

ARTICLE

INFLUENCE OF CONTRADICTIONS IN THE LEGAL FRAMEWORK ON YOUNG WOMEN ACCESSING SAFE ABORTION IN KIBRA SUB-COUNTY, NAIROBI KENYA



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Abstract

In Africa, abortion remains unavailable and inaccessible even when adolescent girls and young women meet the legal eligibility criteria. Young women who become pregnant before marriage are subjected to humiliation therefore, a large proportion resort to unsafe abortion to escape the shame and stigma. Kenya has progressive abortion legislation including the 2010 Constitution; Article 43(1)(a), Article 43(2) and 26(4) that provide the right to reproductive health including abortion and post abortion care. Nevertheless, the 1963 colonial Penal Code is still used as a blanket criminalization of abortion. The Penal Code is used to illegally arrest and detain pregnant girls and health workers seeking and providing the service respectively. The lack of clarity about legal access to abortion has resulted in widespread misinformation and ostracization among abortion seekers and providers. This study aimed at bringing out the contradictions in legal frameworks and their impact on access to safe and legal abortion services for young women in Nairobi, Kenya. It also investigated how gender norms influence access to abortion and identify the extent to which health care workers conscientious objections hinder provision of safe abortion services to young women. The study also examined South Africa's abortion laws on a comparative basis to draw lessons that Kenya can borrow or learn from. The study adopted a mixed methods design. Quantitative data was collected from 216 respondents using semi-structured questionnaires, while participants were selected through purposive and cluster sampling. Data was analyzed using descriptive and inferential statistics in SPSS Version 26, including t-tests and Chi-square tests.

Keywords – Abortion Law; Reproductive Rights; Legal Ambiguity; Gender Norms; Safe Abortion.

I. INTRODUCTION

Legal frameworks play a critical role in shaping access to abortion services by defining the circumstances under which abortion is permitted, restricted, or criminalized. Although the legal status of abortion may not necessarily determine the incidence of abortion, it has important implications for the safety of abortion procedures and for women's ability to access timely and appropriate reproductive healthcare. Restrictive, unclear and contradictory legal frameworks

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create uncertainty among women, healthcare providers, law enforcement agencies, and policymakers, contributing to delayed care, stigma, fear of criminal sanctions, and reliance on unsafe abortion methods.

Access to safe abortion is closely connected to internationally recognized rights to health, life, privacy, dignity, bodily autonomy, and freedom from discrimination. A human rights-based approach therefore recognizes women and girls as rights holders who should be able to access accurate information and reproductive healthcare and make decisions concerning their bodies. It also places obligations on states to establish clear and coherent legal and policy frameworks and to remove unnecessary barriers that prevent access to lawful reproductive healthcare.

Despite these protections, access to safe abortion remains contested across many African contexts. Abortion continues to be shaped not only by law but also by gender norms, religious beliefs, economic inequalities, political contestation, and healthcare systems. Young women may face particularly significant barriers because of stigma surrounding adolescent sexuality and expectations relating to femininity, marriage, motherhood, and sexual purity. Those who seek abortion may consequently encounter social judgement, misinformation, discrimination, financial barriers, or reluctance among healthcare providers to offer services.

These challenges are particularly significant in Kenya, where abortion remains highly contested within legal, political, religious, and cultural debates. Kenya's 2010 Constitution introduced important protections for reproductive health and permits abortion under specific circumstances. However, provisions within the Penal Code continue to criminalise abortion, creating a complex legal environment in which the constitutional grounds for lawful abortion may be misunderstood or interpreted restrictively. This legal ambiguity can affect both women seeking services and healthcare providers responsible for delivering them.

The consequences of this uncertainty extend beyond the existence of legal frameworks. Limited awareness of the circumstances under which abortion is permitted by the law may reinforce the widespread perception that abortion is entirely illegal in Kenya. Healthcare providers may also be reluctant to provide services because of uncertainty regarding the law and fear of potential criminal or professional consequences. The failure to implement the court reinstatement of standards and guidelines relating to abortion care have further contributed to uncertainty regarding service provision. Within this context, legal contradictions interact with gender

norms, cultural and institutional barriers, including abortion-related stigma, poverty, limited information, and gender stereotypes surrounding sexuality and reproduction.

Young women living in informal settlements may experience these barriers more acutely. Kibra Sub-County, one of Kenya's largest informal settlements, is characterized by socioeconomic inequalities and barriers to healthcare access. Young women may face multiple and intersecting challenges when seeking reproductive healthcare, including financial constraints, limited access to accurate information, concerns about confidentiality, community stigma, and unequal gender relations. Legal uncertainty may therefore have particularly significant consequences for young women whose access to services is already constrained by broader social and structural inequalities. The issue of abortion access must also be understood through the influence of gender norms. Societal attitudes towards young women's sexuality frequently construct adolescence as a period in which sexual activity should be avoided, particularly for unmarried girls and young women. Those who experience unintended pregnancies or seek abortion may consequently be subjected to labels and stereotypes that portray them as irresponsible or morally deviant. Such stigma can discourage young women from seeking information and care and can influence how communities, policymakers, and healthcare providers respond to abortion.

Healthcare providers' conscientious objection presents an additional dimension of access. While healthcare providers may hold personal, religious, or moral objections to abortion, the exercise of conscientious objection can create barriers where it results in refusal of care without appropriate information or referral pathways. In settings characterized by legal ambiguity and limited public knowledge, conscientious objection may further complicate young women's ability to identify where lawful services can be accessed.

This paper examines these interconnected barriers through a mixed-methods study conducted in Kibra Sub-County, Nairobi. It investigates how contradictions within Kenya's legal framework, gender norms and societal beliefs, and healthcare providers' conscientious objection influence young women's access to safe abortion services. The paper also undertakes a comparative desk review of South Africa's abortion legal framework to identify lessons relevant to legal and policy reform in Kenya. South Africa provides a useful comparative case because of its relatively progressive legal framework on abortion and its constitutional recognition of reproductive autonomy and access to reproductive healthcare. The transition from a restrictive legal framework to the Choice on Termination of Pregnancy Act provides

important insights into the relationship between legal reform and reproductive health access. However, South Africa's experience also demonstrates that progressive legislation alone does not eliminate barriers associated with stigma, conscientious objection, and health system limitations. The comparison therefore provides an opportunity to examine not only how legal frameworks can be strengthened but also why legal reform must be accompanied by effective implementation and broader social change.

