Thus, social pressure prevailed upon women to ensure that they carried their pregnancies to full term.

2.3 Studies of Unsafe Abortion in the World

The incidence and reasons for induced abortion vary regionally and worldwide. It is estimated that forty-six million abortions occur worldwide annually (Henshaw et al., 1999; Guttmacher, 1996). Of these, twenty-six million occur in countries where abortion is illegal while twenty million occur in countries where it is illegal.

Some countries such as Belgium and the Netherlands have a low rate of induced abortion (of between 10 and 11 induced abortions per 1000 known pregnancies) while others like Russia and Vietnam have a comparatively high rate of (of between 43 and 62 induced abortions per 1000 known pregnancies respectively). In eastern Africa, the estimated number of induced abortions in 2003 was 2.3 million or 39 abortions per 1000 women of reproductive age. One in five maternal deaths was due to unsafe abortion (WHO 2007).

2.4 Studies of Unsafe Abortion in Kenya

In Kenya, over 300,000 spontaneous and induced abortions occur annually. 21,000 women are estimated to be admitted each year to public hospitals of complications for incomplete spontaneous or induced abortion (WHO, 2007). Studies focusing on abortion began in the late 1970's and saw a marked increase in the 1980s and 1990s. The studies are based on data of women admitted in public hospitals seeking care for unsafe abortion-related complications.

This data excludes women who are treated in private facilities and those who do not seek care in any facility. This limitation is due to the difficulty of obtaining reliable abortion-related information and the fact that abortion is illegal and highly stigmatized in Kenya. Aggarwal's (1978) study of 610 in-patients at Kenyatta National Hospital (KNH) provides a vivid scenario of induced abortion in urban areas in Kenya.

The study found that 62% of abortions were either induced or likely to have been induced among women aged thirteen and forty-four years. Another retrospective study by Aggarwal and Mati (1980) found one hundred percent increase in abortion related cases among patients at KNH seeking post abortion care between 1973 and 1978. They also report the association between the risk of unsafe abortion and maternal morbidity and mortality.

Several studies emphasize that a substantial proportion of recipients of post-abortion care in Kenya are adolescents and young unmarried women (Baker and Khasiani, 1992; Lema, 1992; Lema, Rogo & Kamau, 1996; Ankomah, 1997). A national survey of women of diverse ages seeking post-abortion care found that forty percent were aged twenty-five to

thirty-four, twelve percent were older than thirty-four years while sixteen percent were teenagers (IPAS, 2004; Gabreselassies et al., 2005).

Many adolescent and young unmarried women's unwanted pregnancies have devastating effects on their education, career opportunity and acceptance by kinsmen and society. Those who are desperate to get out of the situation often turn to unsafe abortion procedures that endanger their lives.

More recent and larger studies indicate that older and married women also seek post-abortion care in public hospitals. Solo et al. (1999) report that in a study of five health institutions, seventy one percent of women seeking post abortion care were married and sixty two percent had children.

Another study conducted at Kenyatta National Hospital shows that sixty two percent of women seeking post-abortion care were married, twenty two percent were single, twelve percent were separated or divorced while 4.4 percent were widowed (*The Daily Nation*, 4th June, 2009). Of the one hundred and thirty-seven patients who were studied, one hundred and nineteen were procuring abortion for the second time, fifteen for the third time and three for the fourth time. This information is definitely of great concern since those who come forward for post-abortion care are married women. No wonder, according to official information, increasing numbers of new HIV/AIDS infections are taking place within marriage an indication that adultery is prevalent.

A study conducted in western Kenya, shows that 43 percent of patients in a referral hospital had abortion related complications. Of these 65 percent were from rural areas and 59 percent were married (Wamwana, 2006). According to recent studies, it is estimated that 60 percent of costs incurred by public hospitals go to treating probable post-abortion care (IPAS, 2004).

These studies are an indication that in Kenya women who procure abortion for the first or subsequent times resort to procuring the procedure from quacks in a backstreet clinic and other unskilled medical providers (Bakers & Khasiani, 1992). There are studies which focus on the factors that motivate women to terminate their pregnancy (Magadi & Kuyo, 1996; Mitchell et al., 2006; Ndunyu, 2007; Chang, 2008). Cheng's (2008) study of 27 countries reports that the most commonly cited factors that influence abortion are: the desire to delay or end childbearing, and concern over interruption of education or career. Financial issues, relationship stability and perceived immaturity are the other factors cited.

Several studies in Kenya show that adolescents and young unmarried women are motivated to induce abortion due to the stigma attached to childbearing outside the wedlock and single motherhood (Magadi, 2004; Mitchell et al., 2006; Ndunyu, 2007). Some small-scale studies suggest that other reasons women procure abortion include, rape, incest, failure of contraceptive method and lack of access to contraceptive method (Bankole et al., 1998; Finder, 2007; Cohen, 2008). Among married women, common reasons for unsafe termination of pregnancy are related to the desire to space children, preference for children of a specific sex and economic hardship (Baker & Khasiani, 1992).

A study by Maendeleo ya Wanawake reveals that many women are likely to abort unwanted pregnancies for fear of giving birth to boys because of issues pertaining to inheritance of property and future marital prospects (*The Daily Nation*, April 21st 2010).

Some studies also suggest that the unmet need for contraception may be a factor in contribution to the incidence of abortion (Oindo, 2009). This is true among adolescent and married women who do not have access to contraceptive services in public health institutions. The Kenya Demographic Health Survey (KDHS, 2005) shows that in Kenya only 10 percent of sexually active unmarried adolescents aged 15-19 years use any modern contraception. It also found fifty two percent unmet-need for family planning among married women aged 15-19. It is important to observe that the sexual encounters of many adolescents and young unmarried people are unplanned, infrequent and sporadic hence promoting unplanned pregnancy (Oindo, 2009).

In the last decade there has been a shift in studies on unsafe abortion from socio-demographic and descriptive studies to action-oriented research aimed at reducing and preventing the incidence of unsafe abortion in Kenya (Rogo, Orero & Oguttu, 1998). The Pacific Institute for Women's Health (PIWH) reports substantial decline in death from unsafe abortion and 65 percent increase in access to contraceptives in a community-based research program in Suba district in Kenya (PIWH, 2009). This was the result of collaboration between PIWH, the local community, community and medical health providers. The program involved training health personnel, community health workers, especially traditional health providers and local community members on ways of combating unsafe abortion. The conclusion is that effective use of contraception would drastically reduce unwanted pregnancies and by extension, abortion.

In a nutshell, there are few studies in Kenya that focus on abortion in the general population. As a result, national level data on the incidence, attitudes and beliefs about abortion and the conditions under which it occurs is lacking. This study therefore, sought to fill this gap by examining the social aspects of abortion focusing on attitudes and beliefs about abortion and the context within which it occurs.

Women who abort, according to the Maendeleo ya Wanawake, and Kenya Demographic Health Survey among others, in Kenya are mostly younger than 25 years old and 19 percent are teenagers. Another important characteristic is that the majority of them are unmarried – over 57 percent (KDHS, 2005). This is because of economic reason, pursuit of education, training, career and social reasons such as denial of paternity and stigma attached to pregnancy out of wedlock. For married women adultery and unmet need for contraception may contribute to women seeking abortion in circumstances that are unsafe. A national survey found 40 percent of women who seek post-abortion care are aged 25-34 years. 16 percent are teenagers while 16 percent are above 34 years (IPAS, 2004).

Recent studies indicate older and married women also seek abortion (Solo et al 1999). However, studies indicate that young unmarried women are the main recipients of post-abortion care in Kenya (Lema, Rogo &Kamau, 1996). A recent study indicates that 62 percent of women who seek post abortion care are at Kenyatta national hospital are between the ages of 35 to 44 years old (Lema, Rogo & Kamau, 1996).

2.5 Studies on Sexual Behaviour

Before the emergence of HIV/AIDS epidemic social scientists were reluctant to study sexual behaviour, the realities of sexual desire and practice (Ahlberg, 1994). In the 1960s and 1970s studies focused on ethnographies of customary practices related to sex. Later in the 198's and 1990s more studies emerged focusing on fertility, family planning and sexual networking.

Ethnographic studies reveal that sub-Saharan Africa is characterized by diversity in sexual behaviour. In Kenya, there are communities which traditionally proscribed pre-marital sex while others did not. For instance, Kikuyu and Luo girls were expected to be chaste until marriage (Kenyatta, 1962; Parkin, 1973; Ocholla-Ayayo, 1976; Ahlberg, 1994). Similar sanctions are reported among the Maasai of Kenya and Tanzania (Jacobs, 1973).

Among the Akamba unmarried men and women were allowed to engage in sexual relations as long as pregnancy did not occur. However, it is important to observe that even in those societies where unmarried people were not allowed to have sex, they were allowed limited or controlled sexual experience for purposes of sexual satisfaction (Ocholla-Ayayo, 1976; Ahlberg, 1994). Among the Luo young men received female visitors in their '*simba'* or boys' dormitory. During such visits non-penetrative sexual encounter or '*wuowo*' was performed. The visits used to take place between noon and mid-night and the female visitor was accompanied by her friends. A similar practice known as '*gwiko*' existed among the Kikuyu (Kenyatta, 1962).

In contrast, there are communities which gave young unmarried men and women a considerable amount of freedom in sexual activity as long as it did not result in pregnancy. For instance, among the Akamba young men and women were expected to have practical sexual experience before marriage (Ndeti, 1978) to a point that a virgin at marriage was returned to her home to have her deflowered. This was shameful to her family. Premarital pregnancy was equally shameful and jeopardized a girl's prospects for marriage as a first wife who commanded considerable virtual and supervisory powers and rights.

Recent studies show that today many young people are sexually active. In Kenya, the mean age at first sexual intercourse is 16.1 years and 18.4 for first marriage. This involvement of young people in sexual activities puts them at risk of unwanted pregnancy and consequently, unsafe abortion. For instance, Juma (1992) reports that almost every household in Kisumu has a girl who is a single parent. The involvement of young people in sexual activity has also contributed to an increase in the number of girls who drop out of school due to unwanted pregnancy.

Several studies in Sub-Saharan Africa also show that married people have extra-marital sexual relations (Caldwell, Caldwell & Quiggin, 1989; Muange, 1998; Sorre & Akong'a, 2009). The studies reveal that extra-marital relations are more common among men than women. Women's extra-marital relations tend to be discreet. Ethnographic data indicates that traditionally female extra-marital relations were strictly prohibited in a majority of African societies (Potash, 1978; Parkin, 1978, Caldwell, Caldwell & Quiggin, 1989).

In many African societies female sexuality was strictly controlled compared to that of men, whose premarital and extramarital relationships were condoned. For instance, traditionally among the Baganda of Uganda, the Tutsi and Hutu of Rwanda, men's premarital and extramarital relations was expected (Muange, 1991). Thus, men enjoyed a considerable amount of freedom in sexual relations compared to women.

It is imperative, however, to observe that in Sub-Sahara Africa there are regional differences in the extent to which women have control over involvement in sexual relations. In Eastern and Southern Africa women lack decision making power over matters of sex (McGrath et al., 1992; Muange, 1998). This is based on the fact that most societies in these regions have a strong patriarchal system, where women do not have access to resources or power. Customary norms demand that women submit to their male partners' demands under all circumstances. For instance, the Luo community strongly condemns women's extramarital affairs while men's are treated leniently. There is also a widely held belief that adultery can result in '*chira'* a fatal condition among babies of the parents involved who do not take the prescribed precautions. The fear of the consequences of extramarital relations such as divorce also tended to discourage women from such affairs in the past.

By contrast, studies in West Africa show that women enjoy greater autonomy in their sexual relations with men (Oppong, 1983; Orubuloye, Caldwell & Caldwell, 1993). This is based on women's autonomy to engage in off-farm activities such as trade in either villages or towns and the nature of the West African family structure which provides women with a separate resource base from their husband's

Other studies in Sub-Sahara Africa have used the Knowledge, Attitude and Practice (KAP) survey approach to study sexual behaviour (Igstad, 1990; Orubuloye, Caldwell & Caldwell, 1993; Anarfi, 1993). These studies provide evidence of fairly significant levels of partner exchange and sexual networking among men (married and unmarried) and women in the general population.

2.6 Attitudes and Beliefs about Abortion

In most studies, analysis of abortion focuses on its incidence and ignores social attitudes and beliefs. Older studies report negative attitudes to abortion in Kenya (Mboya, 1963; Ocholla-Ayayo, 1976; Rogo, Orero & Oguttu, 1998). Ethnographic data indicates that induced pregnancy termination was greatly abhorred in many traditional communities in Africa (Parkin, 1978; Cohen & Odhiambo, 1989).

Among the Luo for example, a woman who aborted was viewed as careless and morally loose. Such a woman was ridiculed and stigmatized by the community. Traditionally, miscarriage (spontaneous abortion) was viewed as a misfortune and it was believed to be caused by witchcraft and the evil eye. A woman who frequently miscarried was perceived as unclean or having '*chola'* and thus, was not allowed to interact with other people until she was cleansed by a traditional healer using herbs or '*manyasi'*. She could only resume normal social life and sexual relations after cleansing (Mboya, 1963; Ocholla-Ayayo, 1976). In fact, she was a subject of sympathy since she was considered not to be personally responsible for her unfortunate condition. On the other hand, abortion was equated to murder or 'spilling' blood or '*puko remo'* and this was considered a taboo. It

attracted stigma and ostracization from the community and one had to be cleansed to be accepted back in the community.

Traditionally the Luo value the sanctity of life, hence spilling blood was considered a bad omen (Mboya, 1963). The killing of any animal and human beings was believed to 'soil' the killer's hands and those of his future generations. In case one killed, the cleansing ceremony was too costly and elaborate. Punishment included banishment and destruction of one's houses and food stores to prevent the curse from afflicting his kinsmen and the community at large. Today similar views about abortion are widely prevalent; it is stigmatized and regarded as morally debasing.

2.7 Factors Influencing Sexual Behaviour and Unsafe Abortion

This section looks at the socio-cultural and economic factors that influence sexual behaviour and unsafe abortion at macro and micro levels.

2.7.1 Macro-level factors

2.7.1:1 Poverty

Poverty influences sexual behaviour and the risks involved in procuring unsafe abortion. Poverty pressures many poor and ill-educated women to engage in risky sexual behaviour such as unprotected commercial, transactional and casual sexual relations. The escalating costs of living have left many women trapped in extreme poverty hence many engage in risky sexual behaviour as a survival strategy. The increasing cost of education has also

resulted in high girl school dropout rates hence making them vulnerable to risky behaviour.

Many adolescent and young women have limited access to family planning methods hence when they conceive, they resort to unsafe abortion because they are not able to support their children. Poor women are also unable to afford medical care hence in the event of unplanned pregnancy they resort to unskilled health providers for abortion. In fact, the little educated, poor and mostly rural women (in residence or origin) have no bargaining power in sexual engagement with people who take advantage of their economic, physical and social powerlessness.

2.7.1:2 Status and Role of Women

In many African societies, particularly those with patrilineal descent, women are relatively inferior to men. This situation is based on men's control over productive and social resources. As a consequence, women lack decision making power in matters of sexuality and reproduction such as contraception, number of children and sexual relations. Male dominance sometimes leads to coercion of women for sex and many women who conceive due to coercion desire to terminate the pregnancy.

This situation is compounded by low levels of education among women which limits their access to economic opportunities and greater autonomy. The low levels of education of women is attributed to high school drop-out rates by girls due to cultural practices such as early marriage, poverty and unwanted pregnancies. This situation has led to early sexual debut, early marriage and unwanted pregnancy.

Adolescents and young women who are economically disadvantaged have sexual liaisons with men who are economically endowed. In Migori Sub-County, this situation is evident in casual transactional relationships between truck drivers, fishermen and or traders and local unemployed young women. Thus, the lack of access to economic resources and opportunities leads to low status and makes them vulnerable to risky sexual behaviour, unwanted pregnancy and unsafe abortion.

2.7.1:3 Cultural Norms and Practices

The Luo community has traditional practices and beliefs that encourage sexual relations. For instance, every important event is marked by rituals involving sexual relations such as planting/sowing, harvesting, marriage of children, widow cleansing and naming of the children among other events. Some of these coital liaisons involve multiple partners especially in polygamous households. Beliefs about sex and male and female sexual relations are still traditional even though changes have occurred among the young generation, especially the educated.

The dominant patriarchal structure demands sexual monogamy for females but is tolerant to male multiple sexual relations. This partly contributes to weak conjugal bond between couple/ spouses and emphasis is placed on links with the clan. Women's sexual activity is strictly controlled and premarital pregnancy/maternity is abhorred and unacceptable. In the past non penetrative sex known as '*wuowo*' was practiced. It was believed that if pregnancies occurred accidentally, such pregnancies could be halted by herbalists until marriage arrangements were done or the mother was ready to continue with the pregnancy. This practice known as '*umo ich/tweo ich*' ('covering' pregnancy/'tying'

pregnancy) was tricky because if the herbalist who administered the ‘halt’ of pregnancy died before ‘untying’ it-let it progress as such a mother could not give birth in life. Thus, many adolescents and young women who get pregnant out of wedlock are under pressure to terminate the pregnancy to avoid the social stigma and other consequences such as lack of acceptance by their family, loss of chances for marriage and bad reputation.

Society practices double standards by tolerating male sexual adventures while condemning female sexual activity and pregnancy. For those women who are married and are involved in illicit sexual relations, they may be forced to terminate any pregnancy that results from such a relationship because of fear of physical violence, separation and divorce. This situation happens because married women are expected to bear children for their husband’s lineage and clan. Children sired by other men other than a woman’s husband are normally un-welcomed to the lineage and clan and can be killed especially if they are male.

2.7.1:4 Lack of and Access to Reproductive Health Services

Poor distribution, delivery and use of reproductive health services may be a contributing factor to the nature of casual sexual relations and the incidence of unsafe abortion. In Kenya and the southern counties such as Migori in particular, the more-well equipped health facilities and trained medical personnel that offer reproductive health services are based in major towns.

Rural areas are poorly served by health facilities and the services are provided by low-level trained personnel. This has led to poor delivery and use of reproductive health services as attested by the fact that very few women visit gynaecologists except during

pregnancy. Thus, many women who get unwanted pregnancy usually seek care from less skilled health care providers and quacks who provide services in unhygienic conditions.

Besides, many women who undergo abortion sometimes resort to self-administered procedures to induce abortion such as ingesting cocktails of antibiotics, herbs or inserting sharp objects into the reproductive tract. Self-induced abortion procedures have dire consequences such as incomplete abortion, infection, loss of life and economic and other resources.

2.7.2 Micro-Level Factors

At micro-level, socio-demographic characteristics such as age, education, marital status, income and social lifestyles may have influence on sexual behaviour and relations and thus have implications for the incidence of unsafe abortion.

2.7.2:1 Age

Sexual behaviour and the risk of unwanted pregnancy are related to age. The age at which an individual woman begins sexual activity may affect the risk of exposure to unwanted pregnancy. In various studies in Africa adolescents and the youth begin sexual activity early and have multiple partners. This increases the risk of exposure to unwanted pregnancy, sexually transmitted diseases and induced abortion. In Kenya, studies show that adolescents and young unmarried women constitute a major proportion of women who seek post-abortion care in public hospitals due to complications related to unsafe abortion.

2.7.2:2 Education

Education increases chances of upward mobility and accumulation of wealth. It also empowers women both socially and economically thus increasing their decision-making power, including matter pertaining to reproduction. Higher education increases awareness about contraception and access to better health care. Education also exposes women to more information that enables them to make informed decisions such as using contraceptives.

Research in Kenya and elsewhere in Africa reveals that many women who seek unsafe abortion are of low education level and are poor hence they seek unsafe abortion from unskilled health providers under unhygienic conditions (Solo et al., 1999; Magadi, 2004; Gebreselassie et al., 2005). Even though there has been belief in the past especially in rural areas, that abortion is for educated women who do not wish to have children while pursuing higher education and professional career.

2.7.2:3 Marital Status

Marital status may also affect sexual behaviour and the risk of exposure to unsafe abortion. Studies show that young unmarried women do not confine themselves to monogamous relations due to economic, biological, social and emotional reasons. Many unmarried women who conceive unwanted pregnancies because they are desperate to get out of the situation often consider terminating the pregnancy through unsafe abortion procedures. However, recent studies in Kenya also show an increasing number of married women who seek unsafe abortion in order to conceal their infidelity and the risk of family conflicts and divorce (*The Daily Nation*, 16th April, 2009).

2.7.2:4 Income

Income may also affect sexual behaviour and the risk of exposure to unsafe abortion. Women who are socio-economically independent are more likely to have access to better health care facilities and use contraception because they can afford it. Many poor women tend to resort to multiple sexual relations as a survival strategy and they lack access to better and well-equipped health care. Women who are economically deprived who conceive resort to unsafe abortion procedures because they cannot afford better health care and children (especially if they are unmarried).

