

Abortion and Unintended Pregnancy in Kenya

Unintended pregnancy and unsafe abortion are common in Kenya, leading to high levels unplanned births and avoidable maternal injury and death. Until recently, abortion was only legally permissible to save the life of a woman, but a new constitution adopted in 2010 includes language that makes abortion available to protect a woman's health.

In Kenya, abortion is common and is almost always illegal and unsafe, according to the World Health Organization's definition: "carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both."^{1(p. 2)} Remarkably, nearly all ill-health and mortality resulting from abortion is preventable, as are most of the unintended pregnancies associated with abortion.² This report summarizes evidence on the context and consequences of unsafe abortion in Kenya, pointing out knowledge gaps and highlighting implications for improvements in policies and programs to reduce unintended pregnancy and unsafe abortion.

Abortion is now legal to protect the health and life of a pregnant woman.

In 2010, Kenya adopted a new constitution that provides stronger protection for the lives and health of women.³ Whereas the prior law only allowed abortion to protect the pregnant woman's life, the new constitution explicitly permits abortion when "in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the [pregnant woman] is in danger,

or if permitted by any other written law."^{3,4} The constitution also states that "a person shall not be denied emergency treatment."³ However, it is unclear how widely the new abortion law is understood or practiced within the medical community. Furthermore, sections of the Kenyan penal code have not been revised to reflect the language of the new law, and medical providers may be reluctant to perform abortion for any reason for fear of legal consequences, even though these penalties do not apply to the provision of legal abortions.⁵ The Kenyan penal code currently lists self-inducing abortion, or providing any other type of "unlawful" abortion, as felonies punishable by a 7–14-year prison sentence.

Unsafe abortion is prevalent in Eastern Africa and Kenya.

Even though induced abortion is highly restricted in most of Eastern Africa, an estimated 2.4 million unsafe induced abortions occurred in the region in 2008 (Table 1, page 2),¹ representing a slight increase since 2003.⁶ The rate of unsafe abortion is 36 per 1,000 women of reproductive age, and although this rate has declined since 2003, it remains the highest among all subregions in the world.¹

The only national estimate of abortion in Kenya is based on a study of women who were treated in public hospitals for abortion-related complications over a three-month period in 2002.⁷ According to that study, more than 300,000 abortions occur in Kenya annually, or 46 per 1,000 women of reproductive age.* The study, however, did not differentiate between induced abortions and miscarriages, and the true incidence of induced abortion is yet unknown.

Because abortion is highly restricted and stigmatized in Kenya, measuring abortion levels is challenging, and underreporting is common. A 2009–2010 study conducted in four poor urban settlements in Nairobi asked women about pregnancy and pregnancy loss.⁸ Of the 200 women who had experienced a pregnancy loss, fewer than 4% characterized it as a voluntary termination, and the vast majority (80%) reported that they had had a miscarriage.

Unsafe abortion contributes to maternal deaths and ill-health.

Eastern Africa is one of the most dangerous subregions in the world in which to have an abortion: Nearly one in five maternal deaths can be attributed to unsafe abortion (Table 1), and more than 500 women die per 100,000 unsafe abortions.⁹ In comparison, in the United States, where abortion is safe and legal, the case-fatality ratio is 0.6 deaths per 100,000 abortions.¹⁰ In Kenya, a woman has a one in 38 chance of dying from pregnancy-related causes over her lifetime, and about

*This study calculated a national abortion estimate using assumptions and adjustments based on information from the Kenya Demographic and Health Survey and the World Health Organization to account for abortion complications treated in private-sector and lower-level health facilities.

Table 1

Abortion and Maternal Mortality

Abortion incidence and consequences in Eastern Africa and Kenya

Abortion incidence

Eastern Africa (2008)	
Estimated no. of induced abortions	2,430,000
Unsafe abortion rate	36
Unsafe abortion ratio	20
Kenya (2002)*	
Estimated no. of abortions	317,000
Abortion rate	46
Abortion ratio	29

Consequences of unsafe abortion

Eastern Africa (2008)	
No. of maternal deaths due to unsafe abortion complications	13,000
% of maternal deaths due to unsafe abortion	18
Kenya	
No. of women admitted to public hospitals for abortion related complications, 2002	21,000
No. of maternal deaths, 2008	7,900
Adjusted maternal mortality ratio (MMR), 2008	530

*Data include both induced abortions and spontaneous abortions (miscarriages). Sources: Eastern Africa—reference 1. Kenya, except for maternal deaths and MMR—reference 7. Kenyan maternal deaths and MMR—reference 9.