By situating abortion access at the intersection of law, gender, healthcare, and social justice, this paper contributes to broader discussions on reproductive rights and legal reform in Africa. Its findings demonstrate that access to safe abortion cannot be understood solely as a question of whether abortion is legally permitted or prohibited. Rather, reproductive autonomy is shaped by the interaction between legal clarity, knowledge of rights, gender norms, healthcare providers' practices, and the socioeconomic conditions within which young women make reproductive decisions. The paper therefore examines how contradictions within Kenya's legal framework, gender norms, and healthcare providers' practices influence young women's access to safe abortion services, and what lessons can Kenya draw from South Africa's legal experience.

II. METHODOLOGY

Theoretical and conceptual framework

This study was guided by a radical feminist theoretical framework, which conceptualizes reproductive autonomy as a fundamental human right and examines how patriarchal structures, gender norms, and legal systems shape women's reproductive decisions. From this lens, restrictive or contradictory abortion laws may reinforce patriarchal control over women's bodies and perpetuate gender inequalities, with disproportionate consequences for young women.

The radical feminist framework informed the study's examination of how legal ambiguity, gender norms, socio-economic factors, and healthcare providers' beliefs intersect to influence young women's access to safe abortion services. It also provided the analytical lens for understanding how legal frameworks may fail to translate into reproductive autonomy when they operate within broader systems of gender discrimination.

The study was further guided by a conceptual framework that illustrates the hypothesized relationships between the study variables. The framework conceptualizes contradictions within the legal framework, gender norms and societal beliefs, healthcare providers' conscientious

objection, and related structural barriers as factors that may influence young women's access to safe abortion services. Figure 1 presents the conceptual framework used in the study.

Study design

A mixed-methods research design was employed to examine the influence of contradictory legal frameworks on young women's access to safe abortion services in Kibra Sub-County, Nairobi. The design integrated quantitative and qualitative approaches to provide a comprehensive understanding of the legal, social, and cultural factors influencing abortion access. Quantitative methods were used to examine associations between key study variables, while qualitative methods explored participants' experiences and perceptions regarding abortion laws, gender norms, community attitudes, and access to healthcare services.

Study area and target population

The study was conducted in Kibra Sub-County, Nairobi, an informal settlement characterized by high population density, socioeconomic deprivation, limited health service infrastructure, and elevated rates of unintended pregnancy. The sampling frame was derived from the female population of Kibra (N= 91,569), based on 2019 Kenya National Bureau of Statistics (KNBS) census data¹. The target population comprised young women aged 18–30 years residing in Kibra. Minors under 18 years were excluded due to ethical requirements regarding parental consent.

Sample size, sampling, and eligibility criteria

The quantitative sample size was determined using Taro Yamane's (1967) formula at a 94% confidence level with a 6% margin of error ($e = 0.06$), based on Kibra's female population (N = 91,569):

$$n = \frac{N}{1 + N(e)^2}$$

$$\text{Substituting values: } n = \frac{91,569}{1 + 91,569(0.06)^2} = \frac{91,569}{1 + 91,569(0.0036)} = \frac{91,569}{330.6484} = 215.753 \\ \approx 216$$

Thus, a final sample size of $n = 216$ respondents was established.

Sampling combined cluster and purposive sampling techniques. Cluster sampling grouped participants geographically by ward and demographic categories (age group and marital status),

after which clusters were randomly selected. Purposive sampling was used to recruit key informants, including healthcare providers, county health officers, policymakers, and religious leaders.

Data collection and research instruments

Data was collected using self-administered questionnaires, focus group discussions (FGDs), and key informant interviews (KIIs). The questionnaire included closed-ended and open-ended questions, checklist questions, and five-point Likert-scale items. These were used to collect information on socio-demographic characteristics, knowledge of abortion laws, gender norms, societal beliefs, and experiences of accessing safe abortion services.

FGDs were conducted using vignette-based fictional scenarios relating to abortion, followed by guided discussions. Participants were invited to reflect on the scenarios and discuss how the issues represented in the vignettes were experienced or understood within their communities. This approach generated in-depth information on participants' views, perceptions, and experiences regarding access to safe abortion services. KIIs were conducted with healthcare providers, county health officers, policymakers, and religious leaders. These interviews explored participants' knowledge and interpretation of existing abortion laws, healthcare providers' practices, community beliefs and norms, and factors perceived to support or hinder young women's access to safe abortion services. The use of multiple data collection methods enabled triangulation across different participant groups and data sources.

Reliability and validity

The questionnaire was pre-tested to assess the clarity, cultural appropriateness, and relevance of the research instruments to the study objectives. Feedback from the pilot exercise informed the refinement of questions, clarification of key terms, and improvement of the instruments before data collection. Internal consistency of the questionnaire was assessed using Cronbach's alpha. A reliability coefficient of 0.70 was obtained, which was considered acceptable for the study.

Data analysis

Quantitative data were coded and analyzed using the Statistical Package for the Social Sciences (SPSS), version 26. Descriptive statistics, including frequencies, percentages, and means, were used to summarize participants' socio-demographic characteristics and key study variables. Chi-square tests and independent-samples *t*-tests were conducted to examine associations and

differences between relevant variables. Firth logistic regression was used to assess the influence of gender norms and societal beliefs on attitudes towards safe abortion.

Qualitative data from the FGDs and KIIs were analyzed thematically to identify patterns relating to legal ambiguity, gender norms, community perceptions, healthcare providers' practices, and barriers to accessing safe abortion services. Findings from the quantitative and qualitative components were subsequently triangulated to provide an integrated understanding of the factors influencing young women's access to safe abortion services.

Ethical considerations

Ethical approval for the study was obtained from the Egerton University Ethics Review Committee and the National Commission for Science, Technology and Innovation (NACOSTI) before data collection. Participants provided written informed consent before participating in the study. Participation was voluntary, and confidentiality was maintained throughout the research process. Participants were informed of their right to withdraw from the study at any time without consequence.

III. FINDINGS

The findings are presented according to the study objectives: legal awareness and understanding of abortion laws; the influence of gender norms and societal beliefs; healthcare workers' conscientious objection and access to services; and lessons from the comparative analysis of Kenya and South Africa.

