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Reproductive Health Guide for Youth in Western Kenya

A Special Studies Project

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Reproductive Health Guide for Youth in Western Kenya

A Special Studies Project

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Bachelor of Arts Honors, Economics and Global Development Studies

Queen's University

2016

Thesis Committee: Roger Rochat, MD and Fauzia Malik, PhD, MSc

An abstract of

A thesis submitted to the Faculty of the

Rollins School of Public Health of Emory University

in partial fulfillment of the requirements for the degree of

Master of Public Health in Global Health 2019

Abstract

Reproductive Health Guide for Youth in Western Kenya

A Special Studies Project

By Samantha Gikuhi

Background: Young people in Kenya experience poor sexual and reproductive health outcomes like unwanted pregnancy and maternal mortality and morbidity from unsafe abortions because of barriers at the individual, community and structural level that limit access to reproductive health information.

Purpose: As part of Closing the Gap, an ongoing family planning and safe abortion service delivery and advocacy project in Kenya, this special studies project will serve as a tool to educate young people on family planning and unsafe abortion. Pertinent themes that will be discussed are personal and method related considerations for contraceptive methods, safe abortion options, and community resources that young people can leverage to protect themselves from unsafe abortions.

Methods: Qualitative research methodologies like informal key interviews and document analysis were used to assess the need for a tool that young people could consult to make decisions about their reproductive health. Findings were analyzed using thematic analysis to investigate key themes that formed the modules of Reproductive Health Guide.

Results: This Reproductive Health Guide has 3 modules; primary, secondary and tertiary prevention methods that explore methods young people can use to protect themselves against unwanted pregnancies and unsafe abortion. The modules also highlight community resources where young people can seek sexual reproductive information and health services.

Discussion: Stigma and conservative religious norms pose a barrier to young people realizing their sexual reproductive health rights yet there is overwhelming evidence that shows that unmarried youth are sexually active. Improving access to comprehensive and accurate reproductive health information empowers young people to make informed decisions about their reproductive goals and seek family planning methods that align with their comfort levels and lifestyles.

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Contents

Background and Significance

Although Kenya enjoys progressive reproductive health policies compared to other countries in Sub Saharan Africa, young people in Kenya experience poor sexual and reproductive health outcomes. For example, the prevalence of teenage pregnancies has remained at 18% in two consecutive Demographic Health Survey reports (DHS, 2008 and 2014). This means that 8% of girls are already mothers or pregnant with their first child by the time they are between the ages of 15-19 years. Albeit more than half of sexually active teenagers would like to delay childbirth, the unmet need for family planning remains highest among girls aged the 15-19 years (Family Planning [FP]2020, 2018; Population Reference Bureau [PRB], 2014; Guttmacher, 2019). More striking is that 86% of unintended pregnancies in the country are among the same cohort (Guttmacher, 2019). Lack of family planning education to meet the needs of sexually active unmarried young people poses a threat to the reproductive health of young people (Center for Reproductive Rights, 2010). The Kenya Ministry of Health reports that unsafe abortions are the leading cause of maternal mortality and morbidity among girls below 20 years (MoH, 2016). Further, a study of abortion incidence among nationally representative samples of health facilities reports that approximately 45% of severe complications from unsafe abortion were found among girls aged 10-19 years (APHRC et al., 2013).

The World Health Organization (WHO) defines sexual reproductive health (SRH) as a state of complete physical, mental and social well-being in all matters relating to the reproductive system (United Nations Population Fund [UNFPA], 2016).This implies that young people have the right to comprehensive and accurate information to decide if and when to have children. Poor SRH outcomes among young people in Kenya can be explained by barriers at individual, community and structural level. Example of individual barriers include limited sexual reproductive knowledge on how and where to access reproductive services, lack of personal agency, limited self-efficacy, fear, and common myths and misconceptions about contraception. According to national guidelines on adolescent and youth reproductive health services, obstacles at the individual level make it difficult for young people to seek

and use contraception even though they are interested in stopping or delaying childbirth (MoH, 2016). To support this theory, the Demographic Health Survey sites fear of side effects as the most common reason for discontinuing a contraceptive method (2014). In the case of emergency contraceptives, poor understanding of how emergency contraception works places young women at an increased risk of unsafe abortions. This is because young people are unaware of methods that prevent pregnancy due to human or contraceptive method failure (Liambila et al., 2013). A 1999 study on Kenyan urban women's knowledge and attitude on emergency contraception shows that at the time there is low awareness, widespread misinformation on side effects and ability to protect against HIV and STIs (Muia et al., 1999). It is unfortunate that the misconceptions around emergency contraception are still present even today (Liambila et al., 2013).

At the community level, barriers such as restrictive social and cultural norms limit access to life saving information and services. Kenya is a predominantly Christian society where conservative gender norms influence provider's perception of young people's sexuality (Warenius et al., 2006; Kinaro et al.,2015). Young people's sexual activity is often regarded as a moral issue that is against religious values that call for abstinence until marriage (Warenius et al., 2006). Although data shows that comprehensive sexuality education does not promote sexuality activity, parents and religious leaders hold the misconception that providing young people with education on contraception will encourage sexual behavior (United Nations Educational, Scientific and Cultural Organization [UNESCO], 2018; Godia et al., 2013; Haberland et al., 2015). The same data also shows that when young people are unable to readily access information on how and where to access contraceptives, they are at an increased risk of death and injury from unwanted pregnancies and unsafe abortions (Godia et al., 2013; Haberland et al., 2015). Multiple studies on provider attitudes in Kenya have shown that it is common for health providers to disapprove of adolescent use of contraception (Warenius et al., 2006; Reiss et al., 2016; Kinaro et al.,2015). There are also studies that reveal that health providers often impose 'provider barriers' like age restrictions, marital status and socioeconomic status that are informed by social norms about who is

'supposed' to be having sex (Reiss et al., 2016). Such attitudes predispose young people to unwanted pregnancies because they are often denied their preferred contraceptive method or any method of contraception.

At the structural level, barriers like lack of affordable and readily available contraceptive commodities, inconvenient opening hours, long wait times and limited confidentiality are common in limiting young people's access to reproductive health services (MoH, 2016). A 2010 survey identified that only 7% of health facilities in Kenya provide youth friendly services. Further, the withdrawal of Kenya's comprehensive care guidelines could be argued to have led to women's reduced options for managing unwanted pregnancies. This is because the guidelines outlined the provision of adoption services in the event of unintended pregnancies as a measure to reduce maternal mortality from unsafe abortions (MoH, 2012). Further, while abortion on demand is not permitted by the law, the 2010 Kenyan constitution allows for abortion under certain conditions. When it is in the opinion of a trained health professional, if there is need for emergency treatment or if the life or health of the mother is in danger, or if permitted by any other written law (Center for Reproductive Rights, n.d). Limited access to abortion has forced many women to seek services from untrained professionals (Center for Reproductive Rights, 2010). Unsafe abortions in Kenya contribute to 13% of the maternal mortality rate of 362 deaths per 100,000 live births per year (DHS, 2014 and National Coordinating Agency for Population & Development [NCAPD], 2010). Although there lacks abortion incidence data by age, adolescents have the lowest induced abortion rate among women younger than 35 years suggesting that a high proportion of abortions by young people are unsafe (Guttmacher, 2019).