2.7.2:5 Religion

Social morals and values are embedded in socio-cultural beliefs and practices. Cultural norms and beliefs promote chastity and tend to mould attitudes towards sexual relations and induced abortion. These tend to impact on individual decision-making process on sexual behaviour, practice and choice (Ladipo, 1998). Unfortunately, the religious (Christian and Muslim) beliefs which to a large extent are compatible with traditional cultural beliefs today only help to put the girls into dilemma because the real time practices totally ignore these beliefs. Teachers, choir masters, priests, imams, pastors, married men and young men wanting to feel they are men enough cannot let girls alone. In many cases they become pregnant not out of their own will but due to unavoidable circumstances. The tragedy is that even though there is recourse to the law, the culture of silence out of fear and ignorance still grips the nation. Getting pregnant is therefore no longer viewed with horror but tolerated even in churches. Society therefore, seems to

have redefined its situation with regard to sexuality and by extension, attitudes towards abortion.

2.7.2:6 Changes in Norms, Attitudes and Practices

This section focuses on changes which have occurred in the two community that have made it possible for individuals to engage in sexual relations and hence abortion without feeling guilty.

A number of factors have been identified as having brought about changes in norms, attitudes and practices leading to sexual promiscuity and hence abortion in sub-Saharan Africa. In the traditional society, culture provided prescriptions and proscriptions which guided people's behaviour and the way they interacted with one another (Sorre and Akong'a, 2009). Initiation rituals and dances for young men and women provided a conducive environment of imparting traditional norms, customs and practices. This also provided informal and formal education that was aimed at equipping young people with life skills.

In addition, institutions such as age groups/sets and other peer related groups also socialized young people by assigning them statuses and roles and at the same time providing them with life skills. In the past young unmarried men and women were provided with sexual outlets particularly by the traditional practice of '*wuowo'*, which involved the practice of non-penetrative sex (Ocholla-Ayayo, 1976).

In the past seventy years, however, there has been a great impact on Luo culture from urbanization, modern education and other forces of modernization (Muange,1999). They

have contributed to the erosion of traditional norms, attitudes and practices and institutions which regulated sexual behaviour. The conservative attitudes towards sexual relations have weakened because people no longer follow traditional norms regarding pre-marital and extramarital sexual relations.

Kilbride & Kilbride (1990) argue that the process of delocalization resulted in the imposition of alien sexual practices that led to liberalization of sexual practices and attitudes. Delocalization refers to the process by which local knowledge, beliefs and practices give way to external influences that are not in the culture of the people leading to anomie.

According to Kilbride & Kilbride (1990), one of the effects of the delocalization is the increase in pre-marital and extramarital sexual relations due to postponement of marriage without delaying sexual activity and emphasis of sexual relations as a recreational rather than reproductive activity as it were in the traditional society.

As a result, society has a lax attitude towards sex in which young and old people engage in multiple sexual relations without inhibition. Sorre & Akonga (2009: 9) note that today, anyone looking for sex can find it anywhere; in mass media, places of work, schools, colleges, at home, internet, vehicles, parks and so on. As a result, people engage in sexual activities without fear of pregnancy or infection with STI's.

The liberalization of sexual attitudes and practices has made it possible to engage in sexual activities hence abortion without any feelings of guilt and fear of pregnancy or infection with sexually transmitted infections. Weak social controls have encouraged people to get involved in indiscriminate sexual relations. Sorre & Akong'a (2009) further

stress that contemporary society is exposed to sensuous information through the mass media leading to diminished individual and social control mechanisms. Unlike in traditional society that provided options for access to sexuality, today there are many options to sexuality to anyone who is willing but devoid of responsibility.

Poverty has also contributed to increased premarital and extramarital resources and hence induced abortion. Many women who lack economic resources are driven into sexual relations with men who have money. These relationships are devoid of individual and mutual responsibility. Poor women succumb to sexual advances of men who are able to provide money and other material resources of those in positions of authority/control. Many of them are not able to negotiate for safe sex practices, hence running the risk of unwanted pregnancies.

2.8 Reproductive and Sexual Health

The concept of reproductive health has recently emerged in response to the fragmentation of the existing services related to health in reproduction, and to their orientation receiving great attention in the United Nations International Conference on Population and Development held in Cairo in 1994. The term reproductive health was first defined in 1987 and published in 1988 by World Health Organization as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. Reproductive health in the context of this positive definition would have a number of basic elements. It would mean that people have the ability to reproduce, to regulate their fertility and that women are able to go safely through pregnancy and child birth, and that reproduction is carried to a successful outcome through infant and child

survival and well-being. To this may be added that people are able to enjoy and are safe in having sex.

The definition of health was adopted and expanded in the programme of action developed at the International Conference on Population and Development (ICPD) held in Cairo in 1994, and at the International Conference on Women, also sponsored by the United Nations, which was held in Beijing in 1995, where it now reads:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed, to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility, which are not against the law and their right to access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant.

Reproductive health care can be further defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems such as abortion. It also includes sexual health, the purpose of which is the enhancement of life and personal relations

since it is not just a major health issue, but also a development issue and a human rights issue.

The impact of reproductive health is not limited to the individual, family, and society at large. It extends across national boundaries to the world as a whole. Two areas in reproductive health have, in particular, such a major impact: the ability to control and regulate fertility and safety from sexually transmitted diseases (STDs). Inability of individuals and particularly of women in developing countries to regulate and control their fertility is not affecting health of the people immediately concerned, but has implications for global stability and for the balance between population and natural resources and between people and environment, and is a violation of women's human rights.

2.8.1 Sexual Health

In the evolution of Homo sapiens, the temporal relationship between sex and reproduction has been severed. It must have taken ancestors a long time to realize any relationship between the sexual act and the event of pregnancy resulting in birth; it was probably not until they began to observe domesticated animals that the relationship was recognized.

Definition of sexual health by the World Health Organization (2006a):

- The ability to enjoy mutually fulfilling sexual relationships;
- Freedom from sexual abuse, coercion or harassment;
- Safety from sexually transmitted diseases, and;
- Success in achieving or in preventing pregnancy.

2.8.2 Gender Differentials in Health

Reproductive health is an important component of health for both women and men, but it is more critical, however, for women. A major burden of disease in females is related to their reproductive function and reproductive potential, and the way in which society treats or mistreats women because of their gender. White men are more prone to die because of what one may call their 'vices'; women often suffer because of their natural physiological role in the survival of the species, and the tasks related to it. Providers of reproductive care deal mostly with women who have often been subordinated to their societies' needs and have been under-valued. Providers, who are mostly men, should set a male model in respecting women, but also be sensitive to their concerns and perceptions.

2.9 Changes in Attitudes and Practices that Influence Unsafe Abortion

There are a number of changes which have occurred in the last seven decades that have brought about changes in norms, attitudes and practices that make it possible for individuals to procure abortion without the consequence of feeling guilty. In many traditional African societies culture was the source of prescriptions and which guided people's behaviour and how they interacted with one another (Sorre & Akong'a, 2009). Cultural ideals, beliefs and practices have been observed to support the perpetuation of promiscuity and unsafe abortion. In many African societies, initiation rituals and dances for boys and girls provided an environment of imparting formal and informal education and life training skills. In addition, institutions such as age sets and other peer related common groups helped to re-socialize young people by providing them with appropriate

life-skills, status and roles. Peer-related groups also served as a check on individual behaviour.

A number of factors have been identified as being responsible to sexual promiscuity and hence abortion in sub Saharan Africa. Ocholla-Ayayo (1997) has identified the following practices as being responsible for promiscuity: levirate marriage, divorce, separation and widowhood among married people, sexual liberalization due to breakdown of traditional norms, weak conjugal bonds (especially in polygynous marriages) and few sanctions against premarital and extramarital sex.

2.9.1 Expressions of Love and Companionship

Nowadays many people engage in sexual relations as a way of expressing their ‘love’ and companionship. Such relationships lack reciprocity and individual responsibility.

2.9.2 Adolescent Sexuality

Today, to many young men and women sexual intercourse is the ultimate goal of any boy-girl relationship – it is perceived as the only way of expressing love and care. Sorre and Akong’a (2009) note that many young men compete to have sex and impregnate young girls as a way of demonstrating their heroism among peers. Girls who decline their boyfriends’ sexual advances lose them or are ‘dumped’. The fear of losing a partner and perceived disapproval by peers forces many young girls and women to yield to their partner’s sexual demands**.**

2.9.3 Adolescents and Contraceptives

Studies have shown that among adolescents and young relationships the use of contraception including condoms is rare or minimal (Magadi, 2000; Oindo, 2005). Where condoms and other forms of contraception are used in the initial stages of the relationship but they stop using them once they begin trusting one another (Sorre 2004). Many young men believe that girls who insist on using condoms do not trust them.

2.9.4 Adolescent Sexuality

Nyamongo (1997) observes that adolescents tend to take risks through reckless sexual behaviour/activities in spite of their knowledge of the risks involved and contraception (to avoid/protect against the repercussions). He further argues that due to the fact that adolescents undergo biological, psychological and social changes they experiment sexual activity with multiple partners. Adolescent engage in risky sexual behaviour because of peer pressure, economic need, unmet need for contraception, lack of knowledge and social attitude and practices about sexuality.

2.9.5 Culture of Silence

Sorre & Akong'a (2009) argue that the culture of silence has contributed to promiscuity. Unlike in the traditional society people today do not share their social, economic, emotional and psychological problems. This situation has led to unfulfilled sexual desires and frustration hence rapid increase in incidents of rape, extramarital sex, incest, abortion, paedophilia among others. Very few people have come out to publicly discuss the issue of abortion. People pay attention when fatalities occur and they soon go back to

their cocoons. The culture of silence is manifested both at individual and group levels – people do not want to talk about their own reckless behaviour and neither does society strongly condemn irresponsible behaviour such as promiscuity and induced abortions. The society is silent about how individuals behave.

2.10 Research Gaps

Understanding and addressing the socio-cultural and economic factors influencing unsafe abortion in Migori Sub-County was not easy since no study has been done on the same in the same area. Besides members of the Luo of Migori Sub-County have really intermarried with other communities that have different cultures all together. From the literature review done in this study, no literature focused on social attitudes and beliefs other than analysis of abortion incidences in other parts of the world. It is also clear from the literature reviewed that unsafe abortion is a key driver of high maternal mortality in Kenya at 35% of all maternal deaths and disabilities. This was due to lack of sex education, rural-urban migration of spouses, lack of family planning uptake, restrictive law and legal environment, beliefs, attitudes and lack of knowledge (both traditional and contemporary) were found to precipitate unsafe abortions.

In spite of the current constitution and policy provisions that aim to promote women's reproductive rights, the socio-cultural and economic environment added to lack of knowledge has limited the translation of these gains into rights for women and girls seeking abortion services since literature showed abortion incidences in Kenya are on the rise.

The study therefore sought to explore the socio-cultural and economic factors influencing abortion in Migori Sub-County thus the study collected data on perceptions of individuals and community members to draw conclusions.

2.11 Theoretical Framework

This study was guided by the general theory of socio-cultural change as advocated by Emile Durkheim and William Thomas from different perspectives.

2.11.1 The Anomie Theory

In a traditional society (which the Luo was during the pre-colonial period) the individual need not have to define his/her situation at every moment of action partly because society through its cultural beliefs and practices has defined it. The individual therefore, fits into the scheme of the society through social control.

When change takes place however, a crisis ensues by which the old beliefs and practices are put into disarray by new ones, resulting into a state Emile Durkheim referred to as anomie. This is a situation in which old norms have ceased to be effective while the new norms are not yet effectively internalized and operational. This state of limbo may not be conceived as normlessness as Durkheim thought but disorganization.

Thus, when society moves from mechanical to organic solidarity or traditional to modern society, the sacred nature of certain phenomena lessens, giving rise to what Max Weber refers to as secularization. With time, there is lessening of commitment to religion. This decrease in commitment to religious principles leads to secularization, which means the

lessening of the sacredness of things or institutions. What people used to fear or consider sacred is no longer respected or feared for example spilling of blood as in abortion.

With the process of urbanization and cosmopolitism, and in the spirit of nationalism, traditional boundaries are open to outside cultures and interaction leading to dilution of the native traditions, customs and beliefs. Consequently, solidarity lessens because people no longer know each other by name or face or are not concerned with what others do as was in the past. Individuals do things without seeking others' opinions because they no longer adhere to moral principles of traditional society.

The Luo Society is no longer a close-knit society as it was in the past. Issues of promiscuity and abortion among the youth and adults, which were considered immoral, do not hold anymore because people have new forms of reasoning and justification for any behaviour. Because of multicultural interactions and urbanization, individualism, personal gifts and private ownership of property has set in leading to increased individual freedom and responsibility, and less reference to community for guidance. Individualism sets in when society modernizes as people become individualistic for their own survival.

In fact, anomie refers to a state of environment where society fails to exercise adequate regulation or constraint over the goals and desires of its individual members (Durkheim, 1951: 242-276). It is important to note that Durkheim's conceptualization of anomie was based on a general assumption about the psychological or biological nature of individual human beings. He wrote that the human "capacity of feeling is in itself an insatiable and bottomless abyss" (Durkheim, 1951: 247). From Durkheim's view point, individual

happiness and well-being depend on the ability of society to impose external limits on the potentially limitless passion and appetite that characterize the human nature in general.

With regard to the subject matter of this thesis it means that sexuality, pregnancy and giving birth to live babies, which were sacred communal events, are no longer considered sacred by sections of individuals in the society. Sexuality becomes a form of recreation instead of solely for procreation. In such circumstances, pregnancy is viewed as an accident that is no longer desired and respected, while babies seen as a lost and inconvenience and are no longer miraculous "free gift" from God who should be taken care of both in pregnancy and at birth. It is hypothesized that due to the changes that have taken place in the Luo society over time, things are no longer the same in regard to beliefs, attitudes and practices towards sexuality, babies and abortion.

2.11.2 The Theory of Redefinition of the Situation

This is a theory which was formulated by William Thomas following his study of the Polish peasants who had migrated to the United States from Europe. He noted that when the Polish peasants, a rural traditional community, reached the urban centres of the United States, they were quite uneasy with the liberal lifestyle they found there. However, they could not hold on their traditional beliefs and practices for long especially for their children who had to mix with other children in schools, churches and on the streets.

The Polish had to loosen up, meaning, to re-define their situation and go along up to a point. William noted that "if people define their situations as real, they are real in their consequences" (Thomas, 1968). His idea was that under normal circumstances on a day

to day basis people do not have to define their situations as these are defined for them through cultural beliefs, values, aesthetics, materials, technology and practices. However, when there is a crisis (read anomie), individuals and groups of individuals redefine their situations and make decisions on whether they will continue with their uncomfortable situation or change to something they would not have approved before.

In the case of the Luo, many changes have taken place in the society since colonialism, leading to a redefinition of the situation in regard to morality, dress, attitudes and practices. Premarital sexuality, which was controlled socially, has now become a form of recreation leading to unwanted pregnancies. Husbands and wives who used to live together all the time are now physically separated due to rural-urban migration. Physical and occupational mobility have also contributed to the loosening of the moral codes. Some of the consequences have included widespread premarital sexual activities and adultery leading to unwanted pregnancies.

The area of sexuality and having children, which was sacred, and therefore, justified, is now an open area of involvement without responsibility and in a secularized environment, abortion as a means of avoiding the obligation to raise the child has become common for both youth and married women. To paraphrase Emile Durkheim, the society that used to be mechanical is now organic with dire consequences to individual women, families and the society as a whole.

This study adopted the theory by William Thomas who asserted that in the study of man, people define the situations in which they find themselves in and that “if people define situations as real, they are real in their consequences” (Thomas, 1968). This situation in

this study, which needs to be defined, is abortion and its determinant and sexual relations without responsibility. This can be attributed to changed social, cultural and economic circumstances.

If abortion is a moral issue, morality is thus, the general by accepted definition of the situation whether expressed in public opinion, the unwritten law, in a formal legal code, or in religious commandments and prohibitions (Rosenberg, 1969). According to Thomas (1968), in a situation of crisis, people redefine their situation in order to incorporate attitudes, values and practices that were in the past deviant. For example, in the past, it was inconceivable among the Luo to procure an abortion. However, today, the institutions which camouflaged the circumstances that would have led to it such as premarital sexuality, adultery without polygyny and so on, have broken down exposing the women who do not take due precaution such as the use of contraception.

Thomas (1968) further states that the family, especially the individual, is the smallest social unit and the primary defining agency. This means that abortion with its complications and implications should first be defined at the family (individual) level then the community before the wider society (Rosenberg, 1969). This is because what the individual does sometimes goes counter to the common practices in the family and society. Thus, though abortion is procured by individuals, there are no guidelines when and how to do it outside the law. Thus, as much as people redefine their situation to incorporate abortion as a solution to unwanted pregnancies, they can still redefine their current situation to minimize or stop abortion.

This theory was used to study Polish peasants, whose culture was vanishing. Upon redefinition of their situation, in which they were a minority, they decided to allow their children to integrate into the mainstream American culture which Polish parents had earlier despised. With regard to sexuality, it was shameful and rare for a family to have a girl with pre-marital pregnancy or for a woman to engage in adultery. Now this is not the case and soon it may be the norm for girls and women to procure abortion. This transformation from deviant to normal behaviour is what is at stake in this study. The process however can be reversed using the theory of re-definition of the situation.

The Luo are in a socio-cultural crisis because of increased cases of abortion, which was not there before. A crisis brings change and change brings about disorganization in society in terms of socio-economic and psychological. As such people begin to search for new beliefs, status, and norms to bring about stability. In this process people can rethink or redefine their moral standing and reverse the damage that may have been done such as discarding practices and structures that contained or minimized abortion in the Luo community to the extent that there is no single word for abortion in Dholuo.

The study used two theories since each on its own was not sufficient to address the socio-cultural and economic factors affecting the Luo of Migori Sub-County on abortion. The two theories supplement each other. The Anomie theory talks about the environment in which the Luo find themselves and what needs to be done while the Redefinition of the Situation theory reminds the Luo of Migori Sub-County that they are surrounded with many cultures and that calls for integration with others and not standing alone like the Polish.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter describes the research site, research design, sampling techniques and methods of data collection and analysis. Besides, it covers ethical issues considered during the research process and potential sources of bias which might influence the data.

3.2 Study Area

This study was conducted in Migori Sub-County in Migori County, Kenya. It covers an area of 21,505 square kilometres. It borders Homa Bay County and Kisii County in the north; Narok County to the east and Republic of Tanzania to the south. It touches Lake Victoria on its western boundary. It lies between 0º 40' and 0º South and longitude 34º and 34º 50' East. The study was done in six out of eight constituencies of Migori County that make up Migori Sub-County. The constituencies are Uriri, Rongo, Awendo, Nyatike, Suna East and Suna West.

Figure 3.1 Map of the Kenya showing study area (shaded)

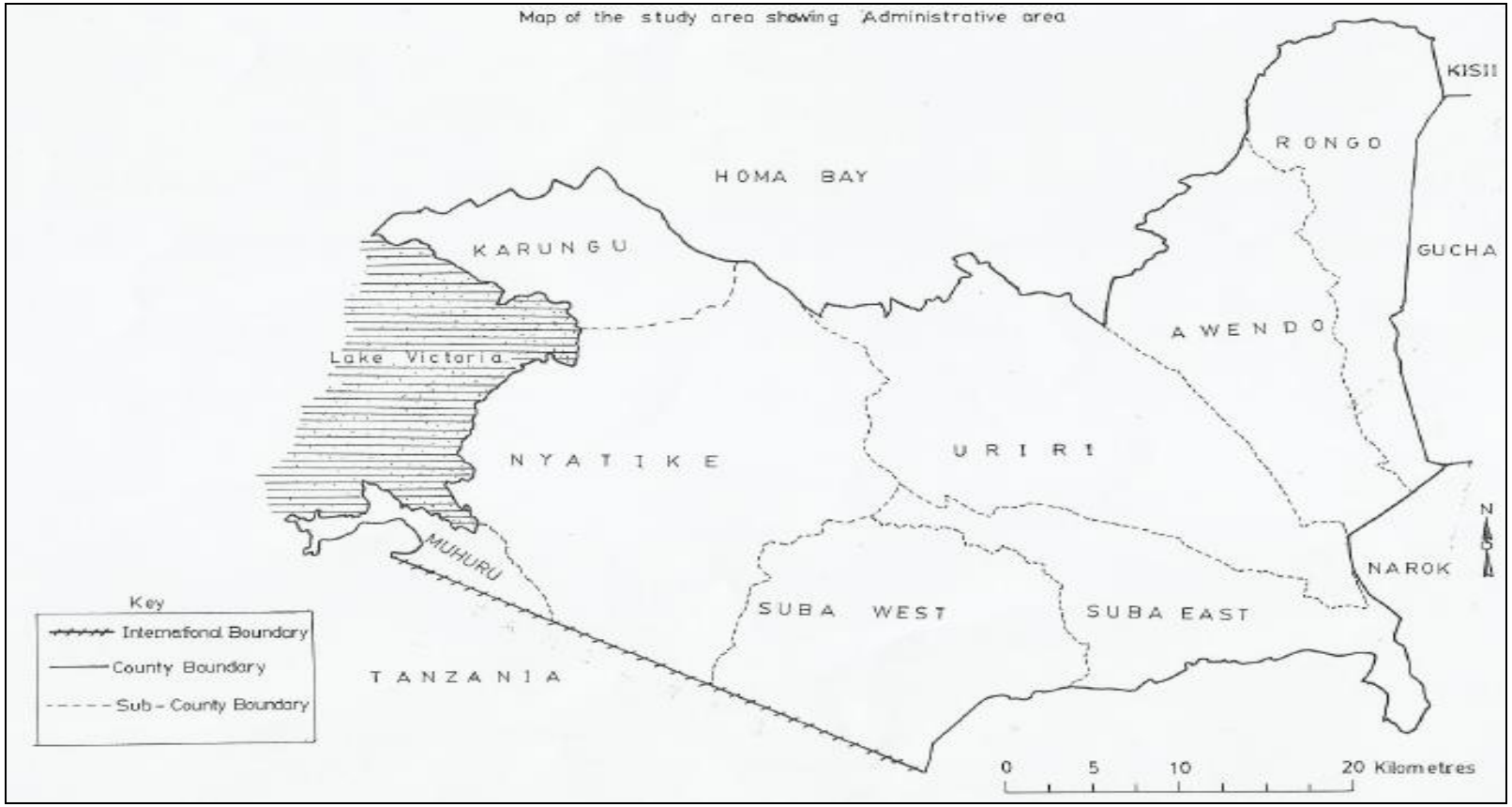

Figure 3.2 Map of the study area showing administrative zones

3.3 Research Design

This study used a cross-sectional and descriptive research design and it contained both qualitative and quantitative data collection methods carried out by the researcher and two research assistants. They Research Assistants were fluent in Dholuo, the language of the target population. The main method of collecting quantitative information was a survey by which a standard questionnaire was administered. The questionnaire was pretested on a small sample of 30 informants. This pretesting also helped in re-designing and re-categorizing questions in order to collect data which were reliable and valid as well as to make it easy to analyse both qualitatively and quantitatively.