Legal awareness and understanding of abortion laws

The study found limited awareness of Kenya's legal framework on abortion among the young women surveyed. More than half of respondents (53.7%) were unaware of the laws governing abortion, while 46.3% reported some knowledge of the legal framework. Among those with some knowledge, understanding was primarily shaped by cultural beliefs (45.3%), followed by the Constitution (44.2%) and religious teachings (10.5%). This suggests that young women's understanding of abortion is frequently mediated through socio-cultural beliefs rather than formal legal knowledge.

Community sensitization programmes were the main source of information on abortion laws (49.54%), followed by friends (24.54%). Relatively few respondents obtained information through schools (4.17%), parents (6.94%), radio (1.85%), or social media (8.80%). A

statistically significant association was found between familiarity with abortion laws and understanding of the constitutional circumstances under which abortion is permitted in Kenya ($\chi^2 = 19.1222$, $p = 0.001$). Respondents with greater familiarity with the legal framework demonstrated a better understanding of the circumstances under which abortion may be legally permitted. Overall, the findings indicate that limited legal literacy, combined with contradictions and uncertainty within the broader legal framework, may restrict young women's ability to understand and exercise their reproductive rights.

Gender norms, societal beliefs and attitudes towards safe abortion

The findings demonstrated that attitudes towards safe abortion were shaped by gender norms, social beliefs, and the local contexts in which young women lived. Perceptions of whether abortion laws were clear and understandable varied significantly across the study wards ($\chi^2 = 21.7744$, $p = 0.040$). Similarly, perceptions that contradictions in abortion laws contribute to abortion-related stigma differed significantly across wards ($\chi^2 = 30.3561$, $p = 0.002$), as did respondents' experiences of accessing safe abortion services ($\chi^2 = 24.4477$, $p = 0.018$).

These findings suggest that experiences of legal ambiguity and abortion-related stigma are not uniform. Rather, they are shaped by different community environments, gender norms and local attitudes towards young women's sexuality and reproductive decision-making.

The independent-samples *t*-test found no significant difference between respondents with high and low attitudes towards safe abortion regarding whether abortion laws were clear and understandable ($p = 0.8327$). This suggests that uncertainty regarding Kenya's abortion laws was experienced across respondents regardless of their overall attitudes towards safe abortion. However, perceptions that contradictions in abortion laws contribute to stigma and bias differed significantly according to attitudes towards safe abortion ($t = 1.7736$, $p = 0.0414$). Respondents who perceived legal contradictions as contributing to abortion-related stigma were more likely to demonstrate positive attitudes towards safe abortion. Firth logistic regression further identified marital status, perceptions of legal ambiguity, and perceptions of abortion-related stigma as factors associated with attitudes towards safe abortion. In particular, respondents who disagreed that contradictions in abortion laws contribute to stigma had significantly lower odds of expressing positive attitudes towards safe abortion ($\beta = -6.017$, $p = 0.046$).

Taken together, these findings demonstrate the interaction between legal ambiguity and gender norms. Legal uncertainty operates within broader social contexts where cultural and religious beliefs influence perceptions of abortion, contributing to stigma and shaping young women's reproductive autonomy.

Healthcare workers' conscientious objection and access to safe abortion services

Most respondents (77.78%) had not attempted to access safe abortion services, while 22.22% reported having sought such services. Among those who had accessed abortion-related services, sub-county health facilities were the most commonly reported source (40.28%), followed by community health outreach programmes (24.07%) and community centres (14.81%). A smaller proportion reported accessing abortion-related services through digital platforms (12.50%).

Respondents identified multiple barriers to accessing safe abortion services, including stigma from healthcare providers, consent-related barriers, lack of information, costs, stock-outs of essential commodities, and other health system constraints. Community attitudes also presented an important barrier, with 42.59% reporting that abortion was commonly viewed within their communities as a sin and that young women should not access abortion services.

Knowledge of healthcare workers' conscientious objection was limited. Nearly two-thirds of respondents (65.87%) were unaware that healthcare providers may refuse to provide certain services on personal or religious grounds. Despite this limited awareness, most respondents supported referral to another healthcare provider or facility where conscientious objection was exercised. The association between respondents' previous access to safe abortion services and their views on referral was not statistically significant ($\chi^2 = 11.8147, p = 0.167$).

However, respondents who had previously attempted to access safe abortion services differed significantly from those who had not in their views on referral to alternative facilities ($t = 4.7135, p < 0.001$). They also differed significantly in their perceptions of community attitudes towards young women seeking abortion services ($t = 2.1923, p = 0.0147$).

The findings suggest that conscientious objection cannot be considered in isolation from the broader structural environment surrounding abortion access. When combined with stigma, negative community attitudes, limited information, and health system barriers, healthcare providers' refusal to provide services may further constrain young women's access to safe abortion.

Comparative analysis of Kenya and South Africa

The comparative desk review identified important differences between Kenya's and South Africa's legal approaches to abortion. South Africa's legal framework provides clearer and broader protections for reproductive autonomy through constitutional guarantees and the Choice on Termination of Pregnancy Act. The transition from a restrictive legal framework to a more liberal approach was associated with substantial reductions in mortality linked to unsafe abortion. However, the comparative analysis also demonstrated that progressive legislation alone does not guarantee universal access to safe abortion services. South Africa continues to experience barriers related to stigma, conscientious objection, health system constraints, and socio-cultural opposition. The comparison therefore suggests that Kenya's efforts to improve access to safe abortion services require more than constitutional protection. Lessons from South Africa point to the importance of greater alignment of the laws, clearer implementation mechanisms, legal literacy, accountability, and health system responses that address the social and structural barriers affecting young women.

Summary of key findings

Overall, the findings demonstrate that access to safe abortion among young women in Kibra is shaped by the interaction of legal, social, and institutional factors. Limited legal literacy and uncertainty regarding abortion laws intersect with gender norms, abortion-related stigma, community attitudes, healthcare providers' practices, and structural barriers. These factors collectively influence young women's understanding of their reproductive rights and their ability to access safe abortion services.

IV. DISCUSSION

This study examined how contradictions within Kenya's legal framework, gender norms, healthcare providers' conscientious objection, and broader social and institutional barriers shape young women's access to safe abortion services in Kibra. The findings demonstrate that access to safe abortion is not determined by the legal framework alone. Rather, reproductive autonomy is shaped by the interaction between legal knowledge, gender norms, stigma, community attitudes, healthcare practices, and structural barriers.