The recent Health Act of 2017 is believed to theoretically make it easier for young women to access safe abortion services for several reasons. This Act is considered a big win for reproductive justice in Kenya because it demystified the use of the term 'trained health professional' in the Constitution that failed to clarify which cadre of health professional was authorized to provide abortions. The Act clarifies that doctors, nurses, midwives and clinic officers are the only trained health professionals authorized to

provide legal abortions. Before this clarification, many providers refused to provide abortions as they were unsure of whether they were protected by the Constitution (Mohamed et al., 2015). The 2017 Act also allows for only one provider to approve an abortion whereas before, a provider had to not only seek the opinion of a senior practitioner but also obtain a psychiatric review of the patient in order to legally provide abortion services (Saoyo, 2018).

Although Health Act 2017 could be viewed as a big win for women's reproductive rights, several factors limit its ability to protect and upholds women's reproductive rights. For example, the perception that abortion is wholly illegal continues to drive women to seek abortion services from untrained professionals who are also unable to provide post abortion care (Ipas, 2016).This is because medical providers who are not knowledgeable of the Health Act continue to deny women safe abortion services for fear of persecution (Saoyo, 2018). To add salt to injury, the recognition of women's right to reproductive health as stated in the most recent constitution is not reflected in the language of the Penal Code. The Penal Code permits a trained health professional to provide safe abortion services only if it is in 'good faith and with reasonable care' (Saoyo, 2018). The vague language leaves room for misinterpretation which predisposes many health providers to legal violations. Such as in the case where law enforcement officers use the penal code to threaten and extort providers even when an abortion is warranted under law (Saoyo, 2018).

In summary, individual, community and structural barriers limit young people's access to accurate and comprehensive family planning and safe abortion education. This is of concern because it exacerbates young people's vulnerability to unintended pregnancies and unsafe abortions.

Problem Statement

For many young people, lack of access to information on contraception and safe abortion services limits their ability to realize their sexual reproductive health rights which include the right to fully and freely decide and control when to have children.

Purpose Statement

In response to the lack of comprehensive and accurate reproductive health information, this special studies project will serve as a tool to educate young people on how to make reproductive health and fertility decisions so that they can protect themselves against unwanted pregnancies and unsafe abortions. Pertinent themes that will be discussed are personal and method related considerations for contraceptive methods, safe abortion options and community resources that young people can leverage to protect themselves from poor reproductive health outcomes.

Project Objectives

This Reproductive Health Guide will be used as part of the Closing the Gap (CtG) project, which is an ongoing sexual and reproductive health service delivery and advocacy project in Kenya, Uganda, and Burkina Faso. CtG's objective is to increase awareness of, access to and use of quality family planning (FP) and comprehensive abortion care (CAC) information among young people. CtG will meet these objectives by reaching communities with information on contraceptives and unsafe abortion and strengthening capacity of organizations to deliver facility-based FP and CAC services.

Kisumu Medical Educational Trust (KMET), is a non-governmental organization based in Kisumu, Kenya and is the main field site of CtG in Kenya. KMET is using peer educators and community health volunteers to educate young people and households respectively on family planning. This special studies project focuses on the CtG objective of raising community awareness on contraceptives and unsafe abortions. This Reproductive Health Guide is a tool that will be used by young people and peer educators to demystify (1) decision making around selecting a contraceptive method and (2) how and where to procure safe abortion services. Additionally, it will serve as an appendix to the present educational tool (CHV Trainers Reference Guide, specifically Module 5: Addressing Unsafe Abortion) in order to discuss more in detail the primary, secondary and tertiary levels of comprehensive abortion care.

This Reproductive Health Guide will discuss the three levels of comprehensive abortion care in the form of 3 separate modules to prevent unwanted pregnancy and unsafe abortion. Ipas developed the concept of comprehensive abortion care which is defined as the wholistic approach to women's reproductive health care that entails contraception counselling, induced abortion, abortion contraception and post abortion treatment (EngenderHealth, 2009). The first module is (1) Primary Prevention Methods, the second (2) Secondary Prevention Methods and the third, (3) Tertiary Prevention Methods. All the methods proposed are evidence-based, consistent with WHO policy, and the Government of Kenya's goal to reduce maternal mortality from unsafe abortion. Under Primary Prevention Methods, pertinent themes addressed are personal, situational and method related factors a young woman should consider when choosing a family planning method including considerations for emergency contraception. The Secondary Prevention Methods module highlights options available to young women upon discovering an unwanted pregnancy including information on where and how to access safe abortion services. Lastly, the Tertiary Prevention Methods module discusses how and where to access post abortion care.

1. Primary prevention methods
    1.1. Personal consideration for contraception
    1.2. Emergency contraception methods
2. Secondary prevention methods
    2.1. Considering being a parent?
    2.2. Considering not being a parent?
3. Tertiary prevention methods
    3.1. Post Abortion Care

Literature Review

The first section of the literature review will use a harm reduction framework to raise awareness on contraception and unsafe abortion in socially and legally restrictive environments. The second section will cover reproductive empowerment as it pertains to the sexual reproductive health of young people.

Harm Reduction

Harm reduction is a framework grounded in human rights that recognizes that an activity will still take place despite its legal prohibition. Harm reduction was first used in the 1980s during the onset of HIV/AIDs in response to high HIV transmission rates among injection drug users (IDUs). This approach came about after the realization that drug abstinence interventions often excluded many IDUs from HIV interventions. Through interventions like needle exchange programs in Europe and Canada, harm reduction approaches have proven to successfully reduce risks and poor health outcomes from risky behaviors (Canadian Pediatric Society [CPS], 2008). Although this model has historically been applied to HIV/AIDs programming, harm reduction principles remain relevant for comprehensive sexuality education specifically, contraception and safe abortion programming. This is because harm reduction is deeply rooted in a rights-based approach to health (Gruskin, 2006).

Although no universal principles apply to harm reduction, there are some general agreed upon tenets that inform a harm reduction approach to reducing mortality and morbidity from risky behavior. The 3 principles this section will discuss are neutralism, humanism, and pragmatism. The neutrality principle views those who are at risk of poor health outcomes as deserving of health interventions that acknowledge the right to health regardless of whether the activity is normatively right or wrong (Erdman, 2011). In countries like Kenya where access to lawful abortion is limited, Erdman suggests the use of harm reduction programming to promote access to life-saving information regardless of the status of women who do not qualify for a lawful abortion (2011). It can also be argued that although premarital sex is at odds with societal norms, young people should be exposed to health information on contraception

and safe abortion care. Not only does this view accept the reality that young people are sexually active, it also recognizes that young people are deserving of reproductive health care and information that meets all their needs.

Erdman argues that the principle of humanism views women as deserving of the right to health and life and by doing so, harm reduction places responsibility on the state and health practitioners to reduce harm and deaths associated with risky behaviors (2011). When applied to safe abortion efforts such as the Uruguay Initiative, harm reduction has been shown to reduce rates of maternal mortality and morbidity from unsafe abortions (Mulumba, 2017). The Uruguay Initiative was developed in 2012 by health professionals in response to high maternal rates from unsafe abortions. At the time, abortion was criminalized in Uruguay with no exceptions. The initiative nonetheless focused on promoting access to information in order to allow women to make informed reproductive decisions. It was also believed that should a woman choose to procure an abortion in such a restrictive environment it would at least be a lower risk abortion (Labandera et al. argue, 2016).

