Social Science & Medicine 141 (2015) 9–18

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

'High profile health facilities can add to your trouble': Women, stigma and un/safe abortion in Kenya

Chimaraoke O. Izugbara*, Carolyne Egesa, Rispah Okelo

African Population and Health Research Center, Nairobi, Kenya

ARTICLE INFO

Article history:
Received 28 November 2014
Received in revised form
18 July 2015
Accepted 20 July 2015
Available online 21 July 2015

Keywords:
Kenya
Unsafe abortion
Abortion safety
Stigma
Women

ABSTRACT

Public health discourses on safe abortion assume the term to be unambiguous. However, qualitative evidence elicited from Kenyan women treated for complications of unsafe abortion contrasted sharply with public health views of abortion safety. For these women, safe abortion implied pregnancy termination procedures and services that concealed their abortions, shielded them from the law, were cheap and identified through dependable social networks. Participants contested the notion that poor quality abortion procedures and providers are inherently dangerous, asserting them as key to women's preservation of a good self, management of stigma, and protection of their reputation, respect, social relationships, and livelihoods. Greater public health attention to the social dimensions of abortion safety is urgent.

1. Introduction

The persistence and high incidence of unsafe abortion in Kenya (despite longstanding public health campaigns on abortion safety, more liberal abortion law, and the rising availability of providers and facilities willing and qualified to offer safe abortion services) have puzzled scholars recently (African Population and Health Research Center, Ministry of Health [Kenya], Ipas and Guttmacher Institute, 2013; Hussain, 2012; H. Marlow et al., 2014; Ndunyu, 2013). Defined as the termination of a pregnancy by persons lacking the requisite skills, or in an environment lacking minimal medical standards or both (World Health Organization, 2003, 2011), unsafe abortion accounts for a quarter of all maternal deaths in Kenya (Center for Reproductive Rights, 2010; East Africa Center for Law and Justice, 2012; Ministry of Health, not dated). In 2012, seventy-five percent of the estimated half a million abortions that occurred in Kenya were unsafe (African Population and Health Research Center, 2013).

Arguments linking the persistence and high incidence of unsafe abortion in Kenya to a mismatch between public health and lay notions of abortion safety have inspired calls for more research on the social dimensions and meanings of safe abortion among women (Izugbara and Egesa, 2014; Ndunyu, 2013). Such research has been viewed as particularly valuable in the context of the ambivalent abortion law and strong and pervasive stigma which surrounds abortion in Kenya (Marlow et al., 2013). These calls notwithstanding, studies directly addressing the social dimensions and lay notions of abortion safety that underpin abortion-seeking behaviors among Kenyan women remain scanty.

In Kenya, current unsafe abortion research has focused on its incidence, associated complications, and health system implications (African Population and Health Research Center, 2013; Gebreselassie et al., 2005; Marlow et al., 2013; H. M. Marlow et al., 2014). Studies also exist on the characteristics of women at risk of unsafe induced abortion; providers and context of unsafe abortion, treatment of unsafe abortion complications, safe abortion access barriers, and providers' attitudes toward abortion patients (African Population and Health Research Center, 2013; Brookman-Amissah, 2004; Center for Reproductive Rights, 2010; Gebreselassie et al., 2005; Izugbara and Egesa, 2014; Izugbara et al., 2011; Izugbara et al., 2009; Johnson et al., 1993; Marlow et al., 2013; Mitchell et al., 2006; Rogo et al., 1998).

Our study seeks to address the knowledge gap regarding the social dimensions of abortion safety. We specifically ask: How, in the context of Kenya's current abortion law as well as severe abortion stigma in the country, do ordinary women perceive and understand abortion safety? And how do lay and public health discourses of abortion safety compare?

* Corresponding author.
E-mail address: coizugbara@yahoo.com (C.O. Izugbara).

http://dx.doi.org/10.1016/j.socscimed.2015.07.019

The global success of public health strategies in shrinking poor health outcomes continues to be considerably hampered by their limited attention to local health notions, social contexts and conditions of people's lives (Lang and Rayner, 2012). Thus, while vaccines, well-trained health personnel, functional and equipped facilities, and advances in diagnostics and treatments have enhanced health outcomes, they have not always translated to better and sustainable health access for those in greatest need (United Nations, 2010). For example, HIV public health prevention and stigma reduction strategies, including condom distribution, free testing services, media campaigns and public education do not appear to have halted the transmission of HIV, and many experts fault their failure to address the reality of people's everyday life (Kippax and Stephenson, 2012; Piot et al., 2008). This has raised the urgent need for stronger focus on the social dimensions of the HIV epidemic, including discrimination, gender inequality, cultural beliefs, and poor livelihoods. Research also shows that people conceive their health needs and issues in complex multifaceted terms that go beyond narrow public health models (Putland et al., 2011). Attention to the social realities, lived experiences and knowledge systems of individuals exposed to specific health issues has thus been stressed as key to effective public health action (Putland et al., 2011).