The other methods of data collection consisted of in-depth interviews, focus group discussions, participant observation and life histories/case studies, personal interviews which form part of qualitative data.

3.4 Target Population

The main target population of the study were females who had procured abortions as well as males whose spouses and/or girlfriends had aborted. However, in order to collaborate information, several key informants including doctors, nurses, midwives and hospital administrators, the local sages, traditional birth attendants as well as opinion leaders such as teachers, chiefs, elders and pastors. The unit of analysis was the individual.

3.5 Sampling Procedure

Four public hospitals and health centres were selected to represent the urban population while another four represented the rural population. The eligibility was done to saturation

given the nature of the subject of study through purposive sampling. Face to face interview was conducted with the help of a structured questionnaire (Appendix III). A total sample of 272 men and women who were health seekers were interviewed. The strata were composed of those who had procured abortion, the spouses and health providers such as doctors, midwives, hospital administrators, sages and traditional birth attendants (TBA). From the hospital records, all those women who presented cases of reproductive health ailments were interviewed. In some cases, snow balling technique was used to identify those who had procured an abortion and were then followed into the villages for in depth interview using question guide (Appendices I and II) thus becoming case studies. Men or spouses of those admitted were interviewed using standard questionnaire in the survey (Appendix III) and some as key informants using question guide (Appendix II). Health care providers in the female gynaecological wards were interviewed including the matron and medical health officers. Standard questionnaire was used to collect demographic data.

3.6 Methods of Data Collection

3.6.1 Questionnaire

The questionnaire guide consisted of unstructured open-ended questions, which gave informants complete freedom responding briefly or at length in their own words. The selected persons were informed about the study and their consent was sought for interviews. Face-to-face interviews were carried out immediately after an informant consented to participate in the study. Interviews were carried out in privacy in the visiting rooms of the medical institutions. This interviewing process was convenient because it

provided an opportunity to establish rapport with the informants as well as to probe further about issues that were unclear during the interviews.

Similarly, respondents were assured of the confidentiality of their responses owing to the sensitive nature of the research topic. An interview session began with a general statement about reproductive health followed by an explanation about the significance of the study. The open-ended questions sought data on socio-demographic characteristics of the informants, childbearing, pregnancy, contraceptive knowledge and use, sexual behaviours, attitudes about abortion, post-abortion care and the experiences of females with abortion. The final section included questions related to ways of reducing and preventing the incidences of induced unsafe abortions.

3.6.2 Key Informant Interviews

Purposive sampling was used to select informants for in-depth interviews. They were selected on the basis of their perceived knowledge and ability to provide information on a wide range of issues of interest to this study. These informants included doctors, nurses, matrons, clinical officers, community health workers, hospital administrators, community health workers, religious leaders, traditional birth attendants, herbalists and provincial administrators. In-depth interviews provided vital ethnographic data about customary norms and practices pertaining to sexual behaviours, miscarriages, induced abortions, the methods used to induce abortions, the reasons for procuring abortions, health-seeking behaviours during pregnancy as well as the prevalence of abortion and abortion-related complications (Appendix II).

3.6.3 Focus Group Discussions

The focus group discussion method provided data through group interactions, which enriched interview responses, particularly with regard to community norms and values. This method also promoted flexibility and provided culturally appropriate language which was critical since there is so little information about the targeted population. Moreover, it costs relatively less than other types of research methods (Krueger, 1994). Focus group discussions with members of the community were used to:

i. Interrogate belief systems and languages used in labelling and interpreting abortion and sexuality;
ii. Assess the community's perceptions of reproductive well being given socio-cultural economic factors, and;
iii. Lastly identify health care concerns and issues regarding abortion and support/help seeking behaviour.

For this study, the focus group discussion variables were identified as gender and reproductive age. Gender distinction was important owing to the sensitive and sexual nature of the topics and gender differences in discussing, experiencing and interpreting issues of gender health especially abortion.

Reproductive age was the other criteria for determining focus group discussions participants since it was necessary to ensure participants spoke the same language and shared similar cultural norms and values since they live in the same cohort. The size of the focus group discussions was determined according to (Krueger, 1994) guidelines which suggest that groups should be small enough to allow for every individual to have

an opportunity to express their points of view, but large enough to achieve a diversity of views. For this particular study, six to twelve people were ideal for each focus group discussion.

There were four focus group discussions that were held and of these, two were selected from urban areas and two from rural ones. Specifically, two focus group discussions were for males and the first one was composed of those who were aged between 20-40 years and another one for those above 50 years. On the other hand, two focus group discussions were for females with one for those aged 20-35 years and another one for those aged 36 years and above. Each of the focus group discussions consisted of an average of six to twelve participants. The focus group interview guide consisted of both closed- and open-ended questions and participants were urged to give their views freely and willingly on a wide range of issues pertinent to the study.

The discussions focused on attitudes and beliefs about sexual behaviours and norms, contraceptive knowledge and use as well as induced abortion and its prevalence, the reasons why it is common today and different ways it can be prevented. The discussions also focused on sexual behaviour, norms and contraceptive use. The discussions were conducted in separate and private rooms within the health institution or under trees in homesteads when convenient for the discussants. The discussions were moderated by two research assistants drawn from the local community. The proceedings of each discussion were tape recorded and transcribed into Dholuo, and later translated into English.

In addition to comments from participants, this transcript included the moderator's and observer's comments noting non-verbal communication such as body language and style

of speech. The participants were assured their remarks would remain anonymous and confidential despite being taped. The focus groups followed the same interview guidelines as the in-depth interviews and were conducted in the same language of the participants, with facilitators of the same sex.

3.6.4 Direct Observation

This method aided in seeking clarifications on various issues which did not come out clearly using other data collection methods. The researcher participated in various community events such as public barazas, weddings and church services. The researcher also attended ante-natal, post-natal and nutrition clinics as well as sites of other reproductive health services in Migori Sub-County. These visits enabled the researcher to gain insights and acquaintances on various issues of interest to this study. The visits also provided the researcher with an opportunity to informally gather data on attitudes and beliefs about sexual behaviours and abortions. The researcher similarly observed day-to-day activities in the research site and interacted with different people conversing on general issues of interest to the study. The researcher also visited various fish landing beaches to observe the interactions amongst fishermen, traders and female fishmongers. Data obtained using this method assisted the researcher to corroborate the information gathered from focus group discussions, life histories and in-depth interviews.

3.6.5 Life Histories

Interaction with health service providers and key informants made it possible to identify individuals who gave data on life histories. The life histories were collected over a series of many lengthy interview sessions. Females who had procured abortions as well as

males whose wives and/or girlfriends had aborted provided the data for the life histories. The strategy used to select such informants was snowballing. The life histories concern the reasons why such individuals and other females in the study region procure abortions. Also, the life histories contain information about life and experiences after the abortions. Male informants who participated in the life histories shared the information with us willingly. However, some female informants became very emotional while others were evasive either because the issue was still traumatic or they did not want to be reminded of what they had gone through.

3.7 Data Analysis

The qualitative data from the questionnaires were tape-recorded, transcribed and analysed by conducting thematic content analysis. This was to generate accounts of issues that were central to the study. On the other hand, quantitative data were coded and entered into the SPSS computer package. The findings of the study have been presented in tables of frequencies and percentages. Conversely, in-depth interviews and life histories were analysed and presented using verbatim quotations from informants.

3.8 Consideration of Ethical Issues

Abortion is a source of considerable debate and controversy, which raises ethical, moral and legal issues. Thus, the researcher had to seek permission to conduct the research from the relevant authorities in the Ministry of Education and Ministry of Health. Specifically, a research clearance permit was obtained from the National Council of Science and Technology in the Ministry of Education. Health personnel who assisted in recruiting informants were requested to maintain confidentiality and privacy. A research permit was

obtained from the National Commission for Science and Technology in the Ministry of Higher Education. Similarly, those informants who had participated in the study were requested to sign consent forms before interviews began (Appendix I, II, and III) after being assured that their responses were confidential. The researcher dealt with female informants and two male research assistants interviewed male ones. This was done in order to take care of cultural norms and elicit a free flow of information. In addition to the standard ethical considerations implicated by conducting research with human subjects (such as obtaining informed consent), several related issues had to be considered in carrying out research on abortion which is as a result of sexual behaviour.

The informants from health facilities were willing to participate in the study. Those who were not in hospital were advised on where to seek help. It was also the responsibility of the researcher to provide informational materials too. This was served through collaborations with local organizations, clinics, hospitals and activists within the county.

The tape recording of in-depth interviews and focus group discussions was also conducted with the signed consent of the participants. While developing the population sample, potential participants were fully informed about the nature of the study and given opportunity to ask questions or express concerns. The researcher and the two assistant researchers further explained the means by which confidentiality was to be assured. In addition, the researcher emphasized that the decision to participate in the study or to answer or not answer any particular question(s) was completely voluntary.

Maintaining data records using only identification numbers and pseudo names minimized risks to informants' confidentiality. Only the researcher and the two research assistants

who were expected to maintain the highest standards of ethical research practice, had access to the data. The interview schedules and tapes of interviews were kept by the researcher.

Participants were not subjected to any physical harm. They were asked about personal matters that may have evoked emotional responses, particularly in recounting events included socio-cultural and economic violence, sexual coercion; however, the psychological risks to participants were minimal and were balanced by the opportunity to discuss such experiences with a sympathetic listener. In addition, interviews were usually conducted in a private and safe space in the community that had been identified with the help of key informants or the participants themselves.

The direct benefits to individuals included the opportunity to inquire about the reproductive health matters such as family planning, HIV infection and other sexual health issues in addition to socio-cultural economic interventions. The researcher also provided advice to participants with a list of a number of places where they can get help within the county.

CHAPTER FOUR

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

4.1 Introduction

This chapter describes the socio-economic, cultural and demographic features of the Luo society in general and the sample in particular, the socio-economic context within which abortion occurs in Migori Sub-County.

4.2 Background Socio-economic Characteristics in Migori Sub-County

At the time of this study, the population of Migori sub-County stood at 514,897 as recorded in the 1999 Population and Housing Census and an intercensal growth rate of 3.1 percent. It was expected to rise to 656,525 by 2010. The sub-county had a life expectancy of 50 years for women, 48 for males, a TFR of 7.1 children per woman and infant mortality rate of 137 per thousand compared to total fertility ratio of 3.76 children born per woman in Kenya (2013 estimated), (KDHS, 2008-2009). Morbidity stands at 37.02% with female at 40.36%, and males at 33.1% giving a total count of 562,266.5 (KDHS, 2008-2009); whereas life expectancy in Kenya stood at 57.08 years (2011), population of 43.18 million (2012) with a population growth rate of 2.7% annual change (2012), (KDHS, 2008-2009). Those in monogamous marriage stand at 48.2%, polygamous 21.1%, separated 1.6%, divorced 0.3%, widow/widower 26.6% and never married 2%. Gender index ration of women to men is 1.08% and the household per square kilometre is 81.83 (KDHS, 2008-2009).

Migori Sub-County experiences unreliable rainfall, hence it has low agricultural productivity. Due to poor fishing practices fish catch is also low. This implies that majority of the population in the county is impoverished as expressed by respondents in the field during the study. Migori Sub-County relies heavily on rain fed agriculture which cannot sustain farming during periods of prolonged drought. This therefore explains why the life expectancy of the county falls below the national life expectancy which stood at 57.08 years (2011) meaning there are challenges faced by the population. Besides, the HIV/AIDS prevalence rate in Migori Sub-County is twice the national average (14% for Migori sub-county and 6.5% the national average). This has also been contributed to by certain cultural practices such as widow inheritance which leads to high incidence of HIV/AIDS and thus low life expectancy in the county.

According to the 2009 Population and Housing Census, Migori Sub-County had a total population of 191,248 people, including 91,874 males and 99,374 females. These people occupied an average household size of 4.77 and number of households of 40,093 that were distributed over an area of 489.98 square kilometres with a population density of 390.32 people per square kilometre (Constituency Density, 2009). According to Constituency Density, 2009, the Total Fertility Rate (TFR) of 7.3 in the Migori Sub-County against 3.76 nationally is double which is alarming. This could be due to early marriages and girls dropping out of school early at Primary level which make them start giving birth at an early age and continue to do so during their reproductive life cycle. Migori Sub-County is poorly served in terms of health services especially reproductive health services that address the issue of abortion and family planning. This has been contributed to the fact that access to family planning services is scarce, and in most cases,

lacking as seen by very few health facilities in the country. Kisumu Medical Education Trust (KMET) and Marie Stopes have set up reproductive health clinics in places such as Migori town and Sori Beach to address the issue of abortion and supply of family planning.

High TFR in the county could be as a result of migration into Migori Sub-County beaches by fishermen from other counties and neighbouring countries Tanzania and Uganda who engage in casual sex referred to as ‘fish and sex’. Monogamous marriage stands at 48.2% higher than 21.1% indicates the collapse of Luo social structures in the county which cushioned all women to belong to a family thus controlling issues such as separation which stands at 1.6%, divorce 0.3%, widow/widower since marriages were lifelong and wife inheritance took care of widow hood. Having high numbers of young people under 15 years old to the population it means Migori just like the rest of the country has a high dependency ratio.

4.2.1 Age specific fertility rates (ASFR)

Reproductive health matters in Migori Sub-County had been surveyed and report in terms of fertility given as follows. In Multiple Indicator Cluster Survey (MICS), Age Specific Fertility Rates (ASFR) and Total Fertility Rates (TFR) are calculated by using information on birth histories of women aged 15-49 years from the sampled households. Birth histories include details of all children ever born alive to a woman, such as child’s name, sex, month and year of birth, survival status and if dead, the age at death. Current fertility rates are based on the date of last birth of each woman for the three years preceding the survey. Rates are underestimated by a very small margin due to absence of

information on multiple births (twins, triplets etc.) and on women having multiple deliveries during the periods preceding the survey.

ASFRs are calculated by dividing the number of births to women in a specific age group by the number of women years lived during a given period, and is expressed per 1000 women. The total fertility rate (TFR) is calculated by summing the age-specific fertility rates calculated for each of the 5-year age groups of women, from age 15 through to age 49. The TFR denotes the average number of children to which a woman will have given birth by the end of her reproductive years if current fertility rates prevailed.

For the three-year period preceding the MICS survey, the total fertility rate in Migori Sub-County was 5.6 children per woman. The adolescent birth rate (age-specific fertility rate for women age 15-19) during the same period was 230 births per 1000 women.

ASFR was highest in the 20 to 24 age group with 260 births per 1000 women. Generally, fertility seems to decline in all age groups over the last decade before the survey. The decline in fertility in the county may be due to free primary and secondary education, which has seen children remain in school longer than before. The presence of Marie Stopes International and Kisumu Medical Education Trust (KMET) in the county whose mandate is to deal with Reproduction Health issues such as family planning and post abortion services could have also contributed to the decline through awareness creation and provision of reproductive health services spread all over the county, especially within the hotspots of casual sex, and where social-cultural structures have declined such as town centres and along the shores of Lake Victoria.

Table 4.1 Fertility Rates

Age specific fertility rates (ASFR) and total fertility rate (TFR) for three year periods preceding the survey, Migori Sub-County, 2011					
	Age specific fertility rates (ASFR)				
	Number of years preceding the survey				
	0 – 2	3 – 5	6 - 8	9 – 11	12 – 14
Age					
15 – 19	230 [1]	230	245	215	234
20 – 24	260	362	316	337	297
25 – 29	247	272	309	277	256
30 – 34	181	268	301	269	209
35 – 39	145	205	174	149	208
40 – 44	55	73	11	0	-
45 – 49	6	0	-	-	-
Total Fertility Rate	**5.6**	**7.0**	**7.3**	**6.2**	**6.0**
[1] MICS indicator 5.1; MDG indicator 5.4 Note: Age-specific fertility rates are per 1,000 women.					

4.2.2 Children ever born and children surviving

Table 4.2 presents the distribution of children ever born and surviving for all women by age groups. The mean number of children ever born to all women aged 15-49 years is 3.6 and that of surviving is 3.

Women in Migori Sub-County have a parity of 7.3 children per woman for the age group 45-49 years, which is at the end of their childbearing period, meaning that women in Migori Sub-County once they start giving birth at 15 years of age, they do not space births and continue up to 49 years when they are almost approaching menopause, which explains why they have a parity of 7.3 children per woman.

Table 4.2 Children Ever Born and Children Surviving

Mean and total numbers of children ever born and children surviving by age and women, Migori Sub-County, 2011					
	Children ever born		Children Surviving		Number of women
	Mean	Total	Mean	Total	
Age					
15 – 19	0.6	109	0.5	103	191
20 – 24	2.0	382	1.9	346	187
25 – 29	3.6	746	3.2	663	207
30 – 34	4.8	591	4.1	503	122
35 – 39	6.2	684	5.1	562	110
40 – 44	6.1	421	5.0	347	69
45 – 49	7.3	485	5.7	378	66
Total	**3.6**	**3418**	**3.0**	**2902**	**952**

Sexual activity and childbearing early in life carry significant risks for young people all around the world. This is a concern because early initiation of sexual intercourse places adolescents, particularly females at elevated risk of being involved in an unintended pregnancy which may lead to abortion, acquiring HIV or other sexually transmitted

diseases (STDs), and of other negative social and psychological outcomes. Early child bearing may be life threatening to both the mother and the child. Mothers younger than 17 years of age face an increased risk of maternal mortality because their bodies are not yet mature to bear children. These young women may not recognize the symptoms of pregnancy or may not wish to acknowledge a conception, delaying prenatal care and endangering the health of the child and the mother which at times may also lead to abortion. Early child bearing in life can lead to complicated obstructed labour pains or other problems which may lead to death of the mother and/or child, or to maternal infertility. Children born to teenage mothers are more likely to be premature, be of low birth weight and suffer from retarded foetal growth (Alan Gunmacher Institute, 1996).

4.2.3 Contraception

Appropriate family planning is important to the health of women and children by: 1) preventing unwanted pregnancies; 2) extending the period between births; and 3) limiting the number of children. Access by all couples to information and services to prevent pregnancies that are too early, too closely spaced, too late or too many is critical.

Current use of contraception was reported by 43 percent of women currently married or in union (Table 4.3). Modern methods of contraception are more commonly used (36 percent) than traditional methods (7 percent) with injectable contraceptives being the most popular method which was used by at least one in five (21 percent) married women in Migori Sub-County. The next most popular methods are male condoms and lactational amenorrhea method (LAM) accounting for 6 percent of married women each. Between

one and three percent of women reported use of female sterilization, implant, intrauterine devices (IUDs), contraceptive pills or periodic abstinence.

Contraceptive prevalence is higher among currently married women in the urban (61 percent) than rural areas (39 percent), a pattern that was also observed nationally (KDHS, 2008-09). The proportion of women who use any contraceptive is higher among those with secondary or higher education (54 percent) than those with primary education (41 percent). The proportion of women who use any contraceptive is highest (54 percent) among women aged 30-34 years. Contraceptive prevalence is highest (59 percent) among women from the richest households. However, there is no clear trend in contraceptive prevalence based on the number of living children a woman has.