Not only did the initiative lead to a decrease in mortality rates from unsafe abortions, the literature also suggests that the model paved the way for the decriminalization of abortion in Uruguay (Mulumba, 2017). Grimes et al. argue that unsafe abortions from lack of access to contraceptive methods and information are a preventable pandemic (2006). This suggests that even in legally restrictive environments, women should be provided with information on contraception to prevent unwanted pregnancies (Coeytaux et al., 2014). Results from a study in Kenya and Tanzania reveal that sensitization of safe abortion in culturally restrictive environments reduce stigma around abortion and aids women to safely exercise their reproductive autonomy (Coeytaux et al., 2014). Therefore, raising young people's awareness of contraception and unsafe abortion empowers them to be active agents in making informed decisions about their reproductive health.

Lastly, the pragmatic principle of harm reduction is the acceptance that an activity is practiced regardless of its legal and social desirability. Erdman argues that the objective of harm reduction is to mitigate harm and injury associated with risky behavior (2011). In the context of young people's

reproductive health, the pragmatic principle recognizes that young people are having sex and seeking (unsafe) abortion services. The Demographic Health Survey reports that 15% of women aged 15-19 years have already had a live birth (2014). It would, therefore, be amiss for institutional actors like health providers not to educate young people on contraception and unsafe abortion on the premise that young people are not in need of sex related health information.

In line with the assertion that young people are not sexually active is the abstinence before marriage framework that has been used in Kenya to justify the lack of readily available information on safe and responsible sex (Sidze et al., 2017). A 2017 review of Kenya's education curricula revealed that sexuality education messages relayed in schools are conservative and focus entirely on abstinence, with educators emphasizing that sex is dangerous and immoral (Sidze et al., 2017). Not only do these messages fail to recognize the lived reality of many young people, it places them at an increased risk of unwanted pregnancy and death from unsafe abortions (Sidze et al., 2017). Evidence shows that abstinence only education violates young people's reproductive health rights to complete and accurate information. Donovan goes so far as to argue that it is an ethical violation to provide potentially harmful information that increases vulnerability to unintended pregnancy, HIV and other STIs (2017).

Aside from reducing risk, the pragmatic principle urges interventions to factor in a woman's social environment to reduce her vulnerability to risk. By acknowledging socio-contextual factors such as income and social norms, the pragmatic principle sheds light on factors beyond the woman's control that increase her vulnerability to unsafe abortions. Family planning interventions should, therefore, incorporate a woman's social networks like family and relationship partner to instill values and attitudes within her support system that respect and uphold her right to control her fertility.

Reproductive empowerment

Reproductive empowerment is defined as a process and outcome where individuals expand their capacity for informed decisions about their reproductive lives, amplify their ability to participate meaningfully in public and private discussions related to sexuality, reproductive health and fertility and

act on their preferences to achieve desired reproductive outcomes free from violence, retribution, or fear (Edmeades, 2018). This Reproductive Health Guide aims to build young people's knowledge on contraception and unsafe abortion and in so doing improve their self-efficacy to make informed decisions. This section will discuss (1) why young people's reproductive empowerment is important and (2) how access to information on contraceptive and unsafe abortions impacts young people's reproductive empowerment.

The sexual reproductive health of young people continues to be of interest to local governments and the development community because of the alarming health indicators among the 10-24 age group even at the global level. For example, complications from pregnancy and childbirth are the global leading cause of death among girls aged 15-19 years (WHO, 2017). It has also been found that the unmet need for family planning is highest amongst 15-19-year-olds. Young people aged 15-24 years on the other hand account for just under half of all unsafe abortions worldwide (UNFPA, 2012). This is of concern to low- and middle-income countries where 74 million unintended pregnancies occur every year (Darroch et al., 2016). These data suggest that although uptake of contraceptives is reported to have increased globally among married women, much is left to be said about sexually active never-married women and girls (UN, 2017).

Outside of poor health indicators in developing nations, attention to sexual reproductive health needs of young people is paramount for social and economic progress. This is because there is evidence to show that the 10-24 age cohort is the fastest growing age group in poor economies (UNFPA, 2014). Nations will, therefore, have to invest more in the health of young people in order to tap into the skills, knowledge, and creativity of their largest population group (UNFPA, 2014). Increased control over spacing and timing of pregnancy, greater control over fertility, lower unmet need for family planning decreased prevalence of STIs/HIV, decreased child marriage and decreased sexual violence on coercion are some of the long-term benefits of empowering young people to make informed decisions about their reproductive health (Edmeades et al., 2018).

Edmeades et al. argue that the research community has only recently begun to explore reproductive empowerment as a distinct sphere of empowerment rather than as an outcome of family planning (2018). With this in mind, young people should be able to freely express their childbearing desires to their networks, including their partners and providers, meaningfully participate in communication and decision-making with those same networks and influence and achieve their marriage, sexual intercourse and contraceptive goals (Edmeades et al., 2018). Access to comprehensive sexual reproductive health knowledge has been found to positively influence young people's reproductive empowerment in many ways. Firstly, it cultivates young people's ability to voluntarily make meaningful choices that are informed. The concept of informed choice refers to a young person's right to make decisions while taking into account full knowledge of all available contraceptive options. For young people to make informed choices, access to complete and accurate information is necessary. Edmeades et al., present the idea of a real versus constrained choice with regard to women's empowerment (2018). This means that providing young people with viable family planning options presents users with a real choice to make personal life choices based on a contraceptive method that aligns with their lifestyle and preference. The Committee on the Elimination of Discrimination against Women (CEDAW) also makes it clear that adolescents need complete information to enjoy and navigate sexual relationships and emotions in order to freely make decisions about their desired reproductive goals.

Secondly, research has shown that some of the skills and values that young people develop from sexual health education include confidence, respect for others, self-esteem, decision-making, and communication. Not only do these skills build young people's confidence to determine whether they want children, they also empower young people to articulate against practices like child marriage and female genital cutting. International bodies like Girls Not Brides and the United Nations Population Fund have also asserted that the right to bodily autonomy is an important skill that young people derive from exposure to comprehensive SRH information. The Center for Reproductive Rights also argue that young

girls' knowledge on their legal rights encourages them to be self-advocates in private spaces like the home where instances of rape and sexual violence often get silenced (2008).

Institutions and governments are also encouraged to promote young people's sexual reproductive health and rights to create environments that nurture adolescent's independence (Center for Reproductive Rights, 2008). The literature on sexual reproductive health education exposure shows that women have improved levels of self-efficacy to discuss and voice their family planning needs (Wegs et al., 2016). Self-efficacy is defined as an individual's belief in their ability to achieve their desired goals whereas voice is defined as the capacity to strongly assert one's interest, articulate opinions and desires, demand change and shape and discuss matters that are relevant to one's life (Edmeades et al., 2018). In the context of family planning, developing the skills to assert one's interest in having or delaying childbirth is argued to enable the realization that young people can influence and pursue their desired outcome. These outcomes motivate young people to proactively make decisions to avoid risky sexual behavior and protect themselves from unsafe abortions. There is evidence that has found a positive relationship between women's empowerment and positive reproductive health outcomes (Edmeades et al., 2018).