In this paper, we analyze Kenyan women's perspectives on abortion stigma and safety as well as choice of pregnancy termination services. Our findings have the potential to facilitate more critical reflection and discussion on un/safe abortion, particularly against the backdrop of global public health discourses that frame abortion safety principally in terms of providers' expertise and the technical environment of the procedure. While the conclusions reached in this paper are not incontrovertible, they have far-reaching salience for current efforts to rethink abortion safety, prevent unsafe abortion, address unintended pregnancy and promote maternal health and wellbeing, particularly in sub-Saharan Africa. With growing global focus on the social dimensions of health and the need for workable and efficient public health actions as most recently expressed in the Sustainable Development Goals (SDGs), the current study rekindles the need for more reflections on the value of lay notions of safety in current public health responses to unsafe abortion. The WHO definition of abortion safety has already been challenged by the availability of abortifacient pharmaceutical drugs which permit women themselves to 'safely' terminate pregnancy in their own homes 'without the presence of a skilled provider and outside what formal providers would consider a hygienic or quality environment (Winikoff and Sheldon, 2012). Research on lay abortion safety perceptions will add complexity to ongoing reflections on the meaning of unsafe abortion. It will also support efforts to save women's lives, lessen the health systems costs of unsafe abortion, and improve access to high-quality comprehensive abortion care which includes counseling; safe and accessible abortion care; rapid treatment of incomplete abortions and other complications; contraceptive and family planning services; and other reproductive health services at all levels of care (African Population and Health Research Center, 2013; Izugbara and Egesa, 2014).

2. Context

With an estimated population of 40 million people and a constitution that explicitly addresses abortion, Kenya presents a remarkable context for interrogating the social dimensions and meanings of abortion safety (Izugbara and Egesa, 2014; Izugbara et al., 2011). Promulgated in 2010, the constitution holds that abortion may be granted to a pregnant woman or girl when, in the opinion of a trained health professional, she needs emergency treatment or her life or health is in danger. The Constitution also empowers trained health professionals, particularly medical doctors, gynecologist and obstetricians, and experienced midwives to offer abortion services. While the 2010 constitution presumably offers a broader basis for legal abortion, it has not really unfettered Kenyan women's access to abortion services. Many Kenyan women also still do not think or know that abortion is legal in the country and health providers continue to decry delays in the release of official guidelines for administering the procedure (East Africa Center for Law and Justice, 2012; Kenya National Commison on Human Rights, 2012; H. Marlow et al., 2014; Ndunyu, 2013; Ziraba et al., 2015). Thus, similar to Ethiopia and South Africa, where more liberal abortion laws are operational, unsafe abortion continues in Kenya. A nationally-representative study showed that nearly half a million induced abortions occurred in Kenya in 2012. The study estimated an induced abortion rate of 48 abortions per 1000 women of reproductive age and an induced abortion ratio of 30 abortions per 100 births for Kenya (African Population and Health Research Center, 2013).

Most of the women who sought abortion in Kenya in 2012 were younger than 25 years of age. Many unsafe abortion patients in Kenya suffer fatalities and severe complications (such as sepsis, shock, or organ failure); experience multiple unintended pregnancies and repeat abortions; are often not provided contraceptives or and family planning counseling upon discharge; and are treated with poor quality procedures such as dilation and curettage (D&C) and digital (finger) evacuation (African Population and Health Research Center, 2013).

The treatment of abortion complications utilizes a large amount of scarce health systems resources. At the Kenyatta National Hospital, Kenya's premier health facility, incomplete abortion accounted for more than half of all the gynecological admissions in 2002. Most of these admissions were emergencies, requiring long periods of hospitalization, repeated visits to hospitals, intensive care, and attendance by highly-skilled health providers (Gebreselassie et al., 2005). Kenya also experiences elevated rates of unintended pregnancy. While contraceptive prevalence in Kenya continues to expand -from 7% in the 70s; 33% in 1993; 39% in 2003; 46% in 2008 to 58% in 2014 (Kenya National Bureau of Statistics, Ministry of Health, National AIDS Control Council, Kenya Medical Research Institute, & National Council for Population and Development, 2015; Kenya National Bureau of Statistics (KNBS) & ICF Macro, 2010; Magadi, 2003), unintended pregnancy has remained commonplace in the country. In 2002–2003, about half of all unmarried women aged 15–19 and 45% of the married women reported their current pregnancies as unintended. In 2008–09, 42% of married women in Kenya reported their current pregnancies as unintended (Kenya National Bureau of Statistics (KNBS) & ICF Macro, 2010). This figure is expected to remain high in the near future (African Population and Health Research Center, 2013; Ikamari et al., 2013; Kenya National Bureau of Statistics, 2015).

Poor access to family planning services and products, lack of comprehensive sexuality education, and fear of the side effects of contraceptives result in low use of contraceptives among women and girls in Kenya (African Population and Health Research Centre, 2009). The cost of family planning services and products may also be out of reach for poor Kenyan women and girls. Facilities that provide subsidized family planning products and services in the country regularly experience both product stock-outs and a dearth of qualified providers. They are mainly found in urban areas, leaving many rural and semi-rural areas underserved (Agwanda et al., 2009). Stigma related to contraceptive use and cultural pressure to have many children, also interfere with the utilization of family planning services among women and girls in Kenya (Izugbara et al., 2011). Economic and livelihood conditions in Kenya continue to