Legal ambiguity and reproductive autonomy

The findings revealed limited awareness of Kenya's abortion laws among young women, with more than half of respondents reporting no knowledge of the legal framework. Even among those who reported some knowledge, understanding was often shaped by cultural and religious beliefs rather than constitutional provisions. The significant association between familiarity with abortion laws and understanding of the constitutional grounds under which abortion may be permitted further demonstrates the importance of legal literacy in enabling young women to understand their reproductive rights. These findings suggest that the existence of constitutional protections does not necessarily translate into meaningful access to reproductive healthcare. Where legal provisions are poorly understood or appear to conflict with criminal provisions, young women may be uncertain about whether abortion is lawful and under what circumstances services can be accessed. This uncertainty may discourage young women from seeking information or healthcare services and may reinforce reliance on informal sources of information.

The findings therefore highlight the gap between the formal existence of reproductive rights and their practical realization. Legal protections must be accompanied by accessible and accurate information that enables young women to understand how those rights apply in practice. Improving legal literacy should therefore be considered an important component of strengthening reproductive autonomy and access to safe abortion services.

Gender norms, stigma and the social context of abortion

The study further demonstrates that legal ambiguity operates within a broader social environment shaped by gender norms, religious beliefs, and community attitudes. Respondents' perceptions of legal clarity, abortion-related stigma, and experiences of accessing services varied significantly across the study wards, demonstrating that access to safe abortion is also influenced by local social contexts. The association between perceptions of legal contradictions and abortion-related stigma is particularly important. Legal ambiguity may reinforce existing negative attitudes towards abortion by creating uncertainty over whether young women are entitled to seek services. Within social contexts where young women's sexuality and reproductive choices are already subject to social regulation, uncertainty about the law can further contribute to judgement, stigma, and silence.

The regression findings similarly suggest that attitudes towards safe abortion are associated with marital status and perceptions of legal ambiguity and stigma. These findings reinforce the feminist positioning of this study by demonstrating that reproductive decisions are not made independently of broader social and gendered power relations. Young women's reproductive autonomy is shaped by how gender norms, social expectations, and legal environments interact. The findings therefore suggest that legal reform alone is unlikely to eliminate barriers to abortion access. Interventions must also address the gender norms and religious beliefs that stigmatize abortion and constrain young women's ability to make independent reproductive decisions.

Conscientious objection and continuity of care

Awareness of healthcare workers' conscientious objection was generally low among respondents. This is significant because young women who are unaware that healthcare providers may refuse services on personal or religious grounds may also be unfamiliar with the procedures available to them when such refusals occur. Although the association between previous attempts to access safe abortion services and views on referral following conscientious objection was not statistically significant, respondents generally supported referral to another provider or facility where a healthcare worker declined to provide services.

Furthermore, respondents who had previously attempted to access services differed significantly from those who had not in their views on referral and community attitudes towards young women seeking abortion services. These findings highlight the importance of continuity of care. Conscientious objection should not result in the abandonment of young women seeking reproductive healthcare, particularly where delays or denial of information may increase health risks. Within the context of this study, conscientious objection intersects with other barriers, including provider stigma, limited information, costs, community attitudes, and consent-related barriers.

The findings therefore suggest that attention should focus not only on whether healthcare providers exercise conscientious objection, but also on how health systems respond when this occurs. Clear referral pathways, accurate information, confidentiality, and non-judgemental care are important for ensuring that individual providers' beliefs do not result in unnecessary barriers to accessing safe abortion.

Lessons from South Africa: legal reform and implementation

The comparative analysis of South Africa demonstrates the importance of coherent and clearly articulated legal protections for reproductive autonomy. South Africa's transition from a restrictive legal framework to the Choice on Termination of Pregnancy Act created broader legal protections for abortion and contributed to reduction of maternal mortality associated with unsafe abortion. However, the South African experience also demonstrates that progressive laws alone do not guarantee equitable access. Persistent barriers relating to stigma, conscientious objection, health system constraints, and socio-cultural opposition continue to affect access to services.

For Kenya, the key lesson is therefore not simply the adoption of more progressive legal provisions, but the importance of aligning legal protections with effective implementation. This includes alignment between constitutional protections and other legal provisions, clearer guidance for healthcare providers and communities, improved legal literacy, and health systems capable of providing accessible and non-judgemental reproductive healthcare.

The comparison also reinforces the need to move towards a broader reproductive justice perspective which recognizes that legal reforms are not enough to debunk abortion stigma and access but rather couple progressive laws with public awareness, shift in institutional barriers and clear implementation guidelines for healthcare workers to know when and how to provide safe abortion services to young women.

Implications for policy and practice

Pieced together, the findings demonstrate that improving access to safe abortion services requires interventions at multiple levels. Legal clarity must be accompanied by public legal literacy, particularly among adolescent girls and young women. At the community level, interventions should address abortion-related stigma and restrictive gender norms that undermine reproductive autonomy. Within the health system, clear referral mechanisms and rights-based, youth-friendly care are necessary to reduce barriers associated with provider practices and conscientious objection. The findings also highlight the importance of recognizing differences in experiences across local contexts. The significant variations observed across the study wards suggest that national legal and policy interventions should be responsive to the

specific social and institutional environments in which young women seek reproductive healthcare.

Overall, this study supports a reproductive justice approach that situates access to safe abortion within the intersection of law, gender, health, and social inequality. Strengthening reproductive autonomy in Kenya will require not only greater legal coherence but also action to address the social and institutional conditions that determine whether young women can meaningfully exercise their reproductive rights.

V. CONCLUSIONS

This study demonstrates that access to safe abortion services among young women in Kibra is shaped by the interaction of legal, social, and institutional factors rather than by the legal framework alone. Contradictions and ambiguity within Kenya's abortion laws, coupled with limited legal literacy, contribute to uncertainty regarding the circumstances under which abortion may be accessed. This uncertainty may limit young women's ability to understand and exercise their reproductive rights. The findings further demonstrate that gender norms, religious beliefs, community attitudes, and abortion-related stigma continue to shape perceptions and attitudes towards safe abortion. Legal ambiguity may reinforce these existing social norms by creating uncertainty around the legitimacy of young women's reproductive decisions. Consequently, reproductive autonomy is influenced not only by legal jurisprudence but also by the broader gendered norms and social environments in which young women make reproductive decisions.