In summary, the goal of this special studies project is to create an educational tool that empowers young people to make informed reproductive health decisions by demystifying the topics of family planning and unsafe abortion.

Methods

Qualitative research methodologies were used to assess the need for a Reproductive Health Guide to support the objectives of the CtG project.

Key Informant Interviews

Several informal interviews were held over the course of the creation of this guide with KMET's Reproductive Health Coordinator who is leading the CtG project in Kenya. Telephone interviews were periodically held to familiarize me with the objective of CtG and discuss key milestones of the project's design. The interviews also ensured the guide was meeting requirements like pictorial representation, updated community resources, appropriate length and easy to understand language in order for peer educators to reach young people with education messages.

Document analysis

I reviewed two key CtG documents; a community health volunteers (CHV) Trainer's Reference Guide and a meeting report of a key meeting held between KMET and its CHVs and peer educators.

The CHV Trainers Reference Guide is the tool presently used by both peer educators and CHVs to facilitate outreach sessions. This document was reviewed several times. The initial read was to familiarize me with the content and subsequent reads sought to explore two key issues. First, if the language used was in the second person and second, if the CHV Trainers Reference Guide relied on the communication and training expertise of the peer educator to relay sexual reproductive health information. The use of the second person is important for this project because it helps create a conversational relationship with the user rather than a didactic relationship instructing the user on how they should make decisions about their reproductive health. Further, the use of the second person creates a somewhat personal relationship with the reader that would allow them to connect with the material. discussed.

The second issue that was analyzed during the review of the CHV Trainers Reference guide is if it had the program beneficiary (who is the young person) in mind. The general organization of the CHV

Trainers Reference Guide revealed that the content was more geared toward the process of training of community health volunteers and peer educators with skills to educate rather than to improve the reproductive health knowledge of young people on family planning and unsafe abortion. The CHV Trainers Reference Guide is also organized in learning modules that take the form of participatory training activities that include information on different methods like group discussion, case studies, reading aloud, role play, energizers and brainstorming to facilitate education sessions. The CHV Trainers Reference Guide also discussed instructions for trainers and key discussion points for each learning module. This was a key finding and overall motivator for the creation of a Reproductive Health Guide tailored to young people to set and identify their reproductive goals and make informed decisions towards those goals.

The second document that was analyzed is a report of a CtG meeting held between KMET and its peer educators and CHVs. The purpose of the meeting was to discuss experiences of community health volunteers and peer educators, and key findings related to young people's knowledge and access to family planning. A thematic analysis of the report was performed on concerns raised during the meeting that related to peer educators' outreach activities. For the purposes of this project CHV concerns were not taken into consideration because CHVs educate at the household level and are therefore not uniquely targeting young people. It was noted that there exists common family planning myths and misconceptions among the communities peer educators reached. Further, young people reported opting for short-acting methods like condoms and the pill because of disputes with sexual partners. It is likely that these two findings suggest the need for a tool that demystifies contraception and family planning decision making including how and where to seek reproductive health services.

This special studies project aims to fill this gap by developing a tool that will be used by young people to make informed reproductive health decisions that are most realistic and reflective of their personal lifestyles. Peer educators on the other hand will also use the Reproductive Health Guide to educate young people on the same.

Results

This Reproductive Health Guide has 3 modules; primary prevention methods, secondary prevention methods and tertiary prevention methods

> Dear young person,
>
> If this guide is in your hands you are on the right path to being more aware of your right to enjoy safe and responsible sex. It is your right to plan for your future by determining if and when to have children with. You will find information on contraceptives and safe abortion that you could use to set and define your reproductive goals. Use this guide to complement the medical advice from a health professional so that you can make more informed decisions about your sexual reproductive health.
>
> Good luck.

Module 1: Primary Prevention Methods

This module will highlight personal and method considerations that young people should factor in when selecting a contraceptive method. This module will not discuss different contraceptive methods that are available because they have been adequately discussed in the CHV Trainer's Reference Guide.

1.1 Personal considerations for contraception

This section outlines practical factors you may find useful to decide on a contraceptive method that best reflects your personal interests and concerns. There is no one best method for birth control. It is therefore important for you to use a method that is effective and that you are comfortable with so that you are more likely to use it regularly and correctly.

Wondering what factors are important when considering a birth control method?

WHAT DO I NEED TO CONSIDER?

Reproductive Intentions

I would (not) like to have children in the next X years

Effectiveness

If I use it correctly everytime I have sex, will I get pregnant?

Discreteness

Can my partner or parent tell I am using it?

Frequency of sex

Do I have unprotected sex frequently?

Ease of use

Do I need to put in effort to use it? Must I remember to use it every day?

Non contraceptive benefits

Does it clear my acne? Does it make my cramps hurt less?

Cost

How much does it cost? Do I have to pay for it more than once?

Access to a provider

Does it need to be administered by a provider? Can I buy it at a pharmacy?.

Side Effects

I'm I able to tolerate different side effects associated with the method I want

of sex partners

Does it protect from HIV& STIs?

1. **Reproductive intentions**

If you are interested in delaying pregnancy for up to 5-10 years, long-acting reversible contraceptives (LARC) like the implant, hormonal/non hormonal intrauterine devices (IUDs) and injectables may be used.

2. Cost

Birth control methods like pills and condoms require users to regularly purchase a packet for us long as they are interested in preventing pregnancy. Methods like LARCs require payment for both insertion and removal.

3. Discreteness

If you would not like your parent to know that you are using contraception or you are unable to discuss using contraception with your partner for fear of violence or being accused of being unfaithful, methods like implants, injectables, the patch, and IUDs may be considered.

3. Frequency of sex

If you have sex frequently, LARC methods can be used without having to constantly think about protecting yourself from unwanted pregnancies.

CDC. (2018). *If you do have sex, use DUAL PROTECTION*. Retrieved from https://www.cdc.gov/teenpregnancy/pdf/Teen-Condom-Fact_Sheet-English-March-2016.pdf

Similarly, for users who have multiple sex partners, it is important to use a method that will protect against HIV and STIs. External (male) and internal (female) condoms are the only methods that provide dual protection against unintended pregnancies and sexually transmitted infections like HIV. If you do have sex, use dual protection.