While injectable contraceptives are the most commonly used contraceptives across all age groups, the proportion of women using lactational amenorrhea method is high among those aged 15-19 years than their older counterparts. The proportion of women who use IUDs is higher among those from the richest households. About contraception use in Migori Sub-County, young mothers do not use modern contraception even though they are expected at their age not to use since they are not looking for children in early marriage but the fact that they start giving birth aged 15-19 years is in itself a risk and a pointer that they are likely to end up with an average of 7.3 children per woman if spacing is not done. Furthermore, in a situation of promiscuity, unwanted pregnancies are unlikely to happen.

Non-use of contraceptives has important implications on fertility and, hence, child bearing and consequently population growth. The proportion of married women not using

any form of contraceptives in Migori Sub-County is 57 percent. Sixty one percent of the married rural women are not using any method compared to 39 percent of the urban women. Similarly, 70 percent of the women with one living child are not using any method. The poorest households and those with women with primary education registered the highest proportion of non-contraceptive use.

The freedom to choose how many children, and when, is a fundamental human right. Better access to safe affordable contraceptive methods is key to achieving the Millennium Development Goals (MDGs) since it has benefits in terms of gender equality, maternal health, child survival and preventing HIV, besides reducing poverty and promoting economic growth for it will improve well-being of the family, raising family productivity and lowering fertility thus one is not tempted to abort in cases of unwanted pregnancies. Migori Sub-County does not paint a good picture of achieving the above benefits considering that the proportion of married women at 57 percent is not using any form of contraceptives and 61 percent of the married rural women are not using any method compared to 39 percent of the urban women. This scenario has been contributed to cultural and informational barriers in the county where use of family planning has been associated with many myths and shunned by many in the community coupled with lack of access to family planning services not being perfect. If these myths are demystified, then the consequences of not using family planning and reproductive health services will be reduced. The non-use of contraception in Migori Sub-County and the developing countries in general, for example, has resulted in overpopulation because of many children per mother and early age of childbearing, leading to increased domestic violence and abortion. When women are empowered to control the spacing of their births, they can

avoid the stress to their bodies these pregnancies cause and also not see abortion as an option to do away with unwanted pregnancies.

Table 4.3 Use of Contraception

Percentage of women age 15-49 years currently married or in union who are using (or whose partner is using) a contraceptive method, Migori Sub-County, 2011

	Not using any method	Percent of women (currently married or in union) who are using:																Number of women currently married or in union
		Female Sterilization	Male Sterilization	Pill	IUD	Injectables	Implants	Male condoms	Female condoms	Diaphragm/ Foam /Jelly	LAM	Periodic abstinence	Withdrawal	Other	Any modern method	Any traditional method	Any method [1]	
Residence																		
Urban	39.1	4.0	0.0	0.3	6.6	32.5	4.3	8.1	0.0	0.0	4.9	0.3	0.0	0.0	55.8	5.1	60.9	126
Rural	61.0	2.4	0.0	2.5	1.3	18.2	2.1	5.0	0.0	0.2	5.7	1.6	0.0	0.0	31.7	7.3	39.0	556
Age																		
15-19	65.5	0.0	0.0	0.5	0.0	15.2	0.0	2.9	0.0	0.0	14.5	1.4	0.0	0.0	18.6	15.9	34.5	62
20-24	59.4	0.0	0.0	1.8	5.4	19.3	1.8	4.8	0.0	0.0	6.5	0.9	0.0	0.0	33.1	7.4	40.6	147
25-29	54.3	0.9	0.0	2.8	1.2	25.0	1.6	5.5	0.0	0.0	7.7	1.0	0.0	0.0	36.9	8.8	45.7	189
30-34	45.6	2.4	0.0	2.9	2.7	34.1	5.4	3.3	0.0	0.0	2.7	0.9	0.0	0.0	50.8	3.6	54.4	108
35-39	54.7	8.1	0.0	3.1	0.0	15.6	2.4	12.5	0.0	1.0	0.8	1.9	0.0	0.0	42.6	2.7	45.3	84
40-44	(60.9)	(12.6)	(0.0)	(0.9)	(1.5)	(6.8)	(7.9)	(8.6)	(0.0)	(0.0)	(0.0)	(0.9)	(0.0)	(0.0)	(38.3)	(0.9)	(39.1)	45
45-49	(75.6)	(3.4)	(0.0)	(0.0)	(3.9)	(8.7)	(0.0)	(1.9)	(0.0)	(0.0)	(2.9)	(3.7)	(0.0)	(0.0)	(17.8)	(6.6)	(24.4)	47
Number of living children																		
0	(78.8)	(0.0)	(0.0)	(0.0)	(16.2)	(2.2)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(2.8)	(0.0)	(0.0)	(18.4)	(2.8)	(21.2)	38
1	69.9	0.0	0.0	0.4	0.0	12.0	1.1	7.7	0.0	0.0	7.9	1.0	0.0	0.0	21.2	8.9	30.1	84
2	56.0	0.0	0.0	2.8	0.9	28.8	2.0	2.4	0.0	0.0	6.7	0.4	0.0	0.0	36.9	7.1	44.0	113
3	45.5	2.6	0.0	1.9	0.0	29.5	2.3	8.4	0.0	0.0	8.9	0.9	0.0	0.0	44.7	9.81	54.5	142
4+	56.4	4.8	0.0	2.7	2.8	18.6	3.5	5.5	0.0	0.3	3.7	1.8	0.0	0.0	38.1	5.4	43.6	305
Education																		
None	(54.5)	(2.4)	(0.0)	(1.9)	(20.1)	(17.1)	(1.9)	(0.0)	(0.0)	(0.0)	(0.0)	(2.2)	(0.0)	(0.0)	(43.3)	(2.2)	(45.5)	35
Primary	59.0	2.5	0.0	1.7	1.0	20.7	2.3	5.4	0.0	0.2	6.1	1.1	0.0	0.0	33.8	7.2	41.0	553
Secondary	46.1	3.7	0.0	4.9	3.0	23.0	3.9	8.7	0.0	0.0	4.4	2.2	0.0	0.0	47.3	6.7	53.9	94
Wealth index quintile																		
Poorest	64.3	1.2	0.0	3.6	0.9	16.1	0.6	4.5	0.0	0.0	7.1	1.7	0.0	0.0	26.9	8.8	35.7	161
Second	55.2	2.3	0.0	2.4	1.7	28.2	3.4	3.1	0.0	0.0	2.8	0.8	0.0	0.0	41.2	3.7	44.8	113
Middle	63.5	3.3	0.0	1.3	0.0	14.6	1.2	7.5	0.0	0.0	6.5	2.0	0.0	0.0	27.9	8.6	36.5	148
Fourth	59.9	5.2	0.0	0.8	2.2	12.9	3.1	8.0	0.0	0.0	5.9	2.0	0.0	0.0	32.2	7.9	40.1	115
Richest	41.4	2.1	0.0	2.1	6.6	32.8	4.8	4.8	0.0	0.6	4.9	0.0	0.0	0.0	53.8	4.9	58.6	146
Total	57.0	2.7	0.0	2.1	2.3	20.8	2.5	5.6	0.0	0.1	5.6	1.3	0.0	0.0	36.1	6.9	43.0	682

[1] MICS indicator 5.3; MDG indicator 5.3
( ) Based on 25-49 unweighted cases

4.3 The Luo: A Socio-cultural Background

The Luo are a Nilotic speaking people and among the four largest ethnic groups (Kikuyu, Kalenjin, Luhyia and Luo) in Kenya. They occupy the areas of South and Central Nyanza around the Kavirondo Gulf in Western Kenya (Ogot, 1967; Cohen & Odhiambo, 1989). The Luo are part of the migration of Nilotic groups from Bahr-el- Ghazal region of Sudan to the present settlement in Western Kenya (ibid). They are closely related to the Acholi of Uganda, Dinka and Nuer of Southern Sudan, who are Nilotic speaking people (the latter two are Dholuo speakers). The Kenyan Luo live in densely populated settlements around the Eastern shores of Lake Victoria. The Luo territory stretches from close to the Ugandan border in the North-West to Tanzania in the South. They neighbour the following communities: Luhyia, Gusii, Maasai, Kuria and Nandi. They have contact with their neighbouring communities as well as others in other parts of the country.

Traditionally, the Luo are both agriculturalists and livestock keepers. Grain, fish and milk make up their diet (Ocholla-Ayayo, 1976). Today they have a mixed economy growing maize, sorghum, millet, and vegetables for subsistence and various cash crops such as sugarcane, cotton, tobacco, ground nuts and coffee depending on rainfall and altitude as well as markets (Shipton, 1989). Some people fish for subsistence as well as commercial purposes around the lakeshores and streams. The Luo also keep livestock for subsistence, commerce and bride-wealth payments.

The Luo have a patrilineal descent system (Evans Pritchard, 1950). The largest lineage segment is called *'piny'* which comprises land occupied by the greater Luo community. This is followed by the *'gweng'* lineage segment, comprising of several households which

are either closely or distantly related to one another (Ocholla-Ayayo, 1976). This is similar to the clan.

The smallest lineage segment or *'jakokwaro'* which is composed of people of the same grandfather but extends to include several generations. Traditionally, Luo lineages were territorial but the degree to which this applies today is debatable because of various changes that have occurred as a result of migration, privatization of land among others.

Luo Kinship groups are based on descent through male ancestors and are divided into clans which are sub-divided into sub-lineages of the same line. The Luo are patrilineal in post-marital settlement and practice polygyny. Women do not belong to their husband's lineage and their social status depends on their fertility especially the number of sons she bears (Ocholla-Ayayo, 1994).

They are expected to produce children for their husband's lineage. Any child that is born out of marital union cannot inherit property from her mother’s lineage, hence clan. They also inherit their father’s property. Thus, the Luo community has a strong patriarchal and patrilocal system in which children (especially sons) are highly valued. This strong patriarchal system can result in great challenges especially for women who conceive outside the wedlock resulting into induced abortions.

It is impossible to describe Luo sexual practices and beliefs without looking at marriage patterns. According to Potash (1978), Luo marriages are exogenous within the marital lineage. Thus, men marry women from non-genealogical related lineages either from the wealthy or from class residing in distant locality (Ocholla-Ayayo, 1976). Upon marriage a woman moves to live amongst her husband kinsmen but only as a partial member of her

husband's kin group. Hence, they are regarded as strangers among inter related men (Shipton, 1989).

Traditionally, the Luo did not have a centralized political system. They had a decentralized political system of leaders with semi-formal positions at the head of clans and lineages (Shipton, 1989). The Luo society is gerontocratic, with older men controlling allocation of resources such as land, livestock and bride-wealth among others. They command respect and total obedience and are custodians of the community's traditions and moral values.

Unlike their Bantu neighbours such as the Luhya and Gusii, and Nilotic Maasai and Nandi, the Luo do not have elaborate ceremonies marking adulthood such as male circumcision and female clitoridectomy. But the increased prevalence of the HIV/AIDS infection has witnessed the adoption of male circumcision by an increasing number of men for health reasons.

For over 60 years, many middle-aged Luo men and women have migrated to areas outside their homeland because of wage labour and commerce either in towns, cities and agricultural plantations both within and outside Kenya. As a result, many households are female-headed and depend on remittances in cash and kind from migrants from Luo Nyanza. Migrants also depend on rural farms for food and social security at old age.

3.4 Ethnic Composition and Social Organization

The predominant ethnic group in the study is the Nilotic-speaking Luo which was the target group of the study. The other ethnic groups include the Maasai, Kipsigis, Kuria, Abasuba, Abagusii, Agikuyu, Abaluyia and Somali which has really influenced the

culture of the Luo in one way or the other. The Luo have a patrilocal, patrilineal and segmentary descent system (Pritchard, 1950; Potash, 1978; Ocholla-Ayayo, 1976, 1994; Shipton, 1989). The smallest unit in the social organization of the Luo is locally known as *jakokwaro* (lineage) and is composed of people who are genealogically related. This unit is followed by the *gweng* (segment) which is composed of several households from different lineages (Ocholla-Ayayo, 1976; Shipton, 1989). The largest segment is called *piny* or region which comprises land occupied by the greater Luo community. Traditionally, Luo lineages in Migori Sub-County were territorial but the degree to which this applies today is debatable because of various changes that have occurred as a result of migration and privatization of land.

Traditionally, the Luo had a decentralized political system with semi-formal leaders at the head of each clan and lineage (Shipton, 1989). In this system, older men controlled the allocation of resources such as land, livestock and bride wealth. The elders also commanded respect and obedience and were custodians of the traditions and moral values regarding, for example, sexuality in the Luo community.

Lastly, over these many years the local people in Migori have out-migrated because of wage labour and commerce in towns, cities and agricultural plantations both within and outside Kenya. As a result, most households are female-headed and depend on remittances in cash and kind. However, migrants also depend on rural farms for food and social security during their old age. Other factors such as education and Christianity have been responsible for the collapse of the traditional structural and moral fabric leading to individualism which then leads to individual being the sole decision maker in moral issues such as sexuality and pregnancy.

4.5 Welfare Indicators

4.5.1 Poverty Analysis

Poverty is defined as the inability to access basic human needs by segments of the population. The Second Poverty Report by the Government of Kenya (June, 2000) identifies the poor in terms of food poverty, hardcore poverty, and absolute poverty. 58 percent of the district population is in absolute poverty whereas a large percentage experience food poverty.

The 2000 District Poverty Assessment Report identifies the main factors that could be giving rise to poverty in the district as being rapid population growth, economic and environmental factors, HIV/AIDS menace and socio-cultural practices and attitudes (such as polygamy and wife inheritance). Inadequate and unreliable rainfall patterns have immensely affected agricultural activities in some parts of the district. Table 4.4 below presents selected socio-economic indicators in the Migori Sub-County.

Table 4.4 Socio-economic Indicators of the Informants

Total number of households	113,930
Average Households size	4.5
Number of female headed households	5,697
Number of disabled	25,000
Children needing special protection	13,000
Absolute poverty (rural & urban)	58%
Income from Agriculture	75%
Income from rural self employment	5%
Wage employment	10%
Urban self-employment	5%
Number of unemployed	79,463

Source: District Statistic Offices, Migori (2001)

4.5.2 Economic Activities

The major economic activities in Migori Sub-County include farming, fishing, livestock keeping, poultry, tourism, mining and light industries **(**Ocholla-Ayayo, 1976; Parkin, 1978; Cohen, 1989**)**. On the other hand, the main cash crops, which are grown, consist of coffee, tobacco, sugar cane and pyrethrum. Conversely, the food crops that are cultivated consist of maize, beans, bananas, millet, sorghum, sweet potatoes, groundnuts, cassava, fruits and vegetables. Finally, the animals that are domesticated are cattle, goats, sheep, rabbits, donkeys, pigs and poultry (Ocholla-Ayayo, 1976; Parkin, 1978; Cohen, 1989). Despite the activities mentioned, Migori still has 58 percent of its residents living in absolute poverty even though income from agriculture stands at 75 percent (table 4.4). This kind of poverty index may easily lead parents, women specifically, to resort to casual sex as a source of income, which can easily lead to abortion, since rearing a child is not a cheap venture.

4.5.3 Education Facilities

Education facilities in the study region are scarce, with only one national Teachers Training College, 44 secondary schools and 410 primary schools. The gross primary school enrolment ratio is 126.3 males and 112.9 females. On the other hand, the dropout rate in primary schools is 6.4%. Conversely, working children as a percentage of the population aged 5-17 years is 27.5 percent. This scenario can negatively affect the people of the area since education is very important in life, for it is the key to economic success and positive social mobility (Kenya, 1999). Child labour can negatively affect the county due to stunted growth of future generations, inability to harness human resources,

inability to contribute and benefit from development, thus lead to future adult unemployment and citizens with accumulated frustration. Working children in the county do so to supplement family income and add to free labour in agricultural activities. Some engage in paid work such as mining gold in Macalder, fishing to fend for themselves and other siblings as a result of being orphaned or neglected by parents.

The total enrolment in primary schools stands at 91 percent in the 410 primary schools in the County. The population in primary schools was 119,115 in 1999 and was expected to increase to 130,724 and 154,447 in 2002 and 2008 respectively. In the 44 secondary schools of the county the total attendance in 1999 was 56,096, which was only 18.5 percent of the total population of secondary school going (15-19), the rest of the students seek education outside the county. The secondary population stood at 56,096 in 1999, and was projected to rise to 61,562 and 74,148 in 2002 and 2008 respectively. In 2014 this has since increased to 131,821.5 133 percent males and 111 percent females. This is because of the introduction of the free primary and secondary education policy and introduction of constituency development fund (CDF) which has seen many children go to school and also construction of more schools. Therefore, desired investment in schools to cater for this increasing population will be necessary. This implies that during change over from primary to secondary schools the dropout rates are very high. At secondary level the completion ratio is low for girls and boys thus resulting into an average attendance of three years for boys and girls. The major challenge that has resulted in low enrolment in schools, non-schooling gap which is wide and increasing, low retention in schools due to high dropout rate is increasing poverty level in the sub-county. Another challenge to education is the spread of HIV/AIDS and its impact on the Migori Sub-

County community. Females aged 15-49 constitute 24 percent of the female population. It set to rise from 124,811 in 1999 to 136,975 and 164,976 in the years 2002 and 2008 respectively (Migori Sub-County Strategic Plan 2005-2010).

4.5.4 Labour Force

The economically active population of about 251,513 in 1999 was just slightly less than half of the population of the district. Females constitute the majority of the labour force, which however is mainly unskilled and will continue to do so even in 2008. The labour population is expected to increase from 251,513 in 1999 to about 326,521 by the year 2014. Migration has contributed to the population increase because of existing fertile soils, good climate and the sugar and tobacco industries and cross border trade (Migori Sub-County strategic plan 2005-2010). Migration has been due to Migori Sub-County bordering Tanzania and Uganda (Migingo Islands) thus attracting many on transit to these countries, hence bringing people from different areas mixing with the locals freely. At times they bring with them their culture. The fact that they are not blood related, this encourages casual or permanent relationships impacting on economic welfare (poverty), sexuality, having children and the possibility for unwanted pregnancies especially from truck drivers on transit and those visiting fish landing beaches to transport fish. Table 4.4 shows urban self-employment very low at 5 percent, wage employment at 10 percent and income from rural self-employment at 5 percent.

4.5.5 Infrastructure Facilities

The study area has dilapidated infrastructure including very poor roads, inadequate fixed telephones, electricity, clean water and sanitation. This poor infrastructure has slowed down development, which has in turn increased the costs of living. The major urban

centres in the study area include Migori Town, Kehancha, Rongo, Muhuru and Nyabikaye (Kenya, 1999). These urban centres as well as highland areas in the study region have high population densities. The percentage of urban population stands at 10.4 percent with migrants at 1.2 percent (Kenya, 1999). The inadequate infrastructure in the area has impacted negatively since transporting agricultural produce and fish to the market is a challenge especially during rainy season. Movement of people too is not easy thus contributing to poverty index of 58 percent.

Unpaid workers by gender are 38.3 percent males and 61.7 percent females (Kenya, 1999). The percentage of households with access to piped water is 3.8 percent, toilet facilities is 62.6 percent and electricity 4.3 percent. The sub-county is served with two tarmac road from Kisumu-Kisii through Migori town up to Sirare/Isebania on the Kenya-Tanzania border (Kenya, 1999) and one from Muhuru to Kehancha.

4.5.6 Health Facilities

The health care system in Migori Sub-County is supported by the government, religious and non-governmental organizations and individuals. In particular, the study region is served by 1 district hospital, 1 mission hospital, 31 dispensaries, 9 health centres, 4 sub-health centres, 14 private clinics and 1 nursing home (Kenya, 1999). Other health institutions include Ojele Memorial Hospital, Machage Hospital, Oruba Hospital and the Marie Stopes Clinic. All these medical facilities provide reproductive services including the provision of family planning as well as procuring abortion and post-abortion care (Government of Kenya, 1999). However, all these health institutions cannot serve the people of Migori Sub-County adequately.

Table 4.5 on health indicators explains the apathy created by lack of an adequate health care system in Migori Sub-County. These figures too could be a reflection of modernity, where structures for taking care of the unborn through to old age in terms of use of herbs and observing taboos and norms have been abandoned. In the traditional Luo society illnesses of all kinds were dealt with in good time before they became a threat to people's life. Fertility was controlled and child spacing done to ensure each child born was given time to grow before another one was born. The rates of sexually transmitted diseases such as HIV and AIDS should not stand at 30 percent if traditional structures of sexuality were in place. Table 4.5 below summarizes some of the health indicators in Migori Sub-County.

Table 4.5 Health Indicators in Migori Sub-County

Crude Birth Rate (CBR)	42/1000
Crude Death Rate (CDR)	17/1000
Life Expectancy	50 years
Infant Mortality Rate (IMR)	137/1000 live births
Under 5 Mortality Rate	213/1000 live births
Total Fertility Rate	7.1
HIV Prevalence Rate	30%

Source: District Statistic Offices, Migori (2001)

4.6 Socio-economic Characteristics of the Sample

Having looked at the general county based on the socio-economic characteristics, this section focuses on specific characteristics of the sample such as sex, marital status, women education and occupation.

Table 4.6 displays the distribution of the respondents in the survey by selected background characteristics.