Healthcare providers' conscientious objection represents an additional barrier when exercised within contexts characterized by stigma, limited information, and structural barriers to healthcare access. The findings underscore the importance of ensuring continuity of care through clear referral mechanisms so that healthcare providers' personal or religious beliefs do not result in unnecessary delays or barriers to accessing reproductive healthcare.

The comparative analysis of South Africa demonstrates the importance of coherent legal frameworks, constitutional protection of reproductive rights, and effective implementation mechanisms. However, the South African experience also shows that progressive legal reform alone is insufficient to guarantee equitable access to safe abortion services. Persistent stigma,

conscientious objection, cultural regression and health system constraints must also be addressed.

Overall, the study concludes that improving access to safe abortion services in Kenya requires a broader reproductive justice approach that goes beyond legal reform. Clarity of the law and public legal literacy should be accompanied by efforts to address gender norms and abortion-related stigma, strengthen health systems, and ensure accessible, confidential, non-judgemental, and rights-based reproductive healthcare for young women. Such an approach recognizes that meaningful reproductive autonomy depends not only on the existence of legal rights but also on the social, cultural, institutional, and political conditions that enable young women to exercise those rights enshrined in international and regional law.

VI. RECOMMENDATIONS

The findings demonstrate that improving young women's access to safe abortion services in Kenya requires interventions that address the legal, institutional, social, and healthcare barriers operating simultaneously. Based on the findings, the study proposes the following recommendations.

Harmonize and clarify Kenya's abortion legal framework

Kenya should harmonize its legal framework on abortion to address contradictions between the Constitution, the Penal Code, the Health Act (2017), and other relevant reproductive health laws and policies. The findings suggest that legal ambiguity contributes to uncertainty among young women, healthcare providers, and other duty bearers regarding the circumstances under which abortion is legally permissible. Harmonization would therefore provide greater clarity for both those seeking and those responsible for providing lawful abortion services.

Develop a comprehensive legal and implementation framework

Parliament and relevant government institutions should consider developing a comprehensive legal and policy framework that operationalises Article 26(4) of the Constitution and provides clear guidance on the provision of safe abortion services. A more coherent framework could reduce inconsistent interpretation and implementation while clarifying the responsibilities of healthcare providers and other duty bearers. Legal reform should also be accompanied by strengthened implementation of national standards and guidelines relating to the prevention of

unsafe abortion. National and county governments should ensure that relevant policies and guidelines are effectively disseminated and operationalized within public health facilities.

Strengthen legal literacy and institutional capacity

The study found limited awareness of abortion laws and constitutional provisions among respondents, with many relying on cultural and social beliefs to interpret the legality of abortion. National and county governments, civil society organizations, community-based organizations, and other relevant actors should therefore strengthen public education and legal literacy initiatives to provide young women and communities with accurate and accessible information. Capacity strengthening should also target healthcare workers, community health workers, policymakers, law enforcement officers, judicial actors, and other duty bearers whose interpretation of abortion laws may influence access to services. Strengthening institutional understanding could promote more consistent interpretation and implementation of the existing legal framework.

Regulate conscientious objection and strengthen referral systems

Clear guidance is needed on the exercise of conscientious objection within reproductive healthcare. Where healthcare providers decline to provide services on grounds of personal or religious beliefs, mechanisms should be in place to ensure timely referral and continuity of care. The Ministry of Health and relevant professional regulatory bodies should therefore strengthen guidelines and accountability mechanisms governing conscientious objection and referral pathways. This would help balance healthcare providers' personal beliefs with young women's need for timely, accurate, and non-discriminatory access to reproductive healthcare.

Strengthen youth-friendly and rights-based SRHR services

National and county health systems should strengthen the availability, accessibility, and acceptability of youth-friendly sexual and reproductive health services. The findings identified confidentiality, respectful and non-judgmental care, counselling, informed consent, and communication that young people can understand as important features of accessible services. Strengthening these elements could improve young women's confidence in seeking reproductive healthcare and reduce barriers associated with fear, stigma, and negative treatment.

Address abortion-related stigma and harmful gender norms

Legal and health-system reforms must be accompanied by efforts to address the social conditions that shape young women's reproductive decisions. The findings demonstrate that

gender norms, societal beliefs, and abortion-related stigma influence attitudes towards safe abortion and may create barriers to accessing services. Government institutions, civil society organizations, religious and cultural leaders, and community-based organizations should therefore collaborate on community dialogue, public education, and gender-transformative interventions aimed at reducing stigma, challenging harmful gender norms, and promoting young women's reproductive autonomy.

VII. REFERENCES

- ACHPR. (n.d.). *of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa AFRICAN COMMISSION ON HUMAN AND PEOPLES' RIGHTS*.
- ACHPR, T. A. C. on H. and P. R. (2014). *of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa AFRICAN COMMISSION ON HUMAN AND PEOPLES' RIGHTS*.
- Alabi, M. A., Bello, B. M., & Maina, B. W. (2024). *GENDER NORMS AND ATTITUDE TOWARDS ABORTION AMONG VERY YOUNG ADOLESCENTS IN KENYA AND NIGERIA*. <https://doi.org/10.1101/2024.04.08.24305479>
- Arroyave, F. A. B., & Gutiérrez, P. A. M. (2018). A Systematic Bibliographical Review: Barriers and Facilitators for Access to Legal Abortion in Low and Middle Income Countries. *Open Journal of Preventive Medicine*, 08(05), 147–168. <https://doi.org/10.4236/ojpm.2018.85015>
- Ayodele Alabi, M., Bello, B. M., & Maina, B. W. (n.d.). *Title Page GENDER NORMS AND ATTITUDE TOWARDS ABORTION AMONG VERY YOUNG ADOLESCENTS IN KENYA AND NIGERIA*. <https://doi.org/10.1101/2024.04.08.24305479>
- Bearak, J. M., Popinchalk, A., Beavin, C., Ganatra, B., Moller, A. B., Tunçalp, Ö., & Alkema, L. (2022). Country-specific estimates of unintended pregnancy and abortion incidence: a global comparative analysis of levels in 2015-2019. *BMJ Global Health*, 7(3). <https://doi.org/10.1136/bmjgh-2021-007151>