4.Ease of use

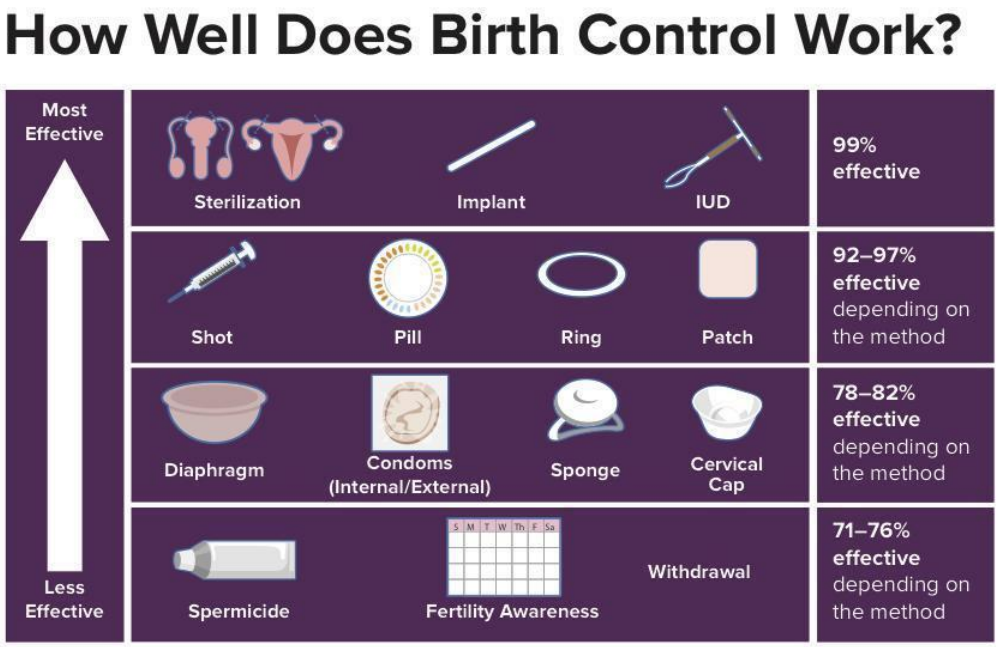
Using LARC methods will eliminate the hassle of remembering to take your pills daily at the same time. Also, once inserted LARC methods are mistake proof. Using other methods like the female condom, the vaginal ring and diaphragm may require one to be comfortable inserting your hands in your vagina.

5. Non-contraceptive benefits

If you would like a method that helps with making periods and period cramps lighter, you may consider using implants and hormonal IUDs. Birth control pills on the other hand, get rid of acne and help smoothen the skin. The pill, patch, implant and hormonal IUD slightly increase your risk of breast cancer but also decrease your risk of ovarian and endometrial cancers.

6. Effectiveness

Sterilization and LARC methods are the most effective at preventing pregnancies. This means that compared to other contraceptive methods, there is little to no room for these methods to fail and result in an unwanted pregnancy.



UC Davis. (2018). *How Well Does Birth Control Work?* Retrieved from https://shcs.ucdavis.edu/topics/birth-control-contraception

The least effective methods that have a higher chance of resulting in an unplanned pregnancy are withdrawal, abstinence, and fertility awareness methods (FAM) like temperature, cervical mucus and calendar methods (also known as cycle beads). FAM methods are used to avoid sex on fertile days or determine use of different contraceptive method like condoms on the fertile days. Withdrawal and fertility methods are considered the least effective because they have the most room for human error. It is encouraged that if you do decide to practice abstinence, be knowledgeable of how to use contraceptive methods like condoms in preparation of an isolated sexual event to protect against unwanted pregnancy.

7. Access to a provider

Methods like the pill and emergency contraception, however, do not require a prescription and can be purchased over the counter. LARC methods on the other hand, require users to visit a health facility in order to be inserted and removed by a health provider.

8. Side Effects

Side effects of birth control are dependent on the method selected. Common side effects of hormonal methods like the pill, the patch, injectables, and hormonal IUDs include nausea, missing periods, breast tenderness and changes in weight. Copper IUDs cause heavier cramps and periods.

If you are still unsure of whether you selected the right contraception method, use the Contraception Comfort and Confidence Scale (Appendix 1).

1.2 Emergency contraception methods:

Emergency Contraception is a birth control method that can be used to protect against unintended pregnancy in the event of unprotected sex or if you make a mistake using your contraceptive method. If you are taking emergency contraception regularly, talk to a health provider or community health worker to help you decided which contraceptive method best works for you.

How do I know if I need emergency contraception?

- If NO contraception was used during sex
- If the male condom slipped or leaked
- If the female condom was placed or removed incorrectly
- If you have consecutively missed more than 3 pills
- If you delayed starting your regular contraceptive method
- If there was ejaculation inside the vagina or on the external genitalia

EMERGENCY CONTRACEPTION

- Emergency contraception prevents pregnancy by preventing or delaying ovulation.
- There are only 2 forms of emergency contraception: emergency pills and copper IUDs

EMERGENCY PILLS (E-pills)

- Must be taken within 5 days of unprotected sex
- E-pills do not protection against pregnancy during future acts of unprotected sex
- Does not protect against HIV and other STIs
- If someone is pregnant, E-pills will not harm the pregnancy
- E-pills can be found at KMET for free

COPPER IUD

- Should be inserted within 5-10 days after unprotected sex.
- More effective than e-pills for preventing an unwanted pregnancy
- Provides protection from an unwanted pregnancy for up to 5-10 years
- Does not protect against HIV and other STIs
- Copper IUDs can be inserted for free at KMET

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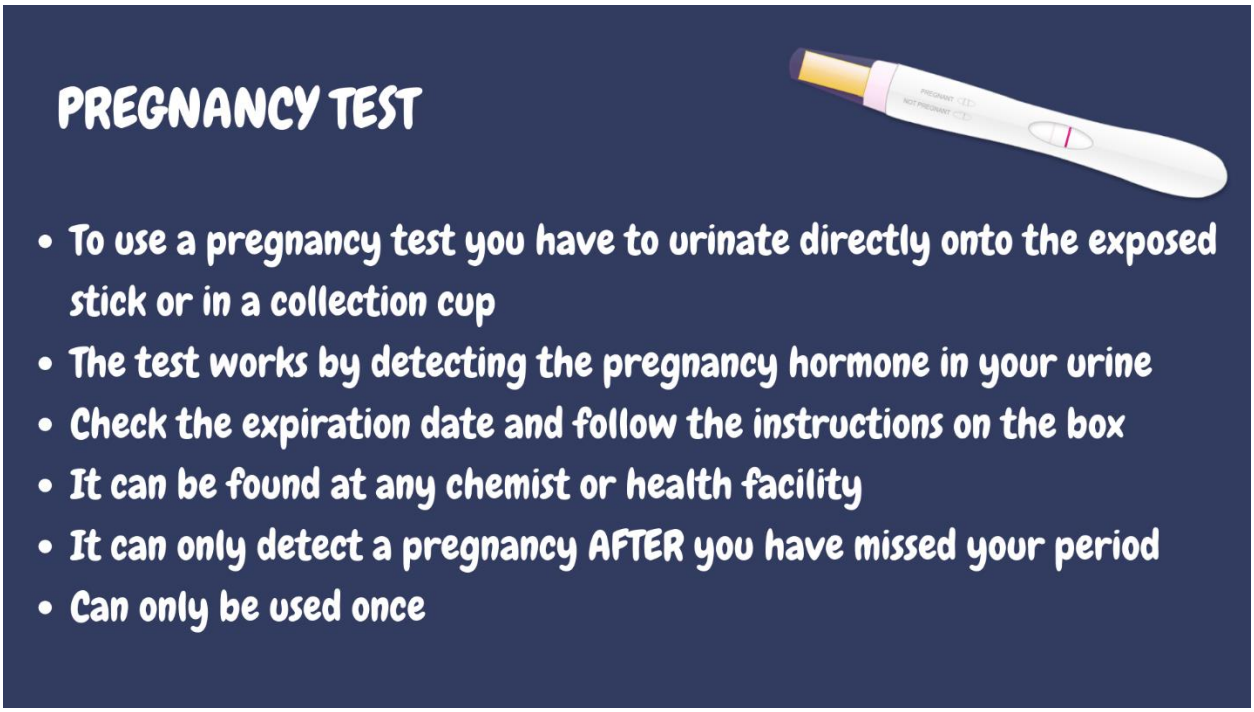
Module 2: Secondary Prevention Methods

This module discusses what to do if you think you are pregnant and the ‘what next?’ after a young person discovers they have an unintended pregnancy. It also highlights existing community resources that young people can call or visit to obtain accurate and reliable information.