Table 4.6 Selected Background Characteristics of Survey Respondents

Variable	Male (n=71) Percent	Female (n=144) percent	Total (n = 215) percent
Sex			
Age			
15-19	11.4	11.2	11.3
20-24	20.0	32.0	29.4
25-29	17.1	20.8	20.0
30-34	17.1	14.4	15.0
35-39	8.6	7.2	7.5
40-44	2.9	4.0	3.8
45+	22.9	10.4	20.0
Marital Status			
Single	11.4	12.8	12.5
Married	88.6	75.2	78.1
Widow/separated/divorced	-	12.0	9.4
Religion			
Christian (Catholic)		30.4	30.0
Christian (Protestant)		56.0	53.4
African/Christian		13.6	14.4
No Religion		-	2.2
Education			
Primary		46.4	45.6
Secondary		33.6	37.5
Post-secondary		13.6	11.9
No education		6.4	5.0
Occupation			
Self-employed		20.8	30.4
Paid employment		15.2	19.1
Farmer/Fisherman/Monger		19.2	22.4
Housewife		19.2	9.6
Unemployed		16.8	14.1
Student		8.8	4.4

n = 215

4.6.1 Sex

22 percent of the respondents were males while 78 percent were females. More females than males were included in this study because they are the ones at the risk of pregnancy and are main recipients of post-abortion care in public and private hospitals.

The percentage is higher than that of men because it is the women who risk the pregnancy though it also depends on the circumstances of the person, since in the traditional society people looked forward to pregnancy as opposed to today. The target was women but men were incidental, which explains the 22 percent.

4.6.2 Age

More than 60 percent of the survey respondents were aged between 20 and 34 years. The mean age for males and females was 35 years and 24 years, respectively. Female respondents were on average younger than males. Over 40 percent of the female respondents were aged between 15 and 24 years. The age distribution displayed in table 1 is typical of the general Kenyan population, which is characterized by high fertility and a larger proportion of the population in the younger age groups than in the older age groups.

In addition, this is also the prime age when women are most fertile and active sexually, and some of them may not be married or if married they might have retained former sexual partners if they have not settled in their marriage. For the unmarried women, they may be desperate to get marriage partners and in the process they pregnant without having planned for the child, which necessitates an abortion.

4.6.3 Marital Status

12.5 percent of the respondents were single compared to 78.1 who were married with more males than females being married. 9.4 percent of the respondents were widowed,

separated or divorced with women being the majority in this category. It is important to note that in the traditional Luo culture a man is never considered a widower.

Traditional Luo marriage arrangements provided a man with a replacement for his dead wife through sororate marriage. Under such marital arrangement the sister to the deceased or a close relative was provided for marriage as a replacement. Besides in the Luo society several women can be married to one man. A sister to the wife can be married to the brother-in-law when the wife is deceased or alive.

The women who are married in a polygamous union may experience incidences of infidelity which is explained by the provision of back gate “rot” behind every woman’s hut/house in a Luo homestead. The “rot” allowed visits by other men discretely to the woman’s hut/house.

4.6.4 Religion

More than 80 percent of the respondents belonged to various Christian religious denominations. Half of all respondents belonged to Protestant church affiliations and 14 percent professed to religious denominations that combine traditional African beliefs and practices with Christianity such as Legio Maria and the Luo Nomiya Church, for example. Members of these churches practice polygyny, the removal of six lower teeth, circumcision of male infants eight days after birth and so on as it was in the Luo tradition.

Christians use Christian standards for their behaviour by condemning cultural practices such as wife inheritance, polygyny, back-gate visits by men, which may have contained unwanted pregnancies since every woman and man belonged to each other through such cultural practices and therefore incidences of abortion were largely minimized.

Christianity has also set very high standards by sexuality without structures to contain followers from trespassing.

4.6.5 Education

In general, more than 95 percent of the respondents had formal education; with 45.6 having primary level education and 37.5 percent secondary school and post-secondary school education. There were more males than females who had secondary education level. This could be explained by the higher school dropout rates among girls in Migori Sub-County due to lack of school fees, teenage pregnancy and cultural practices that encourage early marriage, and discrimination against women's access to education. This has also contributed to high TFR in the county.

Little education is dangerous to women, especially where there is still tradition in cultural beliefs and practices which for example might influence a people by not attending pre-natal clinics. Higher education on other hand instils in people the principles of autonomy and personal responsibility and rational behaviour by use of reasoning and so the educated ones are the ones who are likely to work outside agriculture and can account for their own behaviour thus likely deviate from culture by engaging in promiscuity, adultery and procure abortion.

4.6.6 Occupation

19.1 percent were self-employed, 22.4 percent were either farmers, fishermen or fish mongers or 14.1 percent reported that they were unemployed. Over two thirds of males

interviewed were either formally employed or self-employed compared to 46 percent of female respondents. More women than men were likely to report being unemployed.

The majority of respondents in paid employment were civil servants, teachers, draught men, mechanics, clerks, health workers and those in the service industry such as catering and transport. Those who were self-employed were operating small-scale business enterprises such as retail traders in shops, kiosks, tailors, artisans and craftsmen.

Table 4.7 Selected Background Characteristics of Respondents in In-depth-Interviews

Variable	Male Percent	Female Percent	Total percent
Age			
15-24	28.6	27.8	28.2
25-30	21.4	38.9	30.1
35+	50.0	33.3	42.7
Marital Status			
Married	64.3	50.0	57.1
Single	35.7	39.0	37.4
Widowed/separated/divorced	-	11.0	5.5
Education Level			
Primary	28.6	50.0	39.3
Secondary	50.0	33.3	41.6
Post-secondary	21.4	16.7	19.1
Total	**71**	**144**	**215**

n = 215

The profile of in-depth interview and focus discussion groups informants presented in table 4.7 shows that over 40 percent of the informants were aged 35 years and above. More than three quarters (78 percent) of the interviewees had attained secondary school education. The majority of informants were aged between 25 and thirty years of age and 57 percent were married. There were more females than males who were either widowed or separated at the time of interview.

Table 4.8 Information about Focus Groups

Group Composition	Age Range	Total no. of Participants
Married men	24-34 35-50+	6 7
Married women	18-30 32-50+	5 6
Single men Out of school Wage earners and self employed	 19-24 25-35	 5 5
Single women In school and out of school Wage earners and self employed	 15-29 30-50+	 6 7
Total		**47**

n = 47

3.7 Conclusion

Demographic information was key since it helped show the socio-economic factors in numbers which cannot be captured qualitatively. It showed the disparities in education, age, gender, religion, level of income in relation to the socio-economic factors in Migori Sub-County.

CHAPTER FIVE

SEXUAL BEHAVIOUR AND CONTRACEPTIVE USE

5.1 Introduction

This chapter addresses objective one of this study, which was to describe traditional beliefs, attitudes and behaviour in relation to sexual relations among the Luo of Migori Sub-County. The Chapter highlights sexual behaviour prior to marriage, within marriage and outside marriage. Descriptive statistics are used to shed more light on the general trends in sexual networking in addition to qualitative data.

The first section of this chapter therefore examines premarital sexual behaviour, beginning with an overview of traditional Luo customs, particularly norms regarding premarital sex. This is followed by an examination of age at first sexual intercourse and marriage. The final section focuses on sexual networking, mainly the current number of partners and lifetime partners.

5.2 Premarital Sexual Behaviour

In the past, sexual behaviour among the Luo was controlled through a normative moral code, which permitted certain sexual practices and prohibited others. Luo customary sexual and marriage code strictly prohibited premarital sex and placed emphasis on the importance of virginity at marriage (Evans-Pritchard 1950; Ocholla-Ayayo 1976; Parkin 1978; Wekesa & Otieno, 1993b). In traditional Luo society chastity was highly emphasized Ocholla-Ayayo and his colleagues state that:

It was an honour for an adolescent (girl) to avoid sex before marriage since a girl who maintained chastity until the evening of the marriage would be rewarded by her mother by being given some goats and even cash. This was witnessed by her aunts who had to find whether there was blood on the bed sheets, implying the breaking of the hymen during first mating with the husband.

Cultural morality confined sexual activity and reproduction to marriage unions. Premarital pregnancy and child birth were undesirable because they brought shame to both the girl and her family. A deflowered girl suffered shame which remained a stigma throughout her life (Ocholla-Ayayo 1976). Premarital pregnancy not only ruined a girl's reputation but also jeopardized her chances of good and honourable marriage. Thus, parents especially, mothers and grandmothers, protected their daughters and restricted their movements to ensure they did not engage in sexual activity before marriage (Cohen & Odhiambo 1989).

On the other hand, young men were not subject to restrictions in their premarital sexual relations, even though a boy who impregnated a girl could be forced to marry her or pay a heavy fine. Available literature indicates that in many cultures in Africa, virginity was valued and a source of pride for the bride's parents and her relatives (Konde-Lule, 1991).

In the past, young married Luo males and females were provided with sexual outlets, particularly by the traditional practice known as '*chode*' which involved performance of non-penetrative sex (Ocholla-Ayayo, 1976; Caldwell et al., 1994b). Girls were allowed to have many boyfriends as they wished but not to engage in penetrative sexual intercourse. '*Chode*'-'*wuowo*' used to take place during courtship when a group of girls visited their

suitors in their '*simba*', the boys dormitory. On such visits sexual advances were made but the girls were expected to resist even if they spent the night in the '*simba'*.

Evidence in various literature sources indicate that a boy who indulged in premarital sexual activity was viewed as promiscuous and unworthy of marriage, while a girl who did so was perceived as morally loose and not fit to become a good wife (Ocholla-Ayayo, 1976; Parkin, 1978, Ominde, 1987; Atieno-Odhiambo, 1989).

In the traditional Luo society, there were institutions of education such as '*duol'* and '*siwindhe*', which inculcated societal values and norms to young people. In the past young Luo girls were taught how to protect themselves from penetrative sex and what to do when they got pregnant in marriage.

This knowledge was provided by *'pim*' an old woman, usually referred to as grandmother, who could talk freely with young girls about anything including sexuality. The strict restrictions which existed in the traditional setting provided fewer opportunities for young people to engage in sex thus reducing the risk of unwanted pregnancy and abortion.

In the past half a century, however, there has been great impact on the Luo culture, influenced by colonization, urbanization, modern formal education, mass media and other westernization forces. Colonization has brought new system of governance bringing people like headman, Assistant Chiefs at the locational level which has somehow replaced the political organization of Luo. Back then the clan could deal with its own issues such as punishing wayward behaviour. This is not the case today because of the introduction of courts, Children Act of 2001, advancement of Human Rights thus making

it impossible for parents to discipline their children in the traditional way such as caning. This has liberated the children and made them mistake what is contained in the Children's Act to mean freedom to do what one feels like doing thus resulting into freedom minus responsibility.

Urbanization has also affected Luo customary beliefs and practices because it has encouraged mixing with other cultures thus borrowing new ideas. It has also interfered with the family structure due to rural-urban migration where families at times are separated for long periods of time. This to married couples can be quite tempting and if not checked or put under control may lead to promiscuity, which leads to unwanted pregnancy which then leads to abortion. Besides, in the urban set up, there is no Luo homestead. What there is are estates, where anybody can be your neighbour. This has led to people adapting to practices which make them fit in the modern set up, some of which may not conform to traditional beliefs and practices which upheld issues such as chastity and sexuality with the highest esteem.

Modern formal education has introduced formal structures in the name of schools where children spend most of their time hands of teachers who teach 'modern' curriculum devoid of life-skills which was taught at home as a form of informal education from birth to death thus making it lifelong education. When a child progresses to secondary school, chances are the child will join a boarding school for four years away from home thus further alienate the child from home practices and education. By the time he or she is through with modern formal education, he or she has acquired new beliefs, attitude and practices, some of which may not conform to the Luo customary beliefs and practices.

Lastly, the mass media and westernization have greatly interfered with the traditional beliefs which in the eyes of the "modern Luo" are now seeing western practices as superior to the traditional practices. A good example is the mode of dressing, which, according to one respondent, is demeaning:

Nowadays our children, especially girls, are dressed in tight, brief clothes which make men rape them. I am not saying in the past there were clothes but when the clothes were introduced and people had prescribed long and above the knee dresses for girls/women, it is just in order that we stick to that to avoid unnecessary temptation (male respondent married 50 years). In summary colonization, modern formal education, mass media and other westernization forces as phenomena have affected Luo customary beliefs and practices in a way liberalizing the moral code.

The traditional African family and structure has been undermined by socio-cultural change and mobility. This has resulted in the erosion of traditional institutions such as *siwindhe* and *duol* and systems governing sexuality. When girls visited, they were in groups, this was one defence mechanism against sexuality. In some societies like the Luo, boys also went around in company. Girls of age were sleeping as a group in the house of a widowed old grandmother which was also another institution where she could talk to them on matters on sexuality and growing up, as she herself was past menopause and did not engage in sexuality. Boys sleeping in the *simba* were also part of training in discipline. They slept there in a group till one of them or the owner got married. The others migrated to another *simba.* Grazing of livestock as a group of boys was encouraged. Sex differentiation in sleeping arrangement and moving as a group also provided good company as expressed by one respondent during a group discussion.

The traditional structures that previously safeguarded morality have ceased to exist or disappeared altogether. Shorter (1998) observes that since the 1960s there has been a 'revolution of expression disorder' which is a revolt against the puritanical perception of sexuality (that emphasized fidelity before marriage, especially for women). This puritanical perception that restricts female sexuality and reproductive decision making are supported by patriarchal structures.

Today, sex education is neither provided at home nor school. Consequently, many young people are morally disoriented leading to sexual promiscuity. As a result, there is an increase in premarital sex and the strong conservative attitude to female fidelity has weakened or waned. Nowadays young people perceive sex as recreation rather than a reproductive activity as it used to be in the past. Thus, it is common for young people to have a series of sexual relationships with different partners before marriage.

Virginity at marriage is neither highly valued nor strongly emphasized and it is not accorded the esteem it had in the past (Muange, 1998). This is evident from the following excerpt from one key informant:

Today young people are having sex irresponsibly. Unlike in the past virginity at marriage is no longer expected or desired. A boy or girl who has never had sex is considered a novice by age-mates and school mates. To them sex is part of leisure… They just want to enjoy themselves (*Female key informant; married*).

Today it is considered (albeit covertly) acceptable for young men and women to have several sexual partners. A boy or girl who is sexually inexperienced is always looked down upon by peers. Thus, many young people do not consider it morally wrong to have

sex before marriage as long as the relationship has prospects of economic gain or future marriage. These views were expressed in key informant interviews and focus group discussions

Nowadays it is very common to find very young girls…. Some as young as thirteen years who become pregnant and bear children… There are many of them in this village (*Female key informant; 48 years*)

It is difficult to find girls who have not had sexual relations before marriage. A girl or woman who has never had sex is considered a novice (*Female informant single; 24 years)*

Young girls are lured by men into having sexual relationships with money and promises of future marriage. When they impregnate them, they run away denying responsibility (*Female respondent married; 36 years).*

The forces of modernization, globalization, rural urban migration and exposure to new ideas through the mass media have facilitated the breakdown of traditional norms and diminished family control over the behaviour of young people and thus resulted in more relaxed attitude towards premarital sex:

Young people copy what they see on television, videos, movies and now the internet… they watch and read immoral things which in the past would never have been allowed. They copy what they see and read…. This is why many young girls are getting pregnant at very young age. Others are infected with HIV. (*Male key informant married; 55 years*).

Thus, today young people enjoy sexual activity without guilt and responsibility. Many young people embrace the ‘romantic love ‘regime in which sexual activity is perceived as acceptable as long as the partners are in love. This sexual freedom is devoid of personal responsibility. In fact, with the increased recognition of civil rights, sex is now viewed as a human right. This situation has in turn contributed to sexual permissiveness hence promiscuity. The current globalization culture is also saturated with sex and with the proliferation of information technology particularly the internet, sex is encouraged through pornography which can be accessed by anyone including teenagers. Thus, adolescents and young adults are often caught between competing traditions and parental authority, on one hand, and liberal secular ideas of personal freedom, individualism and independence on the other.

Unlike in the past, many adolescents are sexually active making pregnancy. Studies in Nyanza province show that 42 percent of 15-19 years old teenager are sexually active while 27 percent are either pregnant or are already mothers (Mitchel et al., 2006; UNAIDS Report, 2006).

5.3 Age at First Sexual Intercourse

The first sexual intercourse is an event of great importance since it marks debut into sexual activity and has serious implications because if unprotected it carries the risk of unwanted pregnancy and infection with Sexually Transmitted Infections (STI’s). Thus, data on this event is important in Kenya where teenage pregnancy, unsafe abortion and single parenthood are issues of great concern (Magadi, 2004; Oindo, 2007; Ndunyu, 2007b).

The occurrence of the first sexual intercourse is of interest in this study; questions were asked in the survey to elicit information on the age at first sexual intercourse which was reported in complete years. Table 5.1 shows the distribution percentages of age at first sexual intercourse by current age of the respondent.

Table 5.1 Age at First Sexual Intercourse by Current Age of Respondent

	Males (%)		
Age at first sex	15 – 25	25 – 35	35+
<15	32.6	10.6	9.5
15 – 19	67.4	85.2	71.1
20 – 24	-4.2		19.4
	Females (%)		
<15	52.3	40.8	24.8
15 – 19	45.1	45.8	38.7
20 – 24	2.6	13.4	36.5

n = 215

The majority of the survey respondents were sexually active. The mean age at first sexual intercourse for males and females was 15.4. The lowest age at first sexual intercourse reported by males was thirteen years and for females it was nine years (Not displayed in table 5.1). Females respondents tended to have sexual intercourse two years earlier than males, with mean ages of 14.7 and 16, respectively. Women reported to experience first sexual intercourse with men who were older than them.

Over a half of the women in the survey had first sexual intercourse when under the age of fifteen compared to a third of men. Another striking pattern emerging from table 5.1 is the distinct difference in the age at first intercourse between respondents aged 15-24 and those aged 35 and above. The younger respondents had first intercourse earlier than those

born a decade or two before them (those aged 25-34 and 35 and above). A third of males aged 15-24 had first sexual intercourse below the age of 15 years compared to a tenth of those aged 35 and above. The mean age at which young respondents aged 15-19 experienced first sexual intercourse was about five years earlier than respondents in the older age groups of 35 years and above.

The low mean age at first sexual intercourse in Migori has been reported in other studies. In general, South Nyanza has the lowest mean age at first sex (14.3 years), first marriage and first birth 16.9 years compared to the national averages of 16.1, 18.4 and 18.8years respectively. (NCPD et al 1999, 2009) early initiation of sexual activity in the absence of contraception exposes teenagers to the risk of unintended pregnancy and thus unsafe abortion.

Many girls (adolescents) who drop out of school or get pregnant are forced to get married early at a young age. In fact, a demographic health survey of South Nyanza shows that high rates of teenage pregnancy are responsible for high school dropout among girls and early marriage. The high poverty levels in Migori Sub-County force many adolescents and young women to drop out of school because of lack of school fees. To support themselves socio-economically, many of them have relationships with men for money. The following excerpts illustrate this:

In this area, poverty levels are very high. Girls who drop out of primary and secondary school desperately look for men who can provide their daily necessities and other needs.

Many women who monger fish along the beaches and market cannot strike a deal with fishermen without sexual favours in order to access fish stock… she either has to have

sex with the fisherman or '*jaboya'* (broker)…. That way she will be assured of steady supply of fish…. This is how many women here are getting infected with HIV/AIDS.

These findings correspond to what other studies in South Nyanza report. Magadi & Agwanda (2006) report that about half of girls in South Nyanza aged 12-19 had initiated sex before age 16.

The age at first sexual intercourse has declined progressively through each age group but not uniformly. The fall is marked from the young age group into the older age group. The findings of this study are consistent with other studies conducted in Kenya and elsewhere in sub-Saharan Africa that show a trend towards decline in age of coital debut and high levels of sexual activity (Meeker & Gage, 1994; Blanc et al., 1998; Muange, 1998; Magadi, 2004; Oindo, 2007). To sum up, many young women in Migori and Kenya in general initiate sexual activity at very early ages, which predisposes them to unwanted pregnancy and potential of unsafe abortion. Evidence from in-depth interviews and case studies support this observation:

In the study area poverty levels are high at 5.8%. Girls who drop out of school are forced by hard economic times to look for a man who can provide some disposable income.

I became sexually active at the age of thirteen years while in primary school. My first sexual intercourse was with a truck driver who used to frequent my father's lodging houses. He lured me into having a relationship with him with gifts, money and promises of marriage. He used to give me pocket money to buy anything that I wanted. We had the relationship for several months but after a while he stopped coming to our place. (*Female; single; 19 years*).

I had my first sexual relationship at the age of 14 with my boyfriend who was a classmate. I did not want to have sex because I feared getting pregnant like other girls in the neighbourhood. However, one day after night study my boyfriend tricked me to escort him to a friend's house. When we got there, he insisted on having sex but I refused…. he insisted and I eventually gave in when he promised to marry me if I got pregnant (*Single; female; 18 years)*

Today, there is lack of strict parental supervision and guidance they lack control over their children's behaviour. Evidence from informal interviews supports this evidence:

Parents here in Muhuru Bay do not mind when their daughters move around with fishermen as long as money changes hands. They are no longer in control of them… They do not punish them when they go astray. No action is taken when we teachers summon them to school after noticing unbecoming behaviour… they feign ignorance… we are in a dilemma (Kenya informant, school teacher).

