

Unsafe Abortion in Kenya

Though pregnancy termination is highly restricted in Kenya, induced abortion remains common. Illegal abortion is often unsafe, putting women at risk of death or severe complications. In eastern Africa as a whole, an estimated 14% of all pregnancies end in abortion,¹ and nearly one in five maternal deaths are due to unsafe abortion.²

Virtually all abortion-related deaths and health problems are preventable, as are most of the unintended pregnancies that lead to abortion. More than 40% of births in Kenya are unplanned, and one in four married women have an unmet need for contraceptives.³ In fact, the level of unmet need has changed little since 1998.⁴ This report summarizes research evidence on abortion in Kenya, points out existing gaps in knowledge and highlights key areas in which new research could help to reduce levels of unsafe abortion in Kenya.

Abortion in Kenya is legally restricted and controversial.

Induced abortion is legally permitted in Kenya if it is necessary to save a woman's life.*⁵ In such cases, the abortion must be performed by a certified physician and in a hospital; in addition, two registered medical practitioners must concur that continuation of the pregnancy would pose a risk to the woman's life. These requirements and any bias against abortion among medical personnel likely act as

serious economic and logistical barriers to safe, legal pregnancy termination among poor women.

Publicly available, national-level information on attitudes about abortion and the conditions under which the procedure should be legal is lacking, but a handful of small-scale surveys and qualitative studies shed light on Kenyans' varying views on abortion. For example, a recent study in Nyeri district showed that older women and men were generally aware that abortion occurs in the community, yet they had profound differences in the way they viewed the procedure.⁶ Older women saw abortion in rather pragmatic terms, as a response to the socioeconomic burdens of having another child or having a child too soon. In contrast, men generally viewed abortion as a woman's strategy to conceal the consequences of premarital or extramarital sex.

Views among medical personnel are also divided. A 1990 study in Nairobi found that nearly two in three medical personnel (physicians, clinical officers and nurses) from four specialties (obstetrics and gynecology, pediatrics, surgery and general medicine) had encountered abortion patients in their daily work.⁷ The medical

professionals were evenly divided in their support for liberalizing Kenya's abortion law (doctors were the most supportive), but held generally negative attitudes about abortion. Further research is needed to elucidate the beliefs behind these negative attitudes.

Negative views on abortion may limit women's access to emergency contraception, making it harder for them to prevent pregnancy in the first place. In a study in two hospitals in Nairobi, almost half of the surveyed nurses and nursing students thought emergency contraception was an abortifacient.⁸ Those who believed this were less likely to recommend or intend to provide emergency contraception to patients in the future than those who did not hold this misperception.

Abortion is prevalent in Kenya.

In eastern Africa as a whole, the estimated number of induced abortions in 2003 was 2.3 million, or 39 abortions per 1,000 women of reproductive age (about 20 per 100 live births; Table 1, page 2). Studies over the past two decades suggest that unsafe abortion occurs at a significant level in Kenya, as well. The only national estimate of abortion in Kenya is based on a study of women with abortion-related complications who were admitted to public hospitals over a three-month period in 2002. The study estimated that 316,560 spontaneous and induced abortions occur in Kenya annually—46 for every 1,000 women of reproductive age (or about 29 abortions for every 100 live births).⁹ Measuring abortion is very challenging in settings like Kenya, where induced abortion is highly restricted, and this study relied on assumptions about

*Kenya, like a number of Commonwealth countries whose legal systems are based on English common law, follows the holding of a 1938 English legal decision that would permit abortion to preserve a woman's physical or mental health, but it is not known to what degree this is implemented in practice.