Not sure if you are pregnant?

Use a pregnancy test or visit your nearest health clinic to get a blood test to confirm whether you are pregnant.



Once it is confirmed that you are pregnant, you ideally have 3 options;

- Carrying your pregnancy to term and raising your child
- Carrying your pregnancy to term and giving it up for adoption
- Terminating your pregnancy using safe abortion methods

Although adoption is listed as a pregnancy management option, it is yet to be well defined in Kenya. It will therefore not be discussed in detail in this guide.

2.1 Considering being a parent?

Wondering if parenthood is the right option for you? You can still meet your life goals. Here are some things you should know if you are considering carrying your pregnancy to term and raising your child.

- Talk to an adult you trust about your feelings
- If you don't have someone you can trust talk to a counselor or call a hotline

- You can also call a hotline to ask for advice on how to share the news with the father or a guardian
- You will need support from family and friends to helo raise the child

- **Legally, your school must allow you to return to school**
- **Talk to a provider as soon as you can so that you can begin receiving antenatal care**

- **Asking for help from a health provider on what you should eat or avoid eating is part of being a good parent**
- **Use contraceptives to prevent future unwanted pregnancies**

Deciding to be a parent for a child you had not planned to have is no easy decision. Talk to a friend, parent, boyfriend or counselor to help you process your feelings. Here are some questions to help you think through this option:

- "Do I want to have a baby?"
- "Will the child have a father who is "there?"
- "Can I afford to have a child?
- "What will happen to my goals, my hopes, my life?"
- "What will happen to my boyfriend's life?"
- "Who can help me raise a child?"
- "Can I raise a child by myself?"
- "How will my family react? My friends?"
- "How will this affect my other children?"
- "Is my body healthy enough?"

If you would like to talk to someone who will not be judgmental, treat you with respect and can help you with more accurate information on pregnancy you may call:

1. Aunty Jane Hotline: +254727101919 or +254753700352
2. KMET: 0800724500 (toll free)
3. Childline Kenya: 116
4. One to One: 800 720 121
5. Women help women: email info@womenhelp.org

2.2 Not ready to be a parent?

IN KENYA ABORTION IS ONLY PERMITTED IF THE (PHYSICAL&MENTAL) HEALTH OF THE MOTHER IS AT RISK AND IN THE EVENT OF RAPE OR INCEST

It is only doctors, nurses, midwives or clinical officers who can legally perform abortions

WHAT ABORTION METHODS EXIST?

MEDICAL ABORTION

- This is the termination of a pregnancy using prescribed pills like mifepristone, misoprostol and combination (has both mifepristone and misoprostol) that can be taken at home
- When taken, users experience heavy bleeding and cramping that marks the termination of the pregnancy.

What are the local available drugs?

mifepristone: cytotec, misotrol
misoprostol: misotac, isovent combination: mifeprex

SURGICAL ABORTION

- This is the termination of a pregnancy that is carried out by a health provider inside a health facility
- Depending on how many weeks pregnant you are, the provider will use in-clinic procedures like manual vacuum aspiration and dilation & evacuation to end the pregnancy

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WHY DO PEOPLE GET ABORTIONS?

- To protect the life of the mother if there is the chance the pregnancy will harm the mother
- If the fetus has severe deformities
- To continue with school, advance in a career or achieve other goals before having a baby
- They are unable to afford the cost of raising a child
- They're not in a relationship with someone they want to have a baby with.
- They're in an abusive relationship
- The pregnancy is a result of rape
- Pressure from family, friends or the father of the fetus

Will I regret having an abortion?
(See appendix 3 to help you think through this option)

DECISIONS ABOUT YOUR PREGNANCY ARE PERSONAL AND IT IS ONLY YOU WHO KNOWS WHAT THE BEST DECISION IS IN ORDER TO LIVE A HAPPY AND MEANINGFUL LIFE

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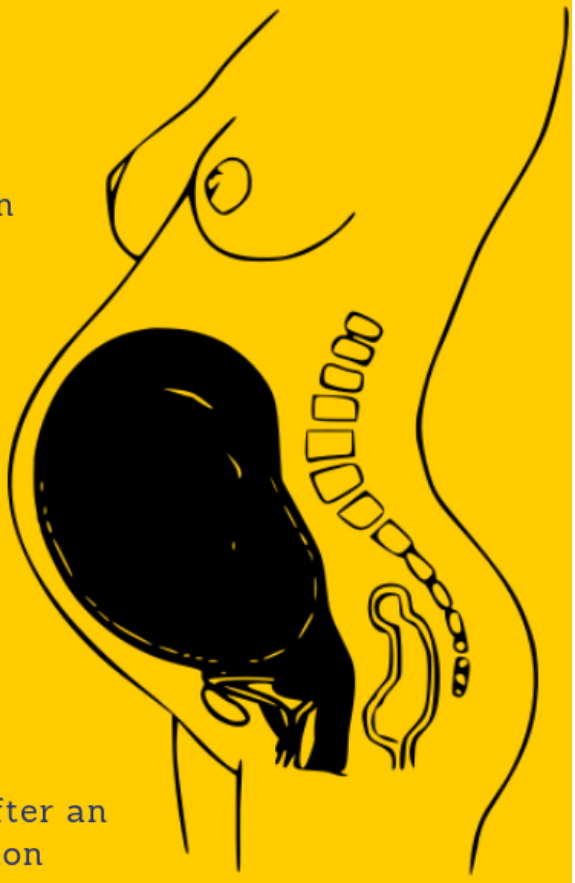
HOW MUCH DOES IT COST?

The cost varies depending on the health facility. At KMET an abortion costs KES 3000



IS THERE AN AGE MINIMUM?

NO. But if you are under 18 you must get the consent of an adult. This could be a friend or relative that you trust

CAN I STILL GET PREGNANT?

Yes. You can STILL get pregnant after an abortion. Get started on contraception immediately to prevent an unwanted pregnancy

WHERE TO FIND MORE INFORMATION ON ABORTION?

- Aunty Jane +254727101919 or +254753700352 (hotline)
- Pink Shoes/ Howtouseabortionpill (website)
- Womenonwaves (website)
- Nimechanuka and Safe Abortion in Kenya (facebook pages)
- MamaNetwork (website)

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Where to find safe and non-judgmental abortion services?

- KMET
- MariesStopes Kenya
- Family Health Options Kenya
- Reproductive Health Services
- Private Hospitals

A safe abortion will feel different for everyone. The pain or discomfort experienced is natural and will depend on medications you may be given and how far along into the pregnancy you are.

If performed correctly by a trained health professional, you will be in good health to return to your daily life.

Abortions at KMET can be obtained via 3 ways: Using the toll free number, by referral of a peer educator or a walk in visit.

What is the process like to get a safe abortion at KMET?