These days children no longer listen to their parents. They think they know everything…. More than their parents know (Kenya informant, school teacher).

Today you cannot reprimand somebody's child… in the past every adult person was allowed to punish and reprimand any child for way word behaviour even without consulting the parent.

5.4 Extramarital Sexual Relations

It has been found in a number of studies in sub-Saharan Africa that married people have sexual relations with other than their spouses (Karanja 1987; Caldwell, Caldwell and

Quiggin, 1989; Muange, 1998). The studies reveal that extra-marital relations are more common among men especially in urban areas. This may no longer be the same because of HIV infection. Rural women and married women are more likely liaisons especially when husbands are away in urban areas for extended periods due to migrant labour as was the case along the beaches as most people were not necessarily from the same area such as the fishermen, the truck drivers who come for fish and other businessmen and women who bring their merchandise to sell.

Unprotected sexual contact outside marriage has implication for the spread of sexually transmitted diseases and the incidence of HIV/AIDS. The following section explores sexual behaviour of married men and women outside marital unions. It examines attitudes to extra-marital relations and their implication for women's sexual rights and risk of unsafe abortion.

There is evidence in literature that shows that extra marital relations for women among the Luo was strictly prohibited (Ocholla-Ayayo, 1976; Potash, 1978; Parkin, 1978; Ominde, 1987). These studies show that women's extra-marital relations were strongly condemned but those of men were/are treated leniently. Among the Luo a married woman is expected to have sexual relations with one man, her husband. Punishment for female extra-marital relations takes the form of beating in some cases, separation and divorce if the offence is persistent. There is also a widely held belief that adultery can result in '*chira'* a fatal disease (Ocholla-Ayayo, 1978; Parkin, 1978).

Extra-marital relations involving the married are not often publicized but they do occur as this study found out. The following excerpts from in-depth interview formations confirm this:

> Nowadays things have changed. In the prevailing hard economic conditions, it is hard for some women to remain faithful to their spouses… many women in rural areas have many responsibilities, to support their families, especially their children when their husbands are in town working. Some women who cannot meet all their needs start having affairs with men who can provide money and other things. Some women, especially fish mongers have secret affairs with rich fishermen. Mainly to get fish stock and other favours they do it secretly behind their husband's back.

There is much secrecy surrounding such relationships because the woman faces serious consequences if she is found out. Men take it seriously when their wives stray with other men because it leads to loss of respect and honour among kinsmen and friends. A man whose wife strays is viewed as weak hence not respected. Parkin (1978) has noted that among the Luo

To lose a wife through desertion or to be cuckold reflects severely on a man's honour… for most Luo, adultery by a woman is always tantamount to divorce, for it is not normally reckoned that a marriage can survive the dislocation of a husband's honour (sixteen. 16).

Some men hold the view that adultery, at least on the part of the wife, is unquestionable ground for divorce. It is expected that when a woman commits adultery and her husband finds out, the relationship between her and her lover breaks up, but if she persists with the affair, the husband has ground for divorce. And yet women are no longer timid in matters of sexual satisfaction. When this is limited, women go out to obtain it. Women in polygynous marriages, whose husbands are away as migrant labour and those whose husbands have low libido are likely to engage in adultery. This enables them to maintain

their married status, which women prefer instead of seeking divorce, which is stigmatized among the Luo and is a source of low status and poverty for the women involved. Polygyny as practiced by the Luo could open a window for adultery although in every homestead the man who was the head of the house was supposed to provide a small gate behind the house/hut of each wife to allow his wife/wives to have access to have sex from other men.

It was a tradition that a Luo man would not come to the homestead unannounced. He had to make his arrival known so that if there was any man in the house(s) of his wife/wives, they were to leave. This practice cushioned both the man and his wife or wives from procreation of children where the man could not sire, seek for quality genes or warm his wife/wives' bed where the man could not 'function'.

Children born out of such arrangements had their parentage concealed in order to safeguard their identity as well as protect the 'father's' ego in cases where the father could not sire. In the past the strength and wealth of a man was in the number of children. A woman could go to all lengths to describe how the child looks like the husband even where he was the social father and not biological. Women and children were cushioned with such structures making abortion having no place in case pregnancy occurred from such unions.

Nowadays with the advent of Deoxyribonucleic Acid (DNA) testing, which can be used to determine a child's parentage and the emergent or rural-urban migration, women and men have been exposed and pregnancy can be labelled and become common knowledge therefore abortion becomes the cheaper option.

It is common among the Luo that when marriages are dissolved which was not easy and the process elaborate, children, especially the boys, remain with their father because by virtue of having paid the bride-wealth they belong to his lineage. Many women interviewed in this study concur that the fear of the consequences of adultery such as divorce or losing children tends to discourage many women from extra marital sexual affairs. The same strict moral code is rarely applied to men's sexual behaviour outside marriage. Men's extra-marital relations are tolerated and tacitly accepted. Even though women may know of their husband's extra-marital relations, there is very little that they can do to change their husband's behaviour. Thus, men are more likely than women to engage in extra-marital relations.

Women who engage in such relations risk mental problems, pregnancy and abortion. Those who conceive in such illicit relationship resort to abortion to avoid marital problems and the social stigma that is attached to having children other than with their husbands. During night dances popularly known as "disco matanga", which are usually held at funerals as part of mourning, village girls risk engaging in unprotected sex and infections. The instances include the day of planning, following a funeral especially by widows, to cleanse the home of death and includes married daughters and sisters when they arrive home from the funeral, the day of starting to harvest etc. following some of these institutionalized patterns of behaviour unwanted pregnancies result with the risk of abortion.

3.6 Conclusion

It is evident from the foregoing discussion that the sexual patterns of men and women in the Luo society in general and Migori Sub-County in particular predispose women to anti natal tendencies. This encourages women to consider abortion not as a family planning strategy per se but as a means of concealing illicit sexuality. It is, therefore, largely rational behaviour.

Most of the relevant literature on the Luo and the findings of this study suggest that premarital sexual relations, especially for females, were uncommon in the past and female chastity at marriage was highly valued. However, the forces of modernization/globalization have undermined structures of authority, which previously enforced social morality and restricted behaviour of young people. It has become socially permissible for unmarried young men and women to be sexually active without any sense of guilt or responsibility. This has consequently contributed to increased sexual activity among young people leading to unwanted pregnancies and unsafe abortion.

This finding fits well with the Redefinition of Situation theory where the Luo have failed to redefine abortion and its determinants and sexual relations without responsibility. Anomie theory, on the other hand, points out that the society has failed to exercise adequate regulation or constraint over the goals and desires of individual members.

This study found that the majority of respondents in this study had sexual relations before marriage. The respondents reported a low mean age at first sexual intercourse. It also reveals that female respondents experienced sexual relations two years earlier than their male counterparts. This could be attributed to social, peer and economic pressure that

leads many young girls to become sexually active before marriage and to have multiple sexual relations. Many poor young girls and women are forced to engage in multiple sexual to for survival and other economic needs. In the contemporary world, economics plays a major role in many relationships involving young men and women. The young generation that is nicknamed ‘dot com’ considers sex the ‘new hug’ and ‘handshake’ where men have to pay something to have sex with their women.

CHAPTER SIX

CONTRACEPTIVE USE AND INDUCED ABORTION

6.1 Introduction

This chapter presents both qualitative and quantitative information on induced abortion. It is divided into three sections. The first section provides respondent's knowledge and attitudes toward contraception and their use. The second section provides knowledge and attitude towards induced abortion and respondent's experience of abortion. The third section details survey respondent's experience with abortion and highlights on ways to prevent induced abortion.

6.2`Knowledge and Use of Contraceptive Methods

This section focuses primarily on knowledge and use of contraceptive methods and their accessibility to the respondents. In addition, respondents were asked whether they had ever used any method to prevent pregnancy. Those who reported ever using pregnancy prevention methods were asked whether they or their partners were currently using a method at the time of survey. Table 6.1 displays percentage age distribution of respondents concerning contraceptive use

Table 6.1 Percentage Distribution of Knowledge and Use of Contraceptive Methods

	Male	Female	Both
Do you know any method of preventing pregnancy?			
Yes	98.7	98.9	98.8
No	1.3	1.1	1.2
	100	100	100
If yes, which methods?			
Pill	18.9	23.1	21.0
Condom	25.8	16.4	21.1
Injectables	10.5	15.3	12.9
Sterilization	7.5	9.3	8.4
IUD	12.2	21.6	16.9
Withdrawal	6.5	3.1	4.8
Periodic Abstinence	13.0	10.2	11.6
Folk Medicine	5.6	1.0	3.3
	100	100	100
Do you know any place you can obtain contraceptives?			
Yes	84.6	89.3	86.9
No	15.4	10.7	13.1
	100	100	100
Have you ever used any method to prevent pregnancy?			
Yes	24.4	38.0	31.2
No	75.6	62.0	68.8
	100	100	100
If yes, are you or your partner using any method?			
Yes	17.7	34.8	26.2
No	82.3	65.2	73.8
	100	100	100

n = 215

There was a 98 percent level of knowledge of at least one method of contraceptives among survey respondents. This high level of knowledge compares relatively well with the national and Nyanza provincial levels of 99 and 97 percent respectively (KDHS, 2009). Information from the interviews show that the main sources of knowledge about

contraceptives were education and health institutions (including schools, hospitals, clinics, peers, friends and relatives.

The majority of respondents knew at least one modern method of contraception – with the pill and condom being the most frequently mentioned methods. Only less than 20 percent of the respondents reported traditional methods such as withdrawal, periodic, abstinence and traditional herbal medicine thus making it 100 percent of knowledge and use of contraceptive methods. 87 percent of the respondents knew of a place where they would obtain contraceptive method, only 13 percent did not know of any place where they can obtain contraceptives. The most frequently mentioned hospitals were public and private hospitals/clinics, pharmacy and retail shops.

Despite the high level of knowledge about their sources, a great majority (68 percent) of the survey respondents had never used any method of contraception. This reflects that the general acceptance of contraceptives is quite low. For instance, only 38 percent of females reported having ever used any contraceptives, while 24.4 percent of the men answered in the affirmative. Only 26 percent of survey respondents supported that they were using a contraceptive method at the time of the survey. However, more women (34.8 percent) were currently using contraceptives while 17.7 percent of women reported to be currently using.

These current levels of use of contraception are far below those of the national and Nyanza provincial levels of 46 percent and 37 percent respectively (KDHS, 2009). In general, the trend observed in this study indicates a wide disparity between contraceptive knowledge and use. This may be due to lack of infrastructure, cultural beliefs and

attitudes, lack and access to contraceptives, pronatalist beliefs, and social attitudes, for example association of contraceptives with promiscuity and misconception about family planning.

Informal interviews with current users of contraceptives revealed that the pill, condom and IUD were the most commonly used because of their effectiveness in preventing pregnancy, the ease of using them and their availability. The majority of males who reported ever-use and current use of contraception used the condom. This is because condoms are easily accessible in local retail outlets and are comparatively of low cost. The current scenario of HIV/AIDS may also influence this trend among men. It is worth observing that the anti-HIV/AIDS campaign has popularized the condom as one of the most frequently used contraceptives.

In depth interviews and focus group discussions offered informants and respondents an opportunity to express their views on accessibility of contraceptives in health centres and family planning clinics. Some informants, especially adolescents and young unmarried women, reported that unmarried people who require contraceptives are not served in FP clinics, except those who were perceived as vulnerable. The Kenya policy on youth contraception is not explicit; it manifests an open-door policy for married couples. Family planning clinics are reluctant to serve unmarried because these people have no families to plan since the society expects only married people should plan their family only after giving birth to at least two or more children according to respondents in FGD drawing from their experience.

Besides it was a mistake to put family planning under child and maternal health department, which serve only woman looking for antenatal and post-natal care. Young unmarried women and men have no option but use chemists, supermarkets and shops for a supply of contraceptives at a price which many may not afford on a regular basis. Some only try to use condoms with casual partners.

The health personnel in the family planning centres are perceived as hostile and inaccessible by the youth. The FP clinics are public or exposed and many women shy away from them for fear of being sent away. Men also feel uncomfortable and embarrassed about visiting family planning clinics because they generally cater for women clients. This implies that there is need to incorporate men fully in family planning program since men have been left out on family planning program yet they are the major decision makers when it comes to matters pertaining to sexuality and reproductive health in the society.

General attitudes towards contraceptives varied widely among respondents and in-depth interview informants. Since participants express mistrust with regard to the use of contraceptives.

For instance, one survey respondents observed, “It is okay for the healthy people to tell us to use contraceptives but they can cause foetal abnormalities, fibroids and infertility if a woman uses them over a prolonged period.”

Thus, some respondents associate contraceptive use with negative health effects. The use of contraceptives is also associated with promiscuity or ‘women who sleep around’. This is illustrated by the following statements from in depth interviews:

"Many women shy away from family planning clinics for fear of being seen by their husbands and relatives…those who visit clinics do it secretly… this is because women who use contraceptives are suspected of unfaithfulness to their spouses."

Thus, women avoid using contraception for fear of being perceived as of loose or of low moral standing. Hence many married women who use contraception do so without their spouse's knowledge for of being suspected as unfaithful. This therefore exposed women and girls to unwanted pregnancies thus seeking abortion.

6.3 Knowledge and Attitudes about Abortion in Survey Population

The survey questionnaire included questions that asked respondents whether they knew about abortion and if they did which type of abortion they knew about. Responses to these questions are displayed in table 6.2

Table 6.2 Knowledge about Abortion

	Male (%)	Female (%)	Total (%)
Ever heard about abortion?			
Yes	91.4	97.6	94.5
No	8.6	2.4	5.5
If yes, which type of abortion?			
Spontaneous abortion	34.3	25.6	30.0
Induced abortion	65.7	74.4	70.0
What causes abortion?			
Disease	14.3	18.4	16.3
Poor diet/malnutrition	11.4	12.8	12.1
Ingesting drugs and other substances	28.6	27.2	27.9
Inserting sharp objects	14.3	12.0	13.2
Physical trauma	17.1	10.4	13.7
Illicit sexual relations	14.3	19.2	16.8
Total	100	100	100

n = 215

There was high level of knowledge (94.5 percent) of at least one type of abortion. Among the Luo there is no single word abortion; spontaneous abortion is referred to as '*ich*

*mawuo*k' or a pregnancy which is '*spilling'* or '*coming out'.* Induced abortion is referred to as '*ich mogol'* or '*ich motoo'* meaning a pregnancy that has been '*broken'*. The majority of respondents get their knowledge about abortion from educational institutions and peers.

Some informants hold various beliefs about abortion, such as:

'Terrouk ng'amarembu ok owinjore sana ka en gituo'. Having sexual relations with someone whose blood does not rhyme with your own is not good… in case of pregnancy the woman will miscarry. Sometimes it can lead to chronic illness where a woman continuously bleeds… if she is not treated it can be fatal.

It also emerged from interviews that dietary practices are also associated with spontaneous abortion:

'The use of yellow cooking fat causes '*rariw*'… It is a very common ailment among young women nowadays… it was not there in the past. The yellow cooking fat settles in the uterus and generates a lot of heat. This causes infertility and miscarriage…. Today women eat a lot of fatty foods such as eggs, chips, fish…. These fatten the uterus and can cause miscarriage or delivering overweight babies.'

However, in general, women who experience induced abortion which normally takes place at home in secret are ridiculed and stigmatized. When it is later known, women who experience miscarriages are equally stigmatized and ridiculed as illustrated by the following case:

Selemina is 57 years. She says that her first miscarriage of a baby boy six months after conception it was caused by a disease called '*ningu*' which 'ate my thighs'. She did not take '*manyasi'* (traditional medicine). Selemina had her second and third miscarriage eight and four months respectively after conception. Although she used '*manyasi*' throughout the period her pregnancies she still miscarried she says that due to these miscarriages her co-wives began ridiculing her… saying that her 'stomach was rotten' she said she confided to her mother who consulted a '*nyamrerwa*' for treatment. From then on, she began carrying her pregnancies to full term and is now a proud mother of five children.

The majority of respondents knew the causes of induced abortion, with 16 percent of the respondents reporting that infection with certain diseases, especially sexually transmitted infections (STIs) cause induced abortion. 27 percent of the survey respondents mentioned that ingestion of drugs for example quinine and other substances such as 'strong tea', detergents and yellow coloured cooking fat are causes of induced abortion. During in-depth interview and focus group discussions it emerged that many young women who get unwanted pregnancies sometimes ingest a cocktail of drug over-dose to induce abortion resulting in complication.

About 13 percent of the respondents reported that insertion of sharp objects into the birth canal induces abortion. It also emerged during key informant interviews with health personnel that many women who reported experiencing complications arising from incomplete abortion insert sharp objects into the birth canal to induce abortion. 13 percent of the respondents reported that physical trauma during pregnancy can cause induced

abortion. One key informant mentioned that domestic violence sometimes results into physical injuries that result in induced abortion:

'I have attended to women who had induced abortion as a result of being physically abused by their husbands… some men are just so cruel. They do not sympathize with their wives even when they are pregnant. Such cases go unreported to the authorities.' (Key female informant)

Nearly 16 percent of the respondents reported that engaging in illicit sexual relationship such as incest or having sexual relations with prohibited persons can result induced abortion. It is believed that in the traditional set up, contravention of social norms is known to induce abortion. Physical assault has been reported to be a factor in causing induced abortion.

Table 6.3 Female Respondents Reporting Ever-experiencing Abortion by Selected Background Characteristics

Variable	Male (%)	Female (%)	Total- (%)
Have you or your partner/spouse ever had an induced abortion?			
Yes	25.7	33.6	29.6
No	74.3	66.4	70.4
Total	100	100	100
If yes, how many times			
Once	66.7	69.0	67.8
Twice	22.2	21.5	21.9
More than twice	11.1	9.5	10.3
Total	100	100	100
Age group			
15-24	33.3	52.4	57.1
25-34	22.2	28.6	35.7
35+	44.5	19.0	7.2
Total	100	100	100
Marital status			
Never married	66.7	47.6	57.2
Married	33.3	38.1	35.7
Formerly married/widowed	-	14.3	7.1
Total	100	100	100

n = 215

Overall, more than a 30 percent of the survey respondents reported to having procured an abortion in their life time or had a partner who ever had induced abortion. 52 percent of the women who reported ever having had an abortion were aged between 15 and 24 years. This implied that women in this age category are at greater risk of pregnancy and experiencing unsafe abortion.

20 percent of respondents who reported ever having had an induced abortion had experienced it more than once. 10 percent of respondents who induced abortion had experienced it more than twice.

Nearly 42 percent of respondents who reported induced abortion were aged below 25 years of age. More than half of the women who reported induced abortion were aged between 15 and 24 years of age. This confirms what other studies conducted in Kenya and Africa that indicate unsafe abortion is a problem among teenagers and young women. It is also a pointer to early sexual debut among many teenagers and young women in the study population.

About 57 percent of respondents who reported induced abortion were single while 43 percent were married or formerly married. This also reflects the findings of other studies that show that young unmarried are at greater risk of experiencing unsafe induced abortion. However, as recent studies show married women are increasingly becoming recipients of post abortion care in public hospitals.

In-depth-interviews (with key informants) and focus group discussion elicited information regarding the reason why women procure induced abortion. Data obtained indicate that a variety of factors influence women's decision to seek unsafe abortion in Migori sub-county.

6.4 Reasons Why Women Abort

A substantial proportion of pregnancies that result into abortion are unwanted. Among adolescents and unmarried young women sexual encounters are unplanned, infrequent and sporadic, a pattern that results in unwanted pregnancy. Unintended pregnancy among the youth has devastating effects on a girl's/young woman's educational career opportunities. In Migori and Kenya as a whole, adolescent young women who get pregnant while in school are forced to terminate their studies. This puts many young

women in desperate situations because bearing a child reduces their chances of career opportunities and advancement, thus many adolescents and young school-going women who get pregnant consider unsafe abortion to avoid losing opportunities of education:

When I realized I was pregnant… I felt bad because I would be chased away from school… I knew my future was doomed without good education.

The fear of losing employment also provokes many women to report to unsafe abortion. Pregnancy jeopardizes women's employment especially those working in the service industry e.g. sales, hotels, restaurants and households and maids. Those who conceive while in employment risk losing their jobs. Some employees also shy away from employing women because they may get pregnant. Thus, some women induce abortion for fear of losing their means of livelihood.