- Bearak, J., Popinchalk, A., Ganatra, B., Moller, A. B., Tunçalp, Ö., Beavin, C., Kwok, L., & Alkema, L. (2020). Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019. *The Lancet Global Health*, 8(9), e1152–e1161. [https://doi.org/10.1016/S2214-109X\(20\)30315-6](https://doi.org/10.1016/S2214-109X(20)30315-6)
- Blystad, A., Haukanes, H., Tadele, G., Haaland, M. E. S., Sambaiga, R., Zulu, J. M., & Moland, K. M. (2019). The access paradox: Abortion law, policy and practice in Ethiopia, Tanzania and Zambia. *International Journal for Equity in Health*, 18(1). <https://doi.org/10.1186/s12939-019-1024-0>
- CEDAW. (n.d.). *General comment No. 1: Reporting obligation*.
- CEDAW, C. on the E. of D. A. W. (2018). *Committee on the Elimination of Discrimination Against Women (CEDAW) Contribution to the 2030 Sustainable Development Goals in response to a call for inputs by the High-Level Political Forum on Sustainable Development (HLPF) 27 April 2018*.
- Chandra, A., Satish, M., Shree, S., & Saxena, M. (2021). *Legal Barriers to Accessing Safe Abortion Services in India: A Fact Finding Study*.
- COVAW, C. on V. A. Women. (2023). *The Right to Choose: A Report on the Impact of Government Reservations on Reproductive Rights under the Maputo Protocol in Kenya*.
- Cresswell, J. A., Schroeder, R., Dennis, M., Owolabi, O., Vwalika, B., Musheke, M., Campbell, O., & Filippi, V. (2016). Women's knowledge and attitudes surrounding abortion in Zambia: A cross-sectional survey across three provinces. *BMJ Open*, 6(3). <https://doi.org/10.1136/bmjopen-2015-010076>
- CRR. (2015). *BREAKING GROUND 2015 Treaty Monitoring Bodies on Reproductive Rights Center for Reproductive Rights 1*.
- CRR, C. for R. R. (2010). *IN HARM'S WAY THE IMPACT OF KENYA'S RESTRICTIVE ABORTION LAW*. www.reproductiverights.org
- Groves, A. K., Gebrekristos, L. T., Smith, P. D., Stoebenau, K., Stoner, M. C., Ameyan, W., & Ezech, A. C. (2022). Adolescent Mothers in Eastern and Southern Africa: An Overlooked

- and Uniquely Vulnerable Subpopulation in the Fight Against HIV. *Journal of Adolescent Health*, 70(6), 895–901. <https://doi.org/10.1016/j.jadohealth.2021.12.012>
- Håkansson, M., Super, S., Oguttu, M., & Makenzius, M. (2020). Social judgments on abortion and contraceptive use: A mixed methods study among secondary school teachers and student peer-counsellors in western Kenya. *BMC Public Health*, 20(1). <https://doi.org/10.1186/s12889-020-08578-9>
- ICPD. (2023). *Sub-Saharan Africa*.
- Ipas. (2019). *Experiences of abortion among adolescents and girls*. www.ipas.org
- Johnson, B. R., Kismödi, E., Dragoman, M. V., & Temmerman, M. (2013). S60-S62 CONSCIENTIOUS OBJECTION Special Programme of Research, Development and Research Training in Human Reproduction. In *Obstetrics and Gynecology Commons International Journal of Gynecology and Obstetrics* (Vol. 123). https://ecommons.aku.edu/eastafrica_fhs_mc_obstet_gynaecol
- Koiwa, Y., Shishido, E., & Horiuchi, S. (2024). Factors Influencing Abortion Decision-Making of Adolescents and Young Women: A Narrative Scoping Review. In *International Journal of Environmental Research and Public Health* (Vol. 21, Issue 3). Multidisciplinary Digital Publishing Institute (MDPI). <https://doi.org/10.3390/ijerph21030288>
- Loi, U. R., Gemzell-Danielsson, K., Faxelid, E., & Klingberg-Allvin, M. (2015). Health care providers' perceptions of and attitudes towards induced abortions in sub-Saharan Africa and Southeast Asia: A systematic literature review of qualitative and quantitative data. *BMC Public Health*, 15(1). <https://doi.org/10.1186/s12889-015-1502-2>
- Makenzius, M., Rehnström Loi, U., Otieno, B., & Oguttu, M. (2023). A stigma-reduction intervention targeting abortion and contraceptive use among adolescents in Kisumu County, Kenya: a quasi-experimental study*. *Sexual and Reproductive Health Matters*, 31(1). <https://doi.org/10.1080/26410397.2021.1881208>
- Maluleke, A. R. (2022). *The Status of Women's Health in South Africa: Evidence from selected indicators Statistician-General*. www.statssa.gov.za
- MOH, M. of H. K. (2024). *7th-RANK-SRHR-Conference-Abstract-Booklet*.

- Moradinazar, M., Najafi, F., Nazar, Z. M., Hamzeh, B., Pashar, Y., & Shakiba, E. (2020). Lifetime Prevalence of Abortion and Risk Factors in Women: Evidence from a Cohort Study. *Journal of Pregnancy*, 2020. <https://doi.org/10.1155/2020/4871494>
- National Bureau of Statistics Nairobi, K. (2023). *Kenya Demographic and Health Survey 2022 Key Indicators Report*. www.DHSprogram.com.
- Nickerson, C. (2023). Theory of Reasoned Action (Fishbein and Ajzen, 1975). *Simply Psychology*.
- OHCHR, U. N. H. R. O. of the H. Commissioner. (2018). *General comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life*.
- Opondo, E. (2020). *Perspectives of an SRHR advocate on the impact of the Global Gag Rule in Kenya*.
- Ouahid, H., Mansouri, A., Sebbani, M., Nouari, N., Khachay, F. E., Cherkaoui, M., Amine, M., & Adarmouch, L. (2023). Gender norms and access to sexual and reproductive health services among women in the Marrakech-Safi region of Morocco: a qualitative study. *BMC Pregnancy and Childbirth*, 23(1). <https://doi.org/10.1186/s12884-023-05724-0>
- Panchaud, C., Keogh, S. C., Stillman, M., Awusabo-Asare, K., Motta, A., Sidze, E., & Monzón, A. S. (2019). Towards comprehensive sexuality education: a comparative analysis of the policy environment surrounding school-based sexuality education in Ghana, Peru, Kenya and Guatemala. *Sex Education*, 19(3). <https://doi.org/10.1080/14681811.2018.1533460>
- Saoyo, T. G. (2018). *LEGAL FRAMEWORK ON PROVISION OF SAFE ABORTION IN KENYA SAOYO TABITHA GRIFFITH KELIN 2*.
- Singh, S., Juarez, F., Prada, E., & Bankole, A. (2019). Estimating Abortion Incidence: Assessment of a Widely Used Indirect Method. *Population Research and Policy Review*, 38(3), 429–458. <https://doi.org/10.1007/s11113-019-09517-2>
- Tallarico, R., Ozah, K., & Orievulu, K. S. (2021). Age of consent: A case for harmonizing laws and policies to advance, promote and protect adolescents' sexual and reproductive health rights. *African Journal of Reproductive Health*, 25(2), 94–102. <https://doi.org/10.29063/ajrh2021/v25i2.9>

UN. (2016). *General comment no.22, 2016*.