1. Call KMET on 0800724500 (toll free) and say that you are worried about missing your period
2. The person on phone will ask you for your location in order to refer you to a clinic closest to you if it is not KMET
3. Once you get to the clinic, the provider will hold a counselling session to talk about your mental, emotional and physical health concerns and discuss the pregnancy option you are most comfortable proceeding with
4. Depending on what pregnancy option you select the provider will either schedule a safe abortion for the same day or provide you with a return date for you to get started on antenatal care
5. You will receive instructions on how to care for yourself after the abortion and how to take any medications you may need
6. The provider will also walk you through how to take medical abortion pills if that is what is medically feasible and advice you on what signs to look out for to ensure you have a safe and complete termination at home

How do I safely have a medical abortion at home?

MEDICAL ABORTION

- A medical abortion is considered safe for pregnancies up to 10 weeks after the first day of your last period.
- Misoprostol is used to safely terminate a pregnancy without the need of additional medical care.

HOW DOES IT WORK?

- Misoprostol works by contracting the uterus and causing the pregnancy to be expelled similar to the process of a miscarriage
- Incorrect use of misoprostol can be harmful,make sure to follow instructions (see appendix 2: How to use misoprostol)
- The pills can be inserted under the tongue or in the vagina
- Common side effects are nausea, vomiting and diarrhea

THINGS TO NOTE:

- The pills can be purchased from your local chemist, some chemists may allow you to buy the pills without a prescription
- Try to have someone with you that you trust who can take care of you or rush you to hospital incase you need emergency treatment
- Make sure you do not have an inserted IUD
- Take a painkiller to help with the pain. The cramping experienced is stronger than period cramps
- The longer your pregnancy the stronger the bleeding and the cramping
- Do not insert anything into your vagina for atleast 5 days
- You can STILL get pregnant after an abortion. Get started on contraception immediately to prevent an unwanted pregnancy

NOT SURE IF IT WORKED? Take a pregnancy test after 3 weeks

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Module 3: Tertiary Prevention Methods

This module discusses lifesaving treatment that young people can access after receiving an unsafe abortion.

3.1 Post Abortion Care

An unsafe abortion occurs when a pregnancy is terminated either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

- If you or someone you know has taken chemicals like bleach or used the services of someone who is not a trained medical provider to terminate an unintended pregnancy, the Constitution of Kenya entitles you to lifesaving treatment regardless of your age.
- This means that it is within your right to seek and receive post abortion care from any health facility that provides post abortion services.

Wondering why going to an untrained 'doctor' to end a pregnancy is unsafe?

Unsafe abortions are dangerous because of complications like excessive bleeding, infections from incomplete abortions and damage to internal organs that may have long-lasting effects on your health. You can also receive post abortion care treatment at a health facility that provides safe abortion services. Refer to the list of facilities under Module 2 to know where you can access safe abortion services.

Discussion

This section will synthesize findings, discuss reproductive health policies specific to unwanted pregnancy options and their public health implications. I will also discuss the strengths and limitations of this special studies project

This special studies project was developed as a tool to educate young people on family planning and unsafe abortion. The state of young people's poor sexual reproductive health outcomes in Kenya suggests the need for accurate and comprehensive information on how to delay childbirth and protect against unwanted pregnancies. Similarly, conservative religious values held by figures like parents, religious leaders, teachers and extended family members in young people's lives make it difficult for young people to freely discuss and seek information on contraception. Further, stigma surrounding abortion has been found to limit young people's access to information on safe abortion including information on how and where to access lifesaving treatment from trained health professionals.

The Reproductive Health Guide is divided into three modules that discuss primary, secondary and tertiary methods to protect against unwanted pregnancies and unsafe abortion. The primary prevention module explores personal and method related factors that young people should take into consideration when choosing a contraceptive method. Further, reviewing personal considerations like reproductive intentions, cost, discreteness, frequency of sex, ease of use, non-contraceptive benefits, number of sex partners and access to a provider reflects the varying reasons young people seek contraception. The Centre for Disease Control argues that preference for one method over another is influenced by a myriad of factors that often change with time (2018). This is further supported by Trussell et al. who contend that it is important for individuals to use a birth control method that fits personal lifestyle to avoid unintended pregnancy and negative health outcomes (2018). Therefore, if young people are unable to select a family planning method that is consistent with their preference or lifestyle, it is likely to be used incorrectly and inconsistently which would ultimately increase their risk of an unwanted pregnancy.

A study on contraceptive failure rates in developing countries shows that when controlled for age, marital status, wealth, residence, contraceptive intention and level of education, differences in failure rates was highest with women younger than 25 years (Polis et al., 2015). This suggests that the 10-24 age group that the Reproductive Health Guide is intended for is a high-risk group for unintended pregnancies. Reasons found to explain the higher risk relative to women older than 25 years are differences in sexual experience, frequency of sex, and stability and length of sexual relationships relative to women over 25 (Polis et al., 2015 and Glei, 1999). Glei further suggests that women older than 25 are more likely to seek long term contraception methods in anticipation of long-lived relationships and frequent sexual activity (1999).

The primary module also discusses emergency contraception as a birth control method that can be used in instances where no family planning was used and when a young person's choice of family planning is not used correctly. While emergency contraception is generally accessible in Kenya at the pharmacy, Liambila et al. argue that this place the responsibility of awareness on women and young girls (2013). This means that emergency contraception is not accessible to young people who are not aware of its use. A 2013 study found that there is a low proportion of women residing in urban cities in Kenya who have ever heard of emergency contraception, few providers trained on its use and negative media coverage (Liambila et al., 2013). Community awareness on emergency contraception is therefore important for young people to better understand how emergency contraception works and where to access it.

The secondary prevention module, on the other hand, explores the decision to either keep or end a pregnancy. In environments like Kenya where abortion access is limited, young people often self-induce or seek the services of an untrained professional to terminate unplanned pregnancies (Darroch et al., 2016). Therefore, demystifying abortion and sensitizing young people on their right to access lifesaving treatment could be argued to reduce young people' risk of mortality and morbidity from unsafe abortion. Finally, the tertiary prevention module outlines community resources like hotlines and health facilities

that young people can access to obtain post abortion care services. The guide also explores long-acting reversible contraceptive methods as a strategy to prevent repeat unplanned pregnancies.

Policy Implications

Although Kenya has extensive reproductive health policies like the Adolescent and Youth Friendly Guideline that outline the minimum essential package for sexual reproductive health services for young people, many still experience harm if not death from unsafe abortions. This special studies project highlights the need for the reinstatement of Kenya's Standards and Guidelines for reducing maternal mortality and morbidity from unsafe abortions for several reasons. For example, these guidelines call for community and media education and sensitization of safe sex, contraception, and unsafe abortion in order to allow women to set and achieve their reproductive intentions. Moreover, the absence of nationally defined guidelines to protect the reproductive autonomy and decision-making of sexually active unmarried women severely undermines young people's options to safely manage unwanted pregnancies in a culturally conservative environment. The Center for Reproductive Rights further argues that the lack of clarity about legal access to abortion produces and proliferates misinformation among young people. This situation ultimately erects additional barriers for women seeking safe abortion services because of the web of misinformation women have to navigate (2010).