Unplanned Births, Contraceptive Use and Abortion

Kenyan women experience high levels of unintended pregnancy and abortion

Unplanned births	
Among women aged 15–49	
Percentage of births that are unplanned (unwanted or mistimed; 2003)	44.5
Percentage unwanted	19.6
Percentage mistimed	24.9
Among adolescents aged 15–19	
Percentage of births that are unplanned (unwanted or mistimed; 2003)	46.6
Percentage unwanted	20.5
Percentage mistimed	26.1
Contraceptive use	
Total contraceptive prevalence rate (2003)	39.3
Any modern method	31.5
Any traditional method	7.8
Percentage of currently married women with an unmet need for a contraceptive method (2003)	24.5
Abortion incidence	
Estimated number of induced abortions in eastern Africa (2003)	2,300,000
Induced abortion rate in eastern Africa (no. of abortions per 1,000 women aged 15–44; 2003)	39
Induced abortion ratio in eastern Africa (no. of abortions per 100 live births; 2003)	20
Percentage of pregnancies ending in induced abortion in eastern Africa (2003)	14
Total number of abortions (spontaneous and induced) in Kenya (2003)	316,560
Abortion rate (no. of spontaneous and induced abortions per 1,000 women aged 15–49; 2003)	45.9
Abortion ratio (no. of spontaneous and induced abortions per 100 live births; 2003)	29.1
Consequences of unsafe abortion	
No. of women hospitalized for induced abortion complications in eastern Africa (2000)	612,940
Percentage of maternal deaths due to unsafe abortion in eastern Africa (2003)	17
No. of women admitted to public hospitals for abortion-related complications in Kenya (2002)	20,893
Estimated number of maternal deaths in Kenya (2005)	7,700
Adjusted maternal mortality ratio in Kenya (deaths per 100,000 live births; 2005)	560

Sources: **Unplanned births and contraceptive prevalence**—reference 25. **Unmet need**—reference 4. **Number of abortions and percentage of pregnancies ending in abortion (regional)**—reference 1. **Abortion rate, abortion ratio and abortion-related maternal mortality (regional)**—reference 2. **Abortion incidence (Kenya)**—reference 9. **Abortion complications (regional)**—reference 26. **Abortion complications (Kenya)**—reference 13. **Maternal mortality (Kenya)**—reference 23.

Access to postabortion care and family planning is limited.

Postabortion care, including the use of manual vacuum aspiration, is a key part of the most recent Kenyan reproductive health plan, but several studies indicate that treatment for abortion complications is less than satisfactory. In 2004, a systematic national assessment

of service provision showed that only 16% of facilities offering delivery services had a vacuum aspirator and 14% had a dilation and curettage kit.¹⁹ Such provisions are probably especially limited in rural areas, where, in 2005, experts rated access to treatment for abortion complications as less than half that for urban settings.²⁰ A detailed 2002 assessment of

the proportion of women who experienced complications but were not treated at public hospitals, including those who went to private facilities for treatment and those who did not require hospitalization.

Women of all ages obtain abortions.

While older and small-scale studies have indicated that young, unmarried women are the main recipients of postabortion care in hospitals,^{10,11} more recent and larger studies show that older and married women also often come to health facilities with complications due to abortion. For example, a study of admissions in five Kenyan hospitals in 1996–1997 showed that 71% of women were married and 67% were already mothers; only one in five women were younger than age 20.¹² In 2002, a larger, national-level study* of women admitted to public hospitals for abortion-related complications showed that patients were diverse in age.^{9,13} Forty percent of women were 25–34 years old, and almost as many women were older than 34 (12%) as were in their teens (16%). Women in the study had had an average of three prior pregnancies.

These empirical studies rely on data from women who are admitted to public health facilities for complications; they exclude women who are treated at private facilities, as well as those who do not seek care at any health facility. However, these are acceptable limitations

*This is the largest study of abortion in Kenya thus far in terms of health facilities involved. Sixty-three hospitals were selected and 60 ultimately provided data (including two hospitals randomly drawn from a list of all district hospitals to replace two that had declined to participate after selection).

given the difficulty of obtaining valid abortion-related information where the procedure is generally illegal and highly stigmatized.

Women seek abortions for different reasons and from different sources.

Demand for pregnancy termination is high, despite the risks of unsafe abortion, and women have varied reasons for pursuing an abortion. Several small qualitative studies have investigated these reasons.

Adolescents and young unmarried women reported being motivated by the stigma attached to bearing a child outside of marriage, their inability to support a child, and the possibility that they would have to quit school and thus limit their socioeconomic opportunities.^{7,9,14,15} Among older and married women, common reasons included economic hardship and the desire to space the births of their children.^{9,15,16}

Small-scale, community-based qualitative studies of women who report having had an induced abortion show that women obtain abortions from a wide range of providers, including medical practitioners in private clinics, midwives, and traditional herbalists and other untrained providers, or they induce abortion themselves.^{15,17} These and other local studies suggest that despite the potential danger of a procedure performed by an untrained provider, cost, stigma and desperation to end an unwanted pregnancy often steer women and girls to these cheaper and more covert abortion providers in the community.^{15,17,18}

postabortion care in two provinces found that private-sector facilities handled more than half of the postabortion care caseload, despite the fact that private-sector services cost patients about three times more than public sector care.²¹