Societal attitudes towards premarital pregnancy and single parenthood prompt many women to consider terminating or seek unsafe abortion. There is widespread negative attitude towards girls and young men having children outside marriage in many households, at school, work places and even places of worship. Pregnancy outside wedlock has social effects including stigma and rejection by family relatives and peers. The excerpts (from FGD) below highlight typical cases young women who get pregnant:

> Q. *How did you feel when you realized you were pregnant*?
>
> *I realized something was amiss when I missed my periods…I was shocked…after a week I went for pregnancy test and the results made me panic…I was afraid that my parents would throw me out. I ran away from home to my boyfriend in town.* Respondent1

> *I was afraid of telling my parents…I feared they would punish me severely…I felt very bad…and ashamed. I feared my school mates would shy away from associating with me* Respondent 2
>
> *A girl who conceives outside marriage ruins her reputation …*
>
> *It is in a dishonour and shame to her family*.

Girls and young women who get pregnant are stigmatized and viewed as morally loose and often find it difficult to get married as a first wife. Although today men marry women who have children other than their own, a large proportion of women who bear children outside marital unions remain unmarried. Such women are ridiculed and blamed for bearing illegitimate children. Among the Luo, illegitimate children are not welcome and are discriminated against when it comes to inheritance of property. They are not accorded the same social status that is given to children born within a marital union. Traditionally, if a man married a woman with another man's child, such a child was eliminated. It was believed that if a man undresses in front of his wife's illegitimate child, the child would contract *'chira'* a fatal illness.

Data also shows that some women resort to induced abortion when their partners deny paternity. Men who impregnate women in casual sexual relationships are unwilling to own up to the responsibilities of parenthood. This situation puts many young girls and women in a dilemma. This is illustrated by the following:

> *Q. How did your partner react when you told him you were pregnant?*
>
> *When I told my boyfriend that I was pregnant he started avoiding and gossiping about me among my friends…claiming I am loose…that I move around with other men. When I confronted him…he denied it…he told me to go and look for the man who had impregnated me or I get rid of it (meaning abortion of the child).* Respondent:

Migori Sub-County is characterized by circulatory migration especially by non-Luo men such as the Kuria, Maasai, Kalenjin, Kisii and Luhya from within and the neighbouring counties. These men come as track drivers and itinerant traders and other transients. The men have a lot of money which they use to confuse girls. When they get pregnant the men run away…they do not want to take responsibility.

Among the two, paternity is very important-it gives children social status and rights of inheritance. Children also belong to their father's clan and lineage. Denial of paternity by men breaks many women resulting in unsafe abortion attempts.

The burden of raising a child as a single parent was also cited by key informants and respondents as one of the reasons why women induce abortion.

Many adolescents and young unmarried women who get pregnant cannot afford the costs of child delivery and care because of lack of means of livelihood even among married women those who do not want an extra child procure unsafe abortion to avoid the additional economic burden of child rearing.

Key informant interviews also reveal that pregnancy resulting from illicit sexual relationships/incest and rape is more likely to result into unsafe abortion. One informant observed that:

Nowadays migration from rural areas to urban areas has made it possible for close kinsmen to meet and start relationships in town…even close cousins can meet unknowingly and live together as man and wife…they realize it too late…but sometimes

when they get to know when the woman is pregnant …it is terminated to avoid it getting '*chira'.*

Thus, pregnancy that results from such incestuous relationships is normally terminated. Some informants also mentioned that married women who engage in illicit relationships that result in pregnancy seek abortion to avoid being discovered by their spouses:

In Luo land, men seek employment in far and distant towns leaving their wives in the rural areas…sometimes they are away for very prolonged periods…say a year or more with occasional visits in between. Due to their prolonged absence their wives have affairs with other men who impregnate them to safeguard their marriage and because of fear of having illegitimate children they abort. (Key informant, rural home)

6.5 Case Studies (Experience with Abortion)

The following section presents the life histories of women who have experienced induced abortion in order to demonstrate that abortion requires difficult decision making and their experiences are not the best. This is something they sometimes have to regret having performed.

Case One

Taabu is a 37-year old unmarried woman from Sori, Migori Sub-County. She comes from a big family of eight siblings. Her parents are peasant farmers. She completed primary school education but her parents could not afford secondary school fees hence she dropped out of school. Taabu became sexually active at the age of 14 and has had several regular and casual partners (she is not ready to reveal how many). After she dropped out of school in 1986, she was employed as a house help (maid) in Migori town. She befriended her employer's neighbour who got her pregnant after six months of the

relationship. Her boyfriend was unemployed and therefore could neither afford to maintain her nor the child. He managed to convince her to terminate the pregnancy. He managed to raise some money and organized for her to procure an abortion in a private clinic in town. Two months after the abortion her employer fired her and she had to return to her rural village. However, life was unbearable in the village and thus had to return to town to seek for work. Taabu says she has terminated four other pregnancies from men who she had relationships with but they were not serious enough to own up responsibility. Taabu says that due to this she is unable to get pregnant despite keeping trying. She prays that one day she gets a child of her own. This is because she is now married and there is pressure on her to give birth to a child yet she cannot disclose her past reproductive health life which she thinks is contributing to her not getting pregnant.

Case Two

Aloo is a 28-year old female from Kadem, Migori sub-county. She has secondary education up to Form two level and dropped out to get married because her parents were too poor to pay her fees. She is married and has four children. She became sexually active at the age of 15. She is the *de facto* head of her family because her husband works as a migrant picking tea in Kericho. She says that initially when her husband got employed, he used to send or remit money home and visit the family on a regular basis. However, about four years ago the monetary remittances and visits started being irregular, he only visits once a year during the December festive season. Aloo says that since her husband no longer sends money for upkeep on a regular basis, she was forced to befriend a primary school teacher who works in a school near her home. The teacher lives away from his family but he affords to buy her basic necessities such as food, clothing, hair and body lotion, sanitary pads etc. A year ago, the teacher got her pregnant. Aloo says that she feared being chased away by her husband if he found out and ridicule from his relatives. She and her lover decided to terminate the pregnancy. She procured an abortion in a private clinic in town that is operated by a retired medical officer. Aloo still maintains her secret intimate relationship with the school teacher.

Case Three

Caren is a 21-year old female informant from Migori town. She comes from a fairly well-off family of nine siblings. Her father owns rental and business premises in Migori town. Currently she works as a barmaid in one of the popular bar and restaurant in Muhuru Bay. Caren dropped out of school in class eight. She became sexually active at the age of thirteen years and has had several regular and casual partners. Caren says that she has had two abortions in her lifetime. The first time she became pregnant was from a truck driver who used to spend the night in her father's lodging houses. He used to come to Migori town frequently to collect fish. He befriended her by luring her with gifts of pocket money to purchase basic necessities. Two months into the relationship, she became pregnant and informed her boyfriend. He did not deny responsibility but said that he was not ready for marriage. Caren says that she feared her parents if they discovered that she was pregnant and that she would be chased from school. It would be a great shame to her and her family. Her friends and relatives would scorn her. To avoid this, she convinced her boyfriend, to assist her procure an abortion in a private clinic. Although it was a very painful experience, she says that there were no complications. The second time she got pregnant was from a former schoolmate but he denied responsibility. To avoid shame and responsibility of raising a child alone she raised some money and procured an abortion with the help of a local nurse. Again, there were no complications.

Case Four

Alice is a 24 years old female in Ongoche. She is a widow having lost her husband two years ago. She has five children. The eldest three children are in secondary school while the last two are in primary school. Currently she is a cross-border business woman selling merchandise along the Kenya-Tanzania border. The business pays for her children's school fees and upkeep. Besides she supplements her income with small-scale farming. She says that about ten months ago, she befriended a fellow trader who used to assist her procure goods/merchandise with ease. After a few months of their relationship she got pregnant. Alice says that because of fear of being ridiculed and rejected by her deceased husband's family she decided to terminate the pregnancy. She also says that having an

additional child would have been another burden. The procedure was performed in a private clinic.

Case Five

Judith, born in Kanyamkago but married in Karungu (around Sori Beach), is a 50-year-old female. She is a widow and has ten children who entirely depend on her for upkeep. Her deceased husband left her nothing to assist her in bringing up the children. She moved to Sori a few years ago to start a small business, buying and selling fish. She says business was poor without the assistance of a 'jaboya' or broker to ensure a steady supply of fish. She befriended a 'jaboya' to ensure steady supply of fish. After a while she became pregnant. Judith says that she was worried that an additional child meant an additional mouth to feed and care. She confided to a friend who advised her to visit a backstreet clinic to terminate the pregnancy. She spent the little money she had to pay for the procedure. The procedure went wrong. She says the experience had painful and devastating effects on her health. She later sought treatment in a private hospital but the problems still persist. Currently she cannot control urine-she has to use sanitary pads.

Case Six

Awino is a sixteen-year old and had an induced abortion in a backstreet clinic. However, complications arose and she sought treatment at the Kisumu Medical Education Trust (KMET) clinic, Karungu division. The abortion resulted in a ruptured uterus and she had to be hospitalized. The doctors had to remove her uterus to save her life.

Case Seven

Adoyo is an orphan being fostered by her grandmother. She is in class eight at a nearby primary school. She is the school librarian and does well in class. One time their math teacher (male) sent her to his house to drop their math workbooks as he followed from behind. Immediately she went in the house, the teacher too went in and locked the door from inside. She was told to make any move or noise. Thereafter the teacher dragged her into the bedroom and raped her. Two months passed without ever having monthly period. She confided in one of her friends in the same class of what is happening to her. Her

grandmother had noticed her physical and psychological change since she was moody and had increased in size. The schools closed for third term. She had been advised by the friend to seek help from an old lady who happens to be the friend's aunt. Her friend advised her that she had had people visiting her for herbs which could make the baby not grow until the desired period since she was afraid of abortion. Secretly, she visited the old lady who told her that it was only possible with married women if not she discloses the name of the father to be to the child as required by '*juogi*' (spirits). Fear of the teacher made her not disclose. Failure to 'hide' or put the pregnancy on hold, she decided to take an overdose of Malariaquine so that the baby would come out so that she could continue with her education. Unfortunately, this caused her death instead.

Case Eight

During one December holiday, the youth from the nearby village organized a disco where students from a mixed secondary school were invited to attend. The party started at 2 p.m. and went through the night. At the party girls were allowed free entry as long as they went in the company of a man. Drinks such as alcohol was served at subsidized price and many girls and boys for the first time took alcohol and one thing led to the other. Come the following term in February three girls from the same school realized they had missed their periods, meaning they were pregnant.

One decided to keep the pregnancy while the other one opted for backstreet abortion since having a baby was going to stop her from pursuing further education because she was in form four first term. The third one too aborted by herself using a cloth hanger. The one who went to the backstreet ended up dying whereas the one who used cloth hanger ended up in hospital with damaged uterus and later on expelled from school. The one who kept the pregnancy gave birth and was married off to an old man who was ready to take her with a baby boy for free.

Case Nine

Mary 30 years old speaks out.

“My abortion was one of the worst, if not the worst. What I went through, I would not want to imagine one opting for abortion. While at the university I had two abortions. The first one was ‘okay’ since it was not like what I felt when I had the second one. I almost died from excessive bleeding. I was admitted for one week in hospital. My friends helped me pay hospital bill out of sympathy. That semester I had three resists despite performing poorly in the three other units scoring an average of D. Even though I am now married with a three-year-old girl, the guilt has not left me; I am feeling hollow somewhere as if a soft spot was removed from me.”

Case Ten

Jane, a single mother of one, says that experience from the church and the clergy as a result of pregnancy, made her to abort the next four pregnancies. The church leadership has made it hard for her to continue serving in the church. She had to be excommunicated from the church.

6.5 Interpretation of Case Studies

Case studies have revealed that the relative prevalence of abortion in the contemporary society may be due to several factors. The high prevalence of infidelity in marriages render sexuality as a tool for recreation rather than procreation may be leading the pack. This has been brought about by colonization. When the colonialists came to Kenya, they introduced labour outside the homesteads in plantations and urban centres. The families never remained the same as men especially left their homesteads to seek employment far away from home as in case two.

Individualism and modern education have also contributed to the societal disintegration as a result of colonialism. Children are no longer a concern of society as it was before

where each adult was any child's keeper and was free to punish or reprimand any child found engaging in unwanted behaviour. Instead parents look upon teachers to handle sex education since the grandparents are no longer with the grandchildren in '*siwindhe*' or '*duol*' especially in urban areas. Unfortunately, some teachers are no longer the leaders they are expected to be as role models but are interested parties who use their positions of power and authority to take advantage of young girls under them for sexual gratification, of course, with disastrous consequences. This is happening all the way from Primary school to the University. One would have expected that high school and university girls are mature and enlightened enough on matters of personal hygiene and to negotiate for contraceptive use if they have to give in, but this is not the case.

Introduction of modern education has made it difficult to inculcate traditional values and norms. Contemporary issues such as sending young girls and boys to boarding schools early, and giving them very little time to interact with parents and other members of the community except during school holidays, have also had their toll. What is worrying is that they 'pick' certain behaviour from these schools some of which is not accepted in the society as was in case eight which make them behave like adults but without responsibility on the part of the girls and boys alike.

Again, children spend more time in school than at home thus very little time is left for teaching personal hygiene within cultural context. Before children were expected to be keen listeners to societal voices of reason. Today, however, children have no patience and time to listen to the voices of reason. Besides (huts, '*simba*' and '*siwindhe*') where they could receive constant lessons on sexual matters are not there anymore or not used for the same purpose as before. This is worse in urban areas where majority of people live in

congested slums. In some cases, a family of grown up boys and girls live in a single room usually referred to as ‘ten by ten’, thus leaving no room for privacy as some are forced to sleep under their parents’ bed.

Besides lack of responsible behaviour and informal education imparted to children by the society, education has taught people things as the educated interact with the outside world beginning at boarding schools, colleges and abroad (foreign countries). The educated are exposed to new cultures thus no longer follow closely or adhere to the traditional norms by the society they came from terming them as outdated. With colonization came religion which has left people in a dilemma on what to do with traditional practices such as naming children, planting, sowing, harvesting, wife inheritance and construction of a new house/hut, which were cleansed with sexuality. Both traditional and those who claim to be educated and modern continue to adhere to their practices, thus making the women involved get pregnant even if they would have not wished to. This has created change and there are no uniform or moral standards for judging appropriate behaviour. Marrying many wives to ensure no woman missed a husband in some cases is shunned by most religions which advocate for one man one wife.

Having many religious organizations has brought confusion since some allow certain practices and others not. This is the kind of change which has brought about a crisis, leaving the Luo in a dilemma as observed in the cases studied. Normative and kinship structures that existed in the traditional society are no longer there. The society was controlled and regulated through norms, taboos and punishment meted out to those who violated them yet most religious teachings talks of punishment after death dismisses the idea of taboos as heathen beliefs and against religion.

Rural-urban migration, the proliferation of marital infidelity and children being brought up by single parents either through divorce or choice was identified as factors responsible for promiscuity, unwanted pregnancy and abortion as in cases one, two and three. A word like ‘divorce’ never existed in the Dholuo vocabulary nor remaining single an option even after the husband’s death. Staying alone or far apart has resulted to unwanted or unplanned pregnancies as in cases four and five. Men, on the other hand, have found themselves making women pregnant without plans as a result of seeking sex for pleasure other than for procreation especially when away on duty from the spouse. This results in the emergence of street children and abortion.

These days, people in rural areas are also promiscuous due to poverty, migrant labour and idleness. Poverty and commercial or transactional sexual norms are on the increase in the sub-county. Case Four and Five best explain this. Married people are engaging in extramarital sex due to poverty for additional income and other marital benefits such as body oil, sanitary towels and other goodies.

The increase in illicit sexual relationships has led to abortions being used today to prevent situations where one is going to sire a child born out of wedlock, adultery, rape, incest and denial by a husband or boyfriend of a pregnancy. In cases where a child is an impediment to career growth as in case seven, leisure and study, abortion has become very handy. Besides, partying leads to compromising situations, combination with alcohol lead to lose moral. Nowadays young people perceive sexuality as part of recreation. Indeed, many believe that every party has to end up in sexual relations. Village social occasions such as parties are viewed as places to meet potential sexual partners as seen in case eight.

During data collection I encountered other reproductive health problems such as obstetric fistula (Case Six), which attracted my attention even though my main concern was abortion. As a researcher, I was obligated to approach my study from the emic perspective which recognizes cultural relativism. However, from the point of view of preservation of human nature, I did resolve the issue of Case Six by advising the lady that her condition is treatable through a simple operation. Since she was in the hospital it was easy to approach the administrators on the spot about transferring her to a hospital where she could seek help even though her condition is considered a disease of poverty because of its tendency to occur in women who do not have access to health resources.

In a nutshell, the case studies demonstrate that

i. Girls are sexually active when they physically, emotionally and psychologically to appreciate the consequences of their behaviour to themselves, society and their children. It is one sure way of perpetuating the cycle of poverty;
ii. That abortion in the county which is predominantly rural is quite common;
iii. That many of those involved are repeaters and once one aborts, she is likely to abort many times subsequently;
iv. The cases demonstrate that many of those involved get pregnant by older men who have economic or social power while the girls have no bargaining power as stated by Sorre and Akong'a (2009) in their article. None of the girls covered by the cases sought redress from the law, implying that Sexual Offenses Act (2006) and the Children's Act (2001) have not been useful to girls whose life chances have been destroyed by their sexuality;

v. What is interesting, however, is that the men and women are responsible, while they do not use contraception, cooperate in making the decision to terminate the pregnancy.

6.6 Summary of Case Studies

Abortion cases in Migori Sub-County, from the findings, have been influenced by the desire to pursue education, increased cases of poverty and the desire to have few or no children at all due to lack of access to family planning (FP) devices.

CHAPTER SEVEN

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

The purpose of this study was to identify the socio economic and cultural factors which influence unsafe abortion among the Luo of Migori Sub-County, Migori County. This chapter summarizes the findings, makes conclusions and recommendation based on each of the study objectives in order to reduce the debilitating effects and deaths that occur as a result of unsafe abortion.

In order to reduce the debilitating effects and deaths that occur as a result of unsafe abortion, it is essential to understand the factors underlying the phenomenon. It is especially important to understand why women undergo unsafe abortion procedures. Overall, this study has explored the social, cultural and economic factors that explain/influence sexual behaviour and the prevalence of unsafe abortion among the Luo of Western Kenya.

The data were obtained through a combination of quantitative and qualitative data collection methods over a ten months period between December 2006 and October 2007. A survey comprising of 125 respondents was conducted in health institutions in Migori sub-county.

The results of the study suggest that, despite the ethical issues and secrecy surrounding sex and induced abortion, the use of qualitative and quantitative data collection methods can help to obtain valid data on sexual behaviour and abortion. The small sample used in

this study provided the researcher with the opportunity to observe behaviour and obtain detailed information, which would have been difficult with a much larger sample.

A much larger sample can be used in future to validate the general observations made in this study. This chapter summarizes the findings on sexual behaviour and induced abortion. This is followed by recommendations and suggestions for future research.

7.2 Summary of Findings

7.2.1 Sexual Behaviour among the Luo of Migori Sub-County

The first objective of this study was to describe traditional, knowledge, attitudes, beliefs and behaviour about sexual relations and contraceptive use in Migori Sub-County.

There is general consensus in literature of African Communities including the Luo and among respondents in the study that in the traditional period (prior to colonialism) sexuality especially that of women was strictly controlled and induced abortion was minimal or less common. In the traditional setting there was strong adherence to norms and moral codes of sexual conduct (which consequently influenced the incidence of induced abortion.

There was more rigid, control of sexual behaviour of young unmarried people by traditional structure of authority. Unmarried girls were expected to remain chaste until marriage. The traditional institution of '*chode'* provided unmarried men and women with the opportunity for sexual experience during courtship but without actual sexual penetration. Premarital sex and pregnancy brought shame to the girl and her family and it

reduced her chances of marriage. This consequently minimized the incidence of pre-marital sex and cases of induced abortion.

There was also strict control of women's sexuality within marriage, adultery by women was strongly condemned and punished. The patriarchal structure of the Luo society has double standards because of the cultural prescription of polygamy allows men to have multiple sexual partners but expects female monogamy. In Luo society male premarital and extramarital relations are treated differently from that of men.

In the past, sexual relations occupied a special role in the society and it was governed by sanctions which made it difficult for people to abuse it. Sex was in the past for procreation and had to be performed during special occasions such as planting, wedding, sowing, and funeral ritual cleansing among others. Among married couples a man could not resume having sex with his wife until the child grew to the point of delivering a calabash of hot gruel/porridge to the father (which was a sign the wife was ready to receive the husband back (Mboya, 1938). This was practiced for purposes of child spacing.

In the past the Luo believed that if either parent committed adultery their children, born and unborn, could be affected by '*chira*', an illness which leads to chronic thinning and debility. Having sexual relations with someone's wife or husband was viewed as a curse since it could result in '*chira*', especially for a woman who was breastfeeding. Subsequently it could lead to spontaneous abortion. Furthermore, a child sired with another man's wife was believed to take away blessings from one's homestead where the

woman is married into. Such children were referred to as '*kimirwa*', and were in some cases secretly killed (Ocholla-Ayayo, 1976).

In spite of this strict code of ethics surrounding the sexuality of women, there were some safety nets by which a woman could entertain a man at dusk and when the husband came home making noise, probably drunk, the intruder used the small gate at the back of the house to leave. Similarly, a man who could not sire children due to erectile dysfunction could have his wife sire children with his brother or cousin secretly. In such cases the issue of adultery did not arise.