UNFPA. (2017). *A review of 23 countries in the region Framework for the Harmonization of the Legal Environment on Adolescent Sexual and Reproductive Health in East and Southern Africa 2*.

UNFPA. (2020). *Laws and Policies Impacting Young People's Sexual and Reproductive Health and Rights in the Asia-Pacific*.

UNHCR. (2020). *Human rights bodies have provided clear guidance*.

WHO. (2018). *WHO recommendations on adolescent sexual and reproductive health and rights*.

WHO. (2022). *Abortion care guideline*.

Women Enabled International. (2021). *Women Enabled International accountABILITY toolkit African Regional Human Rights System Legal Standards on the Rights of Women and Girls with Disabilities*. www.womenenabled.org

Yzer, M. (2012). Perceived behavioral control in reasoned action theory: A dual-aspect interpretation. In *Annals of the American Academy of Political and Social Science* (Vol. 640, Issue 1). <https://doi.org/10.1177/0002716211423500>

OHCHR, U. (2016, December 6). *General comment No. 20 (2016) on the implementation of the rights of the child during adolescence*. ohchr. Retrieved August 27, 2024, from <https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-comment-no-20-2016-implementation-rights>

Youth Coalition for Sexual and Reproductive Rights. (2023, June): *Bodily Autonomy Toolkit*. <https://www.youthcoalition.org/our-toolkits-advocacy-resources>. <https://static1.squarespace.com/static/61e1b12a508a8863b0dded9a/t/649f651984e7ea754f404f05/1688167708718/BodilyAutonomyToolkit.pdf>

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review*, 43(6), 1241–1299. <https://doi.org/10.2307/1229039>

- CRR. (n.d.). *Law and Policy Guide: Criminality*. Center for Reproductive Rights. <https://reproductiverights.org/maps/worlds-abortion-laws/law-and-policy-guide-criminality/>
- WHO. (2024, May 17). *Abortion*. World Health Organization (WHO). <https://www.who.int/news-room/fact-sheets/detail/abortion>
- Youth Coalition for Sexual and Reproductive Rights. (2023, June). *Bodily Autonomy Toolkit*. <https://www.youthcoalition.org/our-toolkits-advocacy-resources.https://static1.squarespace.com/static/61e1b12a508a8863b0dded9a/t/649f651984e7ea754f404f05/1688167708718/BodilyAutonomyToolkit.pdf>
- Blum, R. W., Mmari, K., & Moreau, C. (2017). It begins at 10: How gender expectations shape early adolescence around the world. *Journal of Adolescent Health*, 61(4), S3-S4.
- UN Women. (2020, December). *Gender Equality Glossary | UNW WRD Knowledge Hub*. Women's Resilience to Disasters Knowledge Hub. <https://wrд.unwomen.org/practice/resources/gender-equality-glossary>
- Center for Reproductive Rights. (2022). *Supreme Court Case: Dobbs v. Jackson Women's Health Organization*. Center for Reproductive Rights. Retrieved October 11, 2024, from <https://reproductiverights.org/case/scotus-mississippi-abortion-ban/>
- CRR. (2022). *Abortion in Kenya*. Center for Reproductive Rights. Retrieved October 11, 2024, from <https://reproductiverights.org/kenya-abortion/>
- Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a Field of Intersectionality Studies: Theory, Applications, and Praxis. *Signs*, 38(4), 785–810. <https://doi.org/10.1086/669608>
- Oaknín, M., & Castro, O. (2024). Translating intersectional feminism: a ‘modern’ language classroom. In M. Oaknín & A. B. García-Escribano (Eds.), *Inclusion, Diversity and Innovation in Translation Education* (pp. 177–198). UCL Press. <https://doi.org/10.2307/jj.13027283.16>
- ACHPR. (2022, September 28). *Statement by the Special Rapporteur on the Rights of Women in Africa, on the Occasion of the "Global Day of Action for Access to Safe and Legal Abortion"*. African Commission on Human and Peoples' Rights. Retrieved November 3,

2024, from <https://achpr.au.int/en/news/press-releases/2022-09-28/rights-women-africa-global-day-action-access-safe-legal-abortion>

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Table 1: Legal frameworks addressing abortion in Kenya

Awareness about abortion laws	Frequency	Proportion
Yes	100.00	46.30
No	116.00	53.70
Laws Familiar With		
Abortion based on the constitution	82.00	44.20
Abortion based on religion	19.00	10.50
Abortion based on cultural beliefs	82.00	45.30
The Channel of Awareness		
Through a Friend	53.00	24.54
From Parents	15.00	6.94
Family Members not Parents	9.00	4.17
From School	9.00	4.17
Through Community Sensitizations	107.00	49.54
Through Radio	4.00	1.85
Through Social-Media	19.00	8.80

Aware Constitution guarantees right to abortion

Yes	57.00	26.39
No	159.00	73.61
Parameters for abortions in constitution		
When the woman's health is in danger	31.00	54.39
Abortion is a right to health for the woman	21.00	36.84
Upon discretion of the health practitioner	5.00	8.77

Table 2: Association between respondents' familiarity with abortion laws and knowledge of constitutional abortion provisions

Laws familiar with		Abortion laws from Constitution		Abortion laws under religion		Abortion laws under cultural beliefs		Total	
Parameter for abortion in constitution		Freq.	%	Fre q.	%	Fre q	%	Fr eq	%
When the women's health is in danger		23.00	57.50	0.00	0.00	8.00	61.40	31.00	54.39
Abortion is a right to health for the woman		16.00	40.00	4.00	100.00	1.00	7.69	21.00	36.84
Upon discretion of the health practitioner		1.00	2.50	0.00	0.00	4.00	30.77	5.00	8.77
$\chi^2=19.1222, P=0.001$									