A key to preventing unsafe abortion—and an important component of comprehensive postabortion care—is providing family planning counseling and methods. A study in six Kenyan hospitals in the early 1990s demonstrated the effectiveness of linking these services. These findings led the Ministry of Health to incorporate contraceptive services into their postabortion care expansion for district hospitals,¹² but years later, experts still gave middling ratings on postabortion contraceptive services in Kenyan health centers and district hospitals.²⁰ Given this situation and the persistently high levels of unmet need for contraceptives among Kenyan women, the Ministry of Health has specifically acknowledged that the types of methods available, supplies of available methods and health provider training on contraception were limited in the country; it established guaranteed contraceptive commodity security and strengthened family planning services as high priority action items in the most recent Kenyan Reproductive Health Policy, published in 2007.²²

Abortion is costly to women and society in Kenya.

There is very little information about the costs of unsafe abortion in Kenya, whether they be the cost to the government of treating complications or the costs to a woman and her family,

which can include time off from work, travel, long-term health problems, social stigma and infertility, in addition to the monetary costs of the procedure and postabortion care.

The most recent study on the cost to the government of postabortion care, which used data from 2002, estimated that 60% of postabortion care costs incurred by public hospitals went to treating probable unsafe abortions (1,130 Kenyan shillings per patient requiring postabortion care).⁹ The cost to women of the actual abortion procedure varies greatly. Some small-scale studies show that, in Kenya, an abortion by a skilled provider is much more expensive than a procedure by an unskilled provider or the dangerous or ineffective methods that women may first try themselves.^{15,16} Because the cost of safer procedures may be prohibitive to some, there are likely large differences in economic status between women who can obtain an abortion by a qualified health provider—or even obtain an abortion within the legal scope of Kenyan law—and those who risk their lives to induce abortion on their own or seek the services of dangerously unskilled providers.

Unsafe abortion carries severe consequences for women.

The most severe consequence of unsafe abortion is death. In eastern Africa in 2003, almost one in five maternal deaths were due to unsafe abortion (Table 1).² The overall maternal mortality ratio in Kenya stands at 560 deaths per 100,000 live births.²³ A Kenyan woman has a one in 39 chance of dying from pregnancy-related causes.

Abortion-related hospitalizations are another indicator of the severe health consequences of unsafe abortion. Nationally, nearly 21,000 women are estimated to be admitted each year to Kenya's public hospitals for treatment of complications from incomplete abortion, either spontaneous or induced.⁹ The 2002 national study generating that estimate also found that 28% of women hospitalized had severe complications (e.g., uterine perforation and shock).⁹ Notably, about one-third of women with complications had reached the second trimester, meaning that they were at increased risk of morbidity (compared with women who have earlier abortions) and may have experienced a delay in seeking care. Another 2002 study found that 43% of patients admitted to gynecological wards in a referral hospital in Western Province were admitted for abortion-related complications, the most common diagnosis, and the majority of them were from rural areas (65%), were or had been married (59%), and were housewives or unemployed (71%).²⁴

More research is needed.

While there are many research gaps and much existing evidence needs to be updated, the following areas of research have particularly great potential to support productive policy discussions and improve services for Kenyan women's health.

- *Uncovering the costs to the Kenyan health care system.* It is not known how much the government is currently spending to treat the complications of unsafe abortion. Calculating these costs and comparing

them to the price of preventing more unintended pregnancies (by investing in contraceptive supplies, counseling services, and information and education) could alert policymakers to the financial benefits of preventing unsafe abortion.

- *Linking poverty and unsafe abortion.* Empirical data showing the degree to which poor women suffer abortion-related complications compared with wealthier women would highlight for the Kenyan public, parliamentarians and other policymakers the economic inequities fostered by the current health care system and by the implementation of sexual and reproductive health care, in particular.

- *Documenting the role of stigma in access to safe abortion.* Data on the ways that stigma shapes the abortion debate and affects access to safe abortion and postabortion care in Kenya could help inform communications efforts with various audiences, such as health providers and policymakers, to reduce unsafe abortion and associated morbidity and mortality through more targeted messaging and approaches.

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Advancing sexual and reproductive health worldwide through research, policy analysis and public education

New York

125 Maiden Lane, New York, NY 10038
Tel: 212.248.1111
Fax: 212.248.1951
info@guttmacher.org

Washington D.C.

1301 Connecticut Avenue, N.W., Suite 700
Washington, DC 20036
Tel: 202.296.4012, Fax: 202.223.5756
policyinfo@guttmacher.org

www.guttmacher.org