In a nutshell, sexuality among young unmarried and married people was strictly controlled. Structures were put in place to safe guard irresponsible sexual behaviour. Failure to observe these norms could lead to serious sanctions and punishment because such behaviour in most cases ends with unsafe abortion as a result of unwanted pregnancies.

7.2.2 Changes that have occurred among the Luo of Migori Sub-County

The second objective of this study was to examine the changes that have taken place historically which have changed the knowledge, attitudes, beliefs and practices regarding sexuality and abortion. Since the beginning of the 20th Century several socio-economic factors that accompanied colonialism and the penetration of the capitalist economy into Africa have taken place. This changed the way sexual relations were/are conducted and perceptions about abortion. Colonialism and the introduction of wage (migrant) labour, modern formal education, Christianity and western lifestyles have undermined traditional structures of authority and consequently led to their breakdown.

Rural-urban labour migration has led historically to social dislocation and hence destabilization of the family. Today many children are growing up without proper parental care either because they lack a father-figure due to migrant labour or because they spend little time with their parents due to schooling. Thus, many are left to fend for themselves in a very hostile social environment. Migration has contributed to interaction of people from different social and cultural backgrounds leading to poor moral standards and increased sexual networking.

Christianity as the dominant religious movement in Migori Sub-County brought about strict moral teachings, very few adherents of the religion adhere to its teachings – people still live in two worlds; those who follow traditions and those who combine Christian religion with traditions. It is not practical to live a strict Christian life under the circumstances.

Although in varying degrees both men and women have more economic and social independence from traditional authorities such as clans, lineages, elders and parents, in that they are less accountable to them for their behaviour than in the traditional/pre-colonial period. Nowadays many young people become sexually active before marriage and at an early age. Although women are not expected to be sexually experienced before marriage the data obtained in this study indicate that they do not abstain from sex until marriage.

On average women experience their first sexual intercourse at tender age and marry earlier than men. This state of affairs has made it easier for people to engage in

irresponsible sexual behaviour and procure induced abortion without the fear of any social sanctions as it was in the past.

7.2.3 Factors Influencing Induced Abortion

The third objective of this study was to determine the social, cultural and economic factors that influence unsafe abortion in Migori Sub-County. The study has shown that there are socio-cultural factors which contribute to increased incidence of abortion. Among the two, single parenthood is negatively viewed and hence not desired by many women.

Girls and young women who desire to pursue education or advance their career resort to abortion to avoid bearing children on their own. Pregnancy in school signals the end of schooling and career prospects. This situation is complicated by the escalating poverty, which has made survival difficult for many women, especially those that are economically vulnerable.

Poverty is both a cause and an effect of induced abortion. Women living in poverty are driven into risky sexual behaviour because of economic need. However, those who conceive outside wedlock are forced to bring up children on their own or resort to induced abortion in an attempt to avoid single parenthood. Women who conceive outside the wedlock also tend to have diminished chances of decent marriage due to social and cultural attitudes.

Lack of parental guidance also influences abortion in contemporary Luo society. Today many young people grow up with minimal contact with their parents due to formal

education. The traditional setting for informal education is lacking in the contemporary society. The modern education system also fails to inculcate life-skills in young people. As a result, young people are growing up in an environment of moral vacuum with no-one to turn to for guidance since emphasis of the Kenyan school system is on passing examinations. Hence, many of them end up engaging in risky behaviour including sex and induced abortion. Family instability and single parenthood has also contributed to the lack of parental guidance.

Sexual violence also influences unsafe abortion. In recent times there have been increased reports of sexual violence, even towards minors. This has sometimes resulted in unwanted pregnancy and sometimes induced abortion. Cases of rape and incest abound in today's society and women who find themselves in such situations end up procuring unsafe abortions.

The desire to have fewer children and lack of access to modern contraceptive were also identified as factors that contribute to abortion. Many pregnancies among single and even married women who have attained the desired number of children are not desired (are unwanted). Hence a proportion ends up being aborted. Furthermore, many women and men do not want to own up on their acts of irresponsibility.

7.2.4 Theoretical Conclusions

In this study the guiding theoretical frameworks were the redefinition theory by William Thomas and anomie theory by Emile Durkheim. These theories were adequate to explain what has been happening in the areas of study with regard to sexuality and abortion since they were useful in examining the problem of induced abortion. Emile Durkheim was

relevant because changes that have happened in the society have contributed a lot to the extent that society does not look at pregnancy as sacred and children as gifts from God, which makes it easy to have an abortion.

The findings were evident that when the society modernizes it becomes socially disorganized and thus, with many social ills, including abortion.

There are significant liberal attitudes towards sexuality. However, the 2010 Constitution of Kenya protects the unborn child right from conception. Therefore, the society needs to redefine situations which make abortion happen.

The transformation of the structure, function, beliefs and practices surrounding sexuality has definitely not helped society. The theory of the redefinition of the situation by William Thomas and Durkheim's theory of anomie are, therefore, handy in understanding what has happened in the past and what is likely to happen in future.

7.2.5 Conclusions

According to The United Nations Population Fund (UNFP), 515,000 women almost one in every minute each year will die worldwide from causes related to pregnancy (1999: 2-3). 70,000 women each year will die as a result of unsafe abortion, whilst an unknown number will suffer from infection and other adverse health consequences. An analysis unsafe abortion in August 2013 indicated that an estimated 464,690 induced abortions occurred in Kenya in 2012, corresponding to an induced abortion rate of 48 abortions per 1000 women of reproductive age (15-49 years), and an induced abortion ratio of 30 abortions per 100 births in 2012. It is also estimated that 157,762 women received care

for complications of induced and spontaneous abortions in health facilities in the same year. Of these, 119,912 women were experiencing complications of induced abortions. Based on patient-specific data, women who sought abortion-related care were socially, demographically and economically heterogeneous. They included educated and uneducated women, urban and rural women, Christians, Muslims, and women of "other faiths", students, unemployed and employed women, as well as married, never married and divorced women.

The World Health Organization (WHO) defines unsafe abortion as a procedure for terminating pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both. Although unsafe abortion in Kenya has long been recognized as a leading cause of death and injuries to women – deaths and injuries that are preventable – there is limited scientific information available on the women who seek unsafe abortion, the magnitude of the problem of unsafe abortion in our society, and the severity of complications that arise from unsafe abortion.

From the study it is evident that improving access to affordable and effective family planning and/or contraception is key to preventing unintended pregnancy and unsafe abortion besides socio-cultural practices such as family life and sex education. Effective family planning and/or contraception would also save the country the huge material and other resources that currently go into the treatment of unsafe abortion and the associated complications. If in the traditional Luo community, it was unheard of for women to have had an abortion, why not now with added scientific knowledge available. Finally, the Constitution of Kenya should be implemented effectively since it has the potential to

promote women's access to safe abortion services and support reductions in complications of unsafe abortion.

The problem of abortion is largely due to gender relations and sexuality, which are very important for policy makers, practitioners and activists. Sexuality and gender can combine to make a huge difference in people's lives, such as for individuals' well-being and ill-being, and sometimes between life and death. Today's ideologies, which claim that women should be pure and chaste but which leave out the men who actually control women's sexuality in a patriarchal society have had restrictions on women's mobility, reproductive health, education, economic and political participation. Ideas that men should be 'macho' can mean that sexual harassment should be redefined in order to improve gender relations in society, since sexuality, if not well defined, has repercussions related to poverty, marginalization and death. Proper definition and treatment of gender and sexuality in policy and socio-cultural practices, can instead lead to empowerment, employment and well-being, and can enhance human relations with shared intimacy or pleasure.

Key informants in this study had the view that sexuality is a cultural aspect of being human through life and encompasses sex, gender identities and roles, pleasure and reproduction and, therefore, should be experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. This view is supported by a study commissioned by the Kenya Christian Professionals Forum released in July 2014, which showed that there is serious reproductive health related issues that need to be resolved, and going tongs and hammers against condoms and

castigating anyone who wants to educate the youth on their sexuality and bodies, will not help at all (Sunday, July 6, 2014, *The Standard*).

The World Health Organization's global 'Reproductive Health Strategy' adopted at the 57th World Health Assembly in May 2004 explicitly recognized the links between the MDS and sexual and reproductive health. A group of international experts has further explored the links between sexual health rights and the MDGs at a meeting organized by the World Association of Sexual health (WAS) in May 2006. They suggested that promotion and protection of sexual rights are fundamental not only to achieving sexual health goals but also directly relevant to achieving the MDGs. The presence and accessibility of quality sexual and reproductive health services, information and education to sexuality is a must. Protection of bodily integrity and guarantee of the right of people to freely choose sexual and marriage partners, to make decisions about child rearing, and to pursue satisfying, safe and pleasurable sexual lives, are grounded in and contribute to gender equality and the empowerment of women (MDG 3); access to primary education, particularly for girls (MDG 2); to improvements in maternal health and mortality (MDG 5), which can only be possible by social adaptation instead of redefinition of the situation by the Luo and the society at large in order to achieve sexual rights for all people, in order to contribute to sexual and reproductive health, well-being and better quality of life.

This view is further supported by findings from a study done in Busia, Bungoma and Trans-Nzoia counties, which revealed that some of the barriers that predispose different sub-groups of women in the three counties to unintended pregnancies include: high cost of family planning methods, high travel costs to health facilities, the husband's

disapproval of family planning method usage, unavailability of long term family planning methods, health providers' lack of skills in delivering information on family planning; while in some settings, there was the lack of awareness that youth-friendly services are available, lack of knowledge on family planning and access, transactional and trans-generational sex, and exposure to practices such as disco and community parties that increase the likelihood of engaging in unprotected sex.

Other factors that predispose women in general include high levels of illiteracy, the perception that there is lack of privacy and confidentiality at the health facilities while accessing family planning services, perceptions that family planning has negative side effects, incorrect/inconsistency in use of family planning and multiple sex partners; whereas the youth are faced with unintended pregnancies due to peer pressure to have sex early, alcoholism and use of drugs, lack of parental guidance, lack of access to correct information, early marriages and dropping out of school (IPAS, 2012).

Findings show that while adolescent girls may have knowledge of abortion in general, they lack specific knowledge of sources of care and delay care seeking.

7.2.6 Contributions to Knowledge

Since majority of the respondents were Catholics, religion continued to be a significant factor of avoiding abortion since they consider abortion as murder and sin, no matter what the reason might be although to some extent religion influences sexual liberation and as such consequence the attitude towards abortion thus Catholic faith is a factor of avoiding having an abortion at the same time can make it occur since it does not promote the use of contraceptives.

Abortion is a dilemma for married women in Migori Sub-County since majority of cases in hospital wards presented reproductive health complications which upon diagnosis was a result of unsafe abortion which they preferred to refer to as miscarriage.

7.2.7 Recommendations

One of the expectations of a study is to make suggestions and recommendations based on the findings of research. This study made the following recommendations.

Objective (i)

i. Programs and policies that improve women's and men's knowledge of access to and use of contraceptives methods should be initiated and/or strengthened. This is one of the surest ways of combating the problem of unintended pregnancy, and, thus the need for abortion. The programs should intensify contraceptive education for men and women.

ii. Changes of men's and women's attitude towards sexual relations. There is need for both men and women to change attitudes which encourage them to engage in risky sexual behaviour and discourage the use of contraceptive methods.

Objective (ii)

iii. To reduce the high level of morbidity and mortality that result from unsafe abortion, the provision of post-abortion care (PAC) should be improved and expanded in both public and private health care institutions. Currently in Kenya, post-abortion care is available in five of the country's eight

administrative regions at varying levels of the health care system. Thus, there is a strong demand for PAC to be provided at the community level to increase access to quality services to poor and rural women with abortion-related complications. It is necessary to change the attitudes of doctors and nurses who ignore providing post-abortion, and tend to blame the victims for wrong-doing

iv. Universally accessible and comprehensive sexual and reproductive health services in primary health care centres, family planning clinics and other venues designed to reach both women and men with the information, services and supplies (for example birth control pills, condoms) that they need should be established since in the past when family planning services were introduced it targeted women only, yet men also play a vital part in reproductive health matters.

v. Legislation and other measures are needed or need to be strengthened to enable women exercise their rights to be free from sexual harassment, violence and coercion as well as their right to prevent unwanted pregnancy, to terminate an unwanted pregnancy safely, and to stay in school. There should be sensitization of the population on the Sexual Offences Act, Children's Act and penalties they each carry. Sensitization on back-to-school policy for student mothers should be intensified and embraced, and the stigma attached to each reduced.

vi. For a long time, there has been emphasis on sex education being introduced in the school curriculum. This has provoked heated debate and opposition by parents, religious groups and other stakeholders. This resistance emanates from fear that such a move would encourage adolescents and the youth to be promiscuous. To many people the term ‘sex education’ conjures negative images in their minds. However, studies in many parts of the world show that sex education does not lead to increased involvement of young people in sexual relations. Thus, comprehensive, age-appropriate and cumulative sexuality education should be adopted in and out of school. This will enable adolescents and the youth to acquire more detailed and accurate information about sexuality, reproduction health and safe sexual practices and risks of unsafe abortion. The sex education should offer counseling on sexual relation as well as emotional and psychological support. There should also be national and community-based information education and communication (IEC) campaign promoting safer sexual relations, use of contraceptives and reproductive health.

Objective (iii)

vii. Poverty pressures many women with low education and lack of resources to engage in risky sexual behaviour that predisposes them to unwanted pregnancy, infection with STDs and unsafe abortion. The patrilineal structure of the two societies engenders ideologies and discriminatory practices that marginalize women with regard to access to economic resources and property.

viii. Poverty makes it difficult for women to resist unprotected sex. Thus, there is need to adopt measures and set up programs aimed at alleviating poverty and to address gender imbalances (through legislation) in access to economic resources. This could be done by improving women's education and enhancing their legal rights to property and protecting their civil rights. Income generation projects should be initiated for economically marginalized and vulnerable women, such as adolescents who drop out of school due to lack of school fees, pregnancy, orphan hood, among other reasons. This will empower them socially and economically and give them greater control over their sexuality and reproductive health.

ix. To reduce unsafe abortions arising out of fear of dropping out of school, among adolescents and the youth), provision should be made to allow girls who have children due to unwanted pregnancy continue with their education. Although this policy already exists, it is strictly not enforced. For those girls who drop out of school, income generation programmes should be established to offer vocational training in skills such as tailoring, hairdressing, catering, fish farming, and such other activities. This can be initiated by mobilizing the affected individuals to take up youth and women's fund loans such as Uwezo Fund, Kenya Women Finance Trust Funds (KWFTF), Community Based Organizations (CBOs) and Non-Governmental Organizations (NGOs).

The study also recommended that further studies be conducted.

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GLOSSARY

1. Ayie – money given to the mother to give her consent for marriage negotiations to begin.
2. Chira – a disease causing the body to waste and reduce in weight.
3. Chiyo del – making the body grown unusually thin.
4. Chola – unclean state after losing a relative.
5. Chola – being in a state of moaning a close relative e.g. child, father, mother, husband and wife.
6. Dhi por – re-marrying.
7. Dimbruok – forthrightness, uprightness on behaviour and character.
8. E duol – around the fireplace usually at the middle of the homestead and frequented by then and boys only.
9. Golo cham – beginning of harvesting.
10. Golo dala – constructing a new homestead.
11. Ich mobuogi – miscarriage.
12. Golo pur – beginning of cultivation.
13. Gruel – porridge.
14. Ich – stomach/womb or pregnancy.
15. Ich mogul – criminal abortion.
16. Ich motoo – criminal abortion.
17. Ich pod numu – the womb which is not ready for pregnancy.
18. Ich samba – pregnancy out of wedlock.
19. Ich samba iteri ne chuor wayu ma migumba – if pregnant out of wedlock, you are married off to the husband of your childless aunt.
20. Jagam – a go between before the onset of marriage negotiations.
21. Jatich – a helper hand usually a girl.
22. Juok – casting a spell on someone.

23. Kik ilaw yoo maka ma – do not use a certain path/route.
24. Kimirwa – a baby born out of wedlock.
25. Kothwa – belong to our clan/line.
26. Lido tiende – beating the legs below the knees using a thin twig.
27. Kapo ni ogajore – a taboo to engage in sex when still in state of mourning.
28. Luwo bang nyako – bridal procession carrying gifts immediately the girl is married to her new homestead.
29. Mako ich simba – pregnancy out of wedlock.
30. Manyasi – medicinal herbs.
31. Maro – mother-in-law.
32. Maro ok cham gweno ka nyare – mother-in-law is prohibited from eating chicken where her daughter is married.
33. Mbesene – agemates.
34. Migumba – a barren woman.
35. Nyamrewa – traditional herbalist cum traditional birth attendant.
36. Nyathi agweng – a child born between 'locals'.
37. Nyombo – dowry paid to the father usually in the form of animals (cattle)
38. Pap – open field
39. Pondo – hidden/hiding (i) Apondi – a baby girl born out of habitual abortion (ii) Opondo – a baby boy born out of habitual abortion.
40. Pukoremo – disposing off monthly period.
41. Simba – unmarried boys hut.
42. Siwindhe – an old woman's hut (usually post-menopause grandmothers).
43. Tego tiend nyathi – sex aimed at making the baby strong while in the mother's womb.
44. Tuoche – diseases (in this case STIs).
45. Tweyo ich – stopping pregnancy from progression.

46. Umo ich – stopping a pregnancy from progression or being noticed by the public or anybody.

47. Wii osuri mar oot iumo agulu – the tip/apex of the hut is covered with a pot.

48. Wiye ogawo leche – has head with veins all over.

49. Wuowo – sex without penetration – mock sex on the girl's thighs.

50. Yadh agulu – herbs cooked in a pot.

APPENDICES

APPENDIX I: Focus Group Discussion Interview Guide

Sample questions during FGD

1. What are some of the health problems do you encounter in the area?_____

   _____

2. Do you understand what abortion means? (If Yes, elaborate – types)_____

   _____

3. From the social cultural point of view what has the society (yours) done to prevent abortion? _____

   _____

4. Have you ever known of anybody who has been culturally supported or punished because of the abortion problem? If yes elaborate on type of punishment or support given._____

   _____

5. As far as you can remember has there been any social cultural change in your society towards abortion? (State the changes)_____

   _____

6. Are there traditional socio-cultural ways of educating and preparing people in your community to avoid abortion incidence? (if so elaborate)_____

   _____

7. How have your people been affected by abortion from a socio-cultural point of view? (If yes elaborate)

APPENDIX II: Key Informants Guide

1. Do you understand what abortion means? If yes elaborate (types)_____

   _____

2. From the social cultural point of view what has the society (yours) done to prevent abortion? _____

   _____

3. Have you ever known someone who has been culturally supported or punished because of the abortion problem? If yes elaborate on type of punishment or support given._____

   _____

4. As far as you can remember, has there been any social cultural change in your society towards abortion (state the changes) _____

   _____

5. Are there traditional socio-cultural ways of educating and preparing in your community to avoid abortion incidence? (If so elaborate) _____

   _____

6. How have your people been affected by abortion from socio-cultural point of view? (If yes elaborate) _____

   _____

7. Who are these women who abort and what is their reason for doing so?

APPENDIX III: The Questionnaire

Demography

Age

_____

Sex_____

Religion _____

Parity_____

No. of Children Alive_____

No. of Children Dead _____

No. of Induced Abortions_____

No. of Criminal Abortions_____

No. of Spontaneous Abortions_____

Educational level – None; Primary; Secondary; College; Others

Marital Status

Married_____

Single _____

Widow/Widower_____

Divorced_____

Socio-economic Status

Self-employed Employed Others_____

Level of Income

Low _____

Middle _____

High_____

None_____

Knowledge, Attitude and Practices on abortion

Knowledge

1. What is abortion? _____
_____
2. What circumstance would lead to abortion? _____
_____
3. Name different types of abortion_____
_____
4. How can you prevent abortion? _____
_____
5. What cultural issues do you know that can help prevent abortion? _____
_____

---

5. What social issues do you know that can help prevent abortion? _____
_____

Attitude

1. Has abortion (yours/others') affected you in any way?
   Yes_____ No _____

If Yes, how_____

2. Do you think abortion should be legalized?
   If Yes, Why_____
_____

If No, why/how? _____
_____

3. In what situation do you think abortion should be allowed? _____
_____

4. In what situations do you think abortion should not be allowed? _____
_____

5. Do you think culture is fair towards abortion Yes _____No_____
If Yes, why? _____
_____

If No, why? _____
_____

6. Do you think the social systems are fair towards abortion?
If Yes, why? _____
If No, why? _____

Practice

7. Have you ever had an abortion?
Yes _____ No _____
If yes how many? _____

8. What type of abortion was it? _____

9. How did it affect you? _____

_____

10. In your culture is abortion accepted?
If yes why? _____
_____

If No, why? _____
_____

11. In the society is abortion common?
If Yes, why? _____

_____

If No, why? _____
_____

12. In the society which category of people are prone to abortion? (tick one)
(a) Single (b) married (c) widowed (d) divorcees (e) separated

13. How are they prone to abortion? _____