Strengths and Limitations

Some of the strengths of this project are that it explores topics like emergency contraception and abortion that Chandra-Mouli et al. argue are typically left out of CSE curricula (2015). Further, familiarity of the in-country cultural and legal context informed the careful selection of language that would resonate with the audience of the Reproductive Health Guide. This guide is also reflective of the reality that young people are sexually active which makes it a realistic tool that young people can consult to create reproductive goals.

This project has several limitations. For example, as with any educational tool, this Reproductive Health Guide alone is not enough to reduce young people's risk of death and poor health outcomes from unsafe abortion. Chandra-Mouli et al. found that the use of participatory teaching methodologies is necessary to delivering comprehensive sexuality education-related content to achieve improvement in young people's SRH knowledge and a reduction in risky behaviors (2015). Further, contraceptive methods discussed in the guide may not be accessible at KMET health facilities. The guide does not include information on strategies sexually active couples can use to improve accountability and promote joint responsibility in delaying pregnancy. Moreover, the guide would need to be adapted for different groups such as rural communities to accommodate varying literacy rates among such populations. While it is beyond the scope of the guide, the Reproductive Health Guide does not discuss reproductive health decision-making within the confines of non-consensual sex even though many young people experience sexual violence.

Conclusion

I would recommend the translation of the guide to Swahili and various local dialects to improve access to young people. The pictorial form is also very helpful as a communication strategy for low literacy levels or people who only speak in their local dialect. I would also suggest breaking down the young people age bracket which is typically 10-24 years old into young and old adolescents, and 19-24-year-olds in order to tailor age-specific family planning and unsafe abortion information. The piloting of this guide would also shed light on modules that need to be explored further in depth. I also recommend asking young people if they feel more confident seeking reproductive health information at service delivery points during the pretesting of the guide to evaluate the effectiveness of the guide on easing the decision-making process to seek or access contraception and safe abortion services.

I am hopeful that this Reproductive Health Guide provides a foundation where more modules could be added to support the work of future programming geared towards raising awareness on reproductive health.

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Appendix 1: Contraception comfort and confidence scale

CONTRACEPTION COMFORT AND CONFIDENCE SCALE		
Method of birth control you are considering using		
Length of time you have used this method in the past		
Answer YES or NO to the following questions:	**YES**	**NO**
1. Have I had a problem using this method before?		
2. Have I ever become pregnant using this method?		
3. Am I afraid of using this method?		
4. Am I afraid of my partner finding out I am using this method?		
5. Am I afraid of my parent or guardian finding out I am using this method?		
6. Will I have trouble remembering to use this method?		
7. Do I still have unanswered questions about this method?		
8. Does this method make my period longer or more painful?		
9. Can I afford this method?		
10. Could this method have serious health complications?		
11. Am I opposed to this method because of religious or moral beliefs?		
12. Am I using this method without my partner's knowledge?		
13. Will using this method embarrass me?		
14. Will using this method embarrass my partners?		
15. Will I enjoy sex less because of this method?		
16. If this method interrupts sex, will I continue to use it?		
17. Has a provider ever told me not to use this method?		
18. Am I exposed to the risk of getting HIV if I use this method?		
TOTAL NUMBER OF 'YES'		

Key:

Answers	Potential explanations
Don't Know	There is need for more thinking or need for more information on the method
Yes	The user might not like the method The user might not successful with the method There is potential for future problems in using the method

Contraception comfort and confidence scale. Adapted from "Family Planning Methods and Practice Africa Edition" by CDC, 1999, pg 255

If there are more 'yes' the less likely you are to use this method correctly and consistently and you should consider using an alternative method that you are more likely to be consistent with. Try this scale for each contraceptive method you think you would be most comfortable using.

Appendix 2: How to use Misoprostol

Women on Waves – Safe Abortion with Misoprostol

For Pregnancies up to 9 Weeks

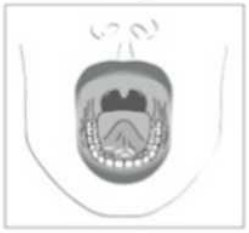
www.womenonwaves.org
www.womenonweb.org

1st

Don't be alone! Have someone with you in case you need to go to the hospital.

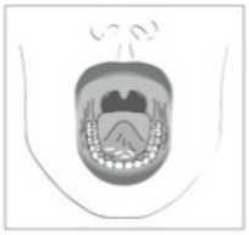
2nd

Put 4 pills (200mg each, for a total of 800mg) of Misoprostol under the tongue for at least 30 minutes – Do not swallow!



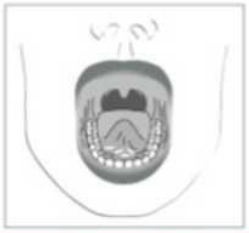
3rd

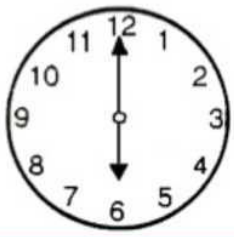
In three hours, put another 4 pills of Misoprostol under the tongue for at least 30 minutes



4th

In three more hours, put another 4 pills of Misoprostol under the tongue for at least 30 minutes





Appendix 3: Will I Regret Having an Abortion?

SCORE USING A 1, 2, OR 3: **1 = Not true for me** **2 = Somewhat true for me** **3 = Really true for me**	**SCORE**
1. I believe abortion is the same as murdering a born person	
2. I am not sure if I am making the right decision.	
3. I don't want an abortion, but I have to have one.	
4. I know I will regret having an abortion.	
5. My parents are rejecting, critical, or abusive.	
6. The man involved is abusive, rejecting, and controlling.	
7. I think God will punish me for having an abortion.	
8. I will not be able to forgive myself for having an abortion.	
9. No one is giving me emotional support right now.	
10. Someone else is forcing me to have an abortion.	
11. I am never going to think about it again after it's over.	
12. I suffer from depression or diagnosed personality disorder.	
13. I am a "perfectionist" and I can't forgive myself for getting in this situation.	
TOTAL	
If your score on this self test is 26 or over, you may want to talk to a community health volunteer or a counsellor about this option	

"Will I regret having an abortion?": Self Test. Adapted from "Pregnancy Options" by PregnancyOptions.info, no date, pg 41

Kisumu Medical& Education Trust (KMET) Letter of Request

Kisumu Medical & Education Trust
(Promoting Health & Education)

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www.kmet.co.ke

10th /January /2019

TO WHOM IT MAY CONCERN

REF: SAMANTHA GIKUHI

With reference to the above subject matter, I confirm that the above mentioned has developed a Reproductive Health Decision Making Model to be used by KMET project dubbed CtG, a Sexual and Reproductive Health (SRH) service delivery and advocacy project that aims to increase awareness of, access to and use of quality family planning (FP) and comprehensive abortion care (CAC) services among high need communities in Kenya. The project has a strong focus on strengthening capacity of partners to deliver facility based FP/CAC service and actively advocate for expansion of SRHR rights, services and policy. The users of the developed model will be Community Health Volunteer/ Peer educator who shall target out-of-school youth (10-24 years) who are the primary audience: and the will adopt Harm Reduction Framework.

I therefore hold no reservations for herto use this model in partial fulfilment of the requirements of a Master of Public Health Degree at Emory University.

Sincerely,

Caroline Nyandat | RH Coordinator | KMET
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Promoting Quality in Health and Education