530 women die per every 100,000 live births.⁹ Some urban slum areas in Kenya have an estimated maternal mortality as high as 706 deaths per 100,000 births.¹¹ As a point of comparison, the maternal mortality rate is 290 per 100,000 births for all developing countries and 14 per 100,000 for developed countries.⁹

Although no national data exist on the contribution of unsafe abortion to maternal mortality in Kenya, evidence from small-scale studies suggest that it is not trivial. A study of hospital records in the slum areas of Nairobi found complications from unsafe abortion to be the fourth greatest cause of maternal mortality in those areas, accounting for 7% of maternal deaths.¹⁰ A pilot study conducted in Nakuru Provincial General Hospital found that complications from unsafe abortion accounted for 25% of all maternal deaths recorded there in 2002.¹²

Many women who have unsafe abortions likely experience negative health consequences. One small-scale study estimated that as many as 60% of all gynecologic emergency hospital admissions are due to abortion complications.¹³ The number of women who go to private providers—trained and untrained—for clandestine abortions or to be treated for injuries resulting from unsafe abortions is unknown, as is the number of women who suffer complications but do not receive the postabortion care they need.

Abortion methods, providers and costs vary in Kenya.

According to several qualitative studies, Kenyan women commonly obtain abortions using unsafe methods and unqualified providers.^{4,14} In some instances, ineffective attempts to terminate a pregnancy force women to resort to multiple methods, often delaying the abortion to later in pregnancy, when complications can be more severe.

Abortion methods vary and include insertion of foreign objects into the cervix or uterus, overdosing on various drugs, ingesting harmful substances, engaging in extreme physical exertion and roughly applying pressure to the abdomen.^{1,4} In a qualitative study of 50 young women in Nairobi who had had an abortion, most had inserted an object into their cervix to induce abortion, and only 5% had had a medically appropriate procedure using manual vacuum aspiration or dilation and curettage.¹⁵

Because the law has been restrictive and widespread stigma persists, most abortions are performed by traditional providers and other private providers, both skilled and unskilled.⁴ Private providers offer confidentiality, but women may not know whether a provider is qualified, and poor women may have very little access to safer providers. Women and men interviewed in 2002–2003 were aware that the strict abortion law led women to procure unsafe procedures from “quacks,” and they believed that rich women could obtain relatively safe abortions, while poorer women were more likely to die from unsafe procedures.¹⁴

Anecdotal evidence from providers suggests that the cost of clandestine abortion varies widely. Private and public providers may charge anywhere from 1,000 to 10,000 Kenyan shillings (US\$12–122),* depending on gestation and sometimes on what the woman can afford.⁴ In one study, women reported paying between 150 and 12,000 Kenyan shillings (US\$2–146) to terminate their pregnancy.¹⁵

Postabortion care is inadequate.

Even though the Ministry of Health deemed postabortion care (PAC) “essential” in its 2006 Health Sector Strategic Plan and required that it be provided in five of the six levels of public facilities, qualitative data from medical professionals in Kenya suggest that many health care providers are insufficiently trained in PAC provision.⁴ While nurses and midwives are legally allowed to provide PAC, in many instances only doctors are adequately trained, and women with abortion complications may have to wait for a trained provider to arrive to receive treatment. One 2010 study found that many more facilities, particularly midlevel facilities, could feasibly provide PAC than currently do and concluded that by training providers, these facilities could improve access to such care in central Kenya.¹⁶

Some women delay getting treatment for abortion complications because they do not recognize the need for care soon enough or because they fear stigma and hostility from medical personnel.⁴ The 2002 national study of public hospitals in Kenya also found that about one-third of women admitted with abortion complications were in their second trimester of pregnancy.⁷ Abortions performed after the first trimester are associated with elevated risks for serious complications, injury and death; in addition, many small facilities are not equipped to handle severe postabortion complications.^{4,13} This is of particular concern in rural areas, where higher level facilities may not be within reach.⁴

*As of March 5, 2012, US\$1=82 Kenyan shillings.

Unintended pregnancy is common in Kenya.

Women typically seek an abortion because they find themselves pregnant when they do not want to be. Unintended pregnancy has two main outcomes—unplanned births and unsafe abortion. In Kenya in 2008–2009, more than four in 10 births were unplanned.¹⁷ Additionally, a Kenyan woman, on average, gives birth to one child more than she wants (4.6 vs. 3.4; Table 2).^{17,18} The difference between the total and the wanted fertility rates highlights just how difficult it is for a woman to meet her fertility desires. This disparity is particularly striking among rural and poor women, who have 1.5–2.0 children more than they intend to (not shown).¹⁷

Much of the gap between actual and desired fertility in Kenya can be attributed to the high level of unmet need for contraception. As of 2008–2009, one in three women of reproductive

age used any contraceptive method, the same proportion as in 1998.^{17,18} The proportion of married women using family planning was greater in 2008–2009 than in 1998 (46% vs. 39%), but contraceptive use did not change much for sexually active unmarried women over the decade. Disparities in modern method use among Kenyan subpopulations are stark: Only 12–17% of Kenya’s poorest and uneducated married women use modern contraceptives, compared with 48–52% of the wealthiest and most educated.¹⁷

Unmet need for contraception has not declined during the past decade. In 2008–2009, about one in four married women had an unmet need for contraception—that is, they did not want a child soon or wanted to stop childbearing altogether, but were not using any method of contraception.¹⁷ Sexually active unmarried women have even more dramatic levels of unmet need for contraception—45%

of these women want to prevent pregnancy but are not using any family planning method. Unmet need levels are higher among rural, less educated and poor women than among their counterparts who live in urban areas, have at least a secondary education or are relatively wealthy.¹⁷

Access to family planning services is often lacking.