Table 3: Descriptive Statistics for healthcare workers conscientious objection

Variable	Frequency	Percent
Access to safe abortion services		
Yes	48.00	22.22
No	168.00	77.78
Place where Safe abortion service was sought		
Sub-county Health Facility	87.00	40.28
Community Health Outreach	52.00	24.07
Community Centre	32.00	14.81
Youth Centre	14.00	6.48
Village Health Team	4.00	1.85
Digital Platforms	27.00	12.50
Reasons that justify abortion among adolescents		
Avoid unwanted pregnancies	45.00	20.83
In cases of rape, defilement, or incest	57.00	26.39
Pregnancy endangers the health either mother or foetus	78.00	36.11
In case of acute poverty	8.00	3.70
Keep a girl in School	4.00	1.85
If it is an adolescent	1.00	0.46
All the above reasons	23.00	10.65
Awareness about health workers right to conscientious objection due to personal or religious beliefs		
No	145.00	65.87
Yes	71.00	34.13
Some cases of conscientious rights as per the respondents		
Interaction with healthcare professionals and advocacy groups	30.00	42.25

Underlying health complications	29.00	40.85
Low self-efficacy of healthcare workers	12.00	16.90
Community perception about young women who access safe abortion		
Safe abortion is a sin and should not be accessed by young women	92.00	42.59
Safe abortion should be accessed only by married young women	20.00	9.26
Safe abortion should only be accessed after parental or spousal consent	48.00	22.22
Safe abortion should be accessible to all groups of adolescents and young women	46.00	21.30
Don't know	10.00	4.63

Table 4: Association between denial of safe abortion due to healthcare providers' conscientious objection and referral of young women to alternative health facilities

	Yes		No		Prefer not to say		Total	
Healthcare workers who refuse to provide abortion services should refer adolescent girls to other facilities	Fr	%	Fr	%	Fr	%	Fr	%
Strongly Agree	10	30	38	24		36	57	26
	.0	.3	.0	.0	9.	.0	.0	.3
	0	0	0	5	00	0	0	9
Agree	15	45	61	38		16	80	37
	.0	.4	.0	.6	4.	.0	.0	.0
	0	5	0	1	00	0	0	4
Neutral		18	31	19		32	45	20
	6.	.1	.0	.6	8.	.0	.0	.8
	00	8	0	2	00	0	0	3

Disagree			18	11		16	24	11
	2.	6.	.0	.3	4.	.0	.0	.1
	00	06	0	9	00	0	0	1
Strongly Disagree			10				10	
	0.	0.	.0	6.	0.	0.	.0	4.
	00	00	0	33	00	00	0	63
$\chi^2=11.8147, P=0.167$								

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Figure 1. Conceptual framework illustrating the relationships between contradicting legal frameworks, gender norms, socio-demographic factors, and access to safe abortion services.

Figure 2. Reported barriers to accessing safe abortion services among adolescent girls and young women in Kibra Sub-County, Nairobi.

FIGURES

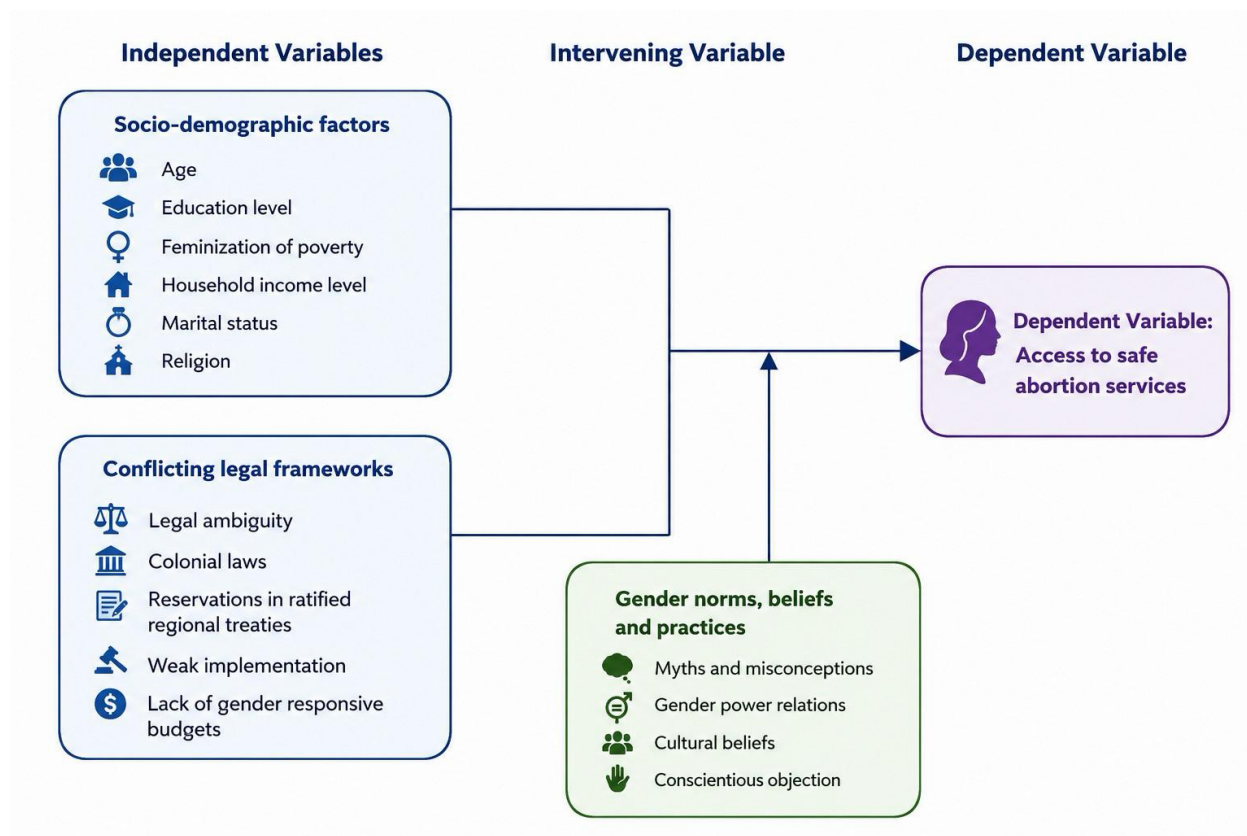


Figure 1: Conceptual framework