Poor access to contraceptive services and counseling is a major barrier to women’s consistent and correct use of family planning. While the government provides slightly more than half of contraceptive supplies in Kenya at no cost, contraceptive stock-outs are common and may involve shortages of the most popular method, the injectable.^{19,20} In such situations, many women who do not have the resources to buy methods in the private sector may be forced to go without them. Additionally, injectables can be given legally only by providers who are registered and trained by the government’s Nursing Council, a restriction that limits the pool of eligible providers and impedes women’s access to the method.²⁰

Reaching poorer women with family planning services and information can be especially challenging in remote rural settings, urban slums and informal settlements. Slums often lack sufficient public services, leaving residents dependent on private-sector providers, who may not offer adequate or accurate services and information and may be costly.²¹ Qualitative research from poor areas of Kenya, both urban and rural, have revealed that misinformation and misconceptions, lack of male engagement and support,

cultural and religious beliefs, hidden costs for services and inadequate quality of care are other important barriers that may contribute to unmet need for contraception.²²

Young women are at risk for unintended pregnancy and abortion.

Young women and adolescents are particularly vulnerable to the consequences of unintended pregnancy and abortion in Kenya. Premarital sex is common—the average age at first sex among Kenyan women is nearly two years younger than the average age at first marriage (Table 2). Nearly 40% of unmarried women aged 15–24 have had premarital sex, and more than one in seven are sexually active. Of these young sexually active, unmarried women, only 30% use a modern method of contraception (not shown), and as a result, the large proportion who use no method or a traditional method but do not want to have a child are at high risk of unintended pregnancy.¹⁷

While premarital sex is widespread, the stigma around it persists. One recent study on Kenyan adolescents’ attitudes toward sex and abortion found that only 28% of female students believed that a sexually active schoolgirl should be allowed to use contraceptives.²³ Pregnancy is the second most common reason for adolescent girls’ dropping out of secondary school in Kenya, with 13,000 teenagers leaving school for this reason each year.¹⁵ Even though expulsion for pregnancy is no longer legally permitted, many adolescents believe that if a girl becomes pregnant, abortion is the only way to avoid expulsion from secondary school.²⁴

Table 2

Fertility and Contraceptive Use		
Characteristics of Kenyan women, 1998 and 2008–2009		
	1998	2008–2009
General		
% urban	23	25
% with at least 7 years of schooling	37	72
Fertility		
Total fertility rate	4.7	4.6
Wanted total fertility rate	3.5	3.4
Sexual activity		
Age at first sex (among 20–49-year-olds)	16.7	18.2
Age at first marriage (among 25–49-year-olds)	19.2	20.0
% aged 15–24 and unmarried who are sexually experienced	42	38
% aged 15–24 and unmarried who are sexually active	23	15
Contraceptive use		
Married women		
% using any method	39	46
% using a modern method	32	39
% with unmet need for contraception	24	26
Sexually active unmarried women		
% using any method	39	41
% using a modern method	29	37
% with unmet need for contraception	46	45

Sources: references 17 and 18.

Sex education both in schools and in the home is very inadequate in Kenya. Few adolescents receive comprehensive sex education, and often teachers do not have sufficient training or information.²⁵ Religious and cultural taboos prevent open dialogue about premarital sex at home or in schools, despite the fact that such sexual activity is common. One study of urban slum dwellers found that mothers struggle to discuss sex and unintended pregnancy with their daughters because they feel embarrassed or shy.²⁶

More measures are needed to end unsafe abortion.

New and updated research, including an estimation of the current magnitude of unsafe abortion and its consequences, is needed to better inform reproductive health policies and interventions in Kenya. Yet existing evidence highlights several areas in which policy-makers can take action now to help reduce the toll of unintended pregnancy and unsafe abortion.

- Reduce unmet need for contraception and eliminate barriers to obtaining family planning services. The government should ensure that public-sector facilities reach all women, especially those who are poor and young, with free or low-cost family planning services. Programs should offer comprehensive family planning services, enabling women to choose the best methods for themselves by providing counseling, information and a wide range of contraceptive methods.
- Improve sex education in school. Comprehensive programs should offer vital information that adolescents need to make informed deci-

sions and protect their health and future.

- Expand postabortion care services. Until unsafe abortion is eradicated in Kenya, the need for PAC will persist. More providers must be trained in comprehensive PAC to properly address the need for services in all parts of the country.
- Increase access to safe abortion under the existing legal criteria, and emphasize the government's obligation to provide access to safe and legal abortion under the new constitution. Both providers and the general public should be made aware that abortion is an available option to protect the health of a woman.

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