Women’s perceptions about abortion in their communities: perspectives from western Kenya

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Abstract: Unsafe abortion in Kenya is a leading cause of maternal morbidity and mortality. In October 2012, we sought to understand the methods married women aged 24–49 and young, unmarried women aged ≤ 20 used to induce abortion, the providers they utilized and the social, economic and cultural norms that influenced women’s access to safe abortion services in Bungoma and Trans Nzoia counties in western Kenya. We conducted five focus groups with young women and five with married women in rural and urban communities in each county. We trained local facilitators to conduct the focus groups in Swahili or English. All focus groups were audiotaped, transcribed, translated, computerized, and coded for analysis. Abortion outside public health facilities was mentioned frequently. Because of the need for secrecy to avoid condemnation, uncertainty about the law, and perceived higher cost of safer abortion methods, women sought unsafe abortions from community midwives, drug sellers and/or untrained providers at lower cost. Many groups believed that abortion was safer at higher gestational ages, but that there was no such thing as a safe abortion method. Our aim was to inform the design of a community-based intervention on safe abortion for women. Barriers to seeking safe services such as high cost, perceived illegality, and fear of insults and abuse at public facilities among both age groups must be addressed. © 2014 Reproductive Health Matters

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Globally each year there are 42 million abortions, of which half are estimated to be unsafe.3 In countries where women’s access to abortion is prohibited or severely restricted under the law, unsafe abortion rates are higher compared to those where abortion laws are more liberal.2,3 Kenya recently liberalized the abortion law under Article 26 of the new Constitution, adopted in 2010. The language of the article reads: “Abortion is not permitted, unless, in the opinion of a trained health professional, there is a need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law”.4 The effects of the law change and the application of the article and the new Constitution were expected to increase women’s access to safe abortion services as they are made more available in the public sector,7 and this is proving to be true, as abortion services are becoming available in public health facilities and expanding. The most recent national estimates of unsafe abortion indicate that more women are seeking induced abortion at health facilities, yet the complications due to unsafe abortion remain high and persist as a serious public health issue for Kenyan women of reproductive age.5–8

Unsafe abortion in Kenya is a leading cause of maternal morbidity and mortality.9–12 Several hospital-based studies have documented that incomplete abortions account for over one-third
of gynaecological admissions and are a leading cause of maternal mortality. A 2004 hospital-based study of abortion incidence in the public, private and non-governmental (NGO) sectors in all regions of Kenya estimated that over 300,000 abortions occurred annually, with a national incidence of abortion of 45.9 abortions per 1,000 women aged 15–49 years. Although the authors did not distinguish between induced and spontaneous abortions, 28% of women had severe complications, suggesting that many abortions were induced. The most recent study of national abortion incidence derived from public, private and NGO health facilities estimated that 464,690 induced abortions occurred in 2012, with an incidence rate of 48 abortions per 1,000 women aged 15–49 years. An estimated 25% of women experienced complications, for which they received care in a health facility. Based on these data, which are hospital-based only, between 2004 and 2012 the estimated number of induced abortions has increased and the complication rate has remained high. The estimated abortion incidence is higher than the East Africa estimate of 38 and the global rate of 28.

These estimates, being hospital-based, are likely to under-estimate true incidence, as many women who have an abortion never visit a health facility. Such abortions are either induced by women themselves or by trained or untrained providers, utilizing a variety of methods. Complex social, cultural and economic contexts shape women’s abortion options and their ability to seek abortion services, and shroud abortion in secrecy. Additional research in communities where women have abortions outside of a health facility is needed to understand the factors that shape their pathways to abortion.

This study sought to understand the different methods married women (aged 24–49) and young, unmarried women in school (aged 20 or younger) used to induce abortion and the providers they utilized in the community, and to learn about the social, cultural and economic norms that influenced women’s access to safe abortion services.

Methods
We conducted community-based participatory research in Busia, Bungoma and Trans Nzoia counties for three weeks in October 2012 to inform the design of a community-based intervention on safe abortion. The larger study included focus groups, in-depth interviews, mystery client visits to pharmacists and participatory methods (transect walks/community resource mapping, free listing and ranking exercises, individual case studies, causal flow analysis and pocket voting).

For this analysis, we were interested in women’s descriptions of the social and cultural norms that influenced their access to safe abortion care and their perspectives on abortion. Hence, the data included in this paper are from the focus groups only; they were very rich and proved to be the best source for our analysis. The findings will be used to develop a community-based intervention to increase women’s knowledge about the law on abortion and the safety of bona fide abortion methods, and to encourage increased access to safe abortion services. Pilot-test focus group data from Busia were not included in this analysis. The first and second authors trained eight women from Busia, Bungoma and Trans Nzoia counties in focus group facilitation. The women were selected because of their roles as leaders, health care providers and social workers in their communities. During the training, we reviewed written informed consent in English and Swahili, research ethics, the semi-structured focus group guides in English and Swahili, and note-taking. We practised focus group facilitation and the use of a digital recorder. The eight women piloted the focus group guides and practised focus group facilitation in teams of two in Busia county. Four women were selected to continue as focus group facilitators, and were split into two teams of two each to conduct groups in Bungoma and Trans Nzoia. We ensured that they facilitated groups in counties different from where they resided.

Four focus groups conducted in Trans Nzoia county and six in Bungoma county are included in this analysis. Of these, two focus groups with married women (aged 24–49) took place in Trans Nzoia (1 urban, 1 rural) and two with younger, unmarried women in school (1 urban, 1 rural). Three focus groups were conducted with married women in Bungoma (1 urban, 2 rural) and three with younger, unmarried women in school (1 rural, 2 urban). The inclusion criteria for older women were that they were aged 24–49 and married. The inclusion criteria for the younger women were that they were aged 20 years or younger and in school. Other demographic data were not collected. Participants were recruited by local contacts in the Ministry of Health, school leaders and local non-governmental organizations. All were read an informed consent form in English or Swahili, depending on their preference, and written
informed consent was obtained from all participants. If a participant could not read or write, the consent form was read to her and an X on the form marked her consent, along with the signature of a witness. All focus groups had 8–14 participants each. Participants were given a snack after their participation. The focus group methods and procedures had administrative approval from the Kenyan Ministry of Health and the Allendale Institutional Review Board, Allendale, USA, a private IRB.

Two semi-structured focus group guides were developed: one for the older women and one for the younger women. The guides covered: pregnancies that women do not want, abortion, community attitudes toward women who have abortions, available drugs or medicines for abortion, methods used to induce abortion, perceived need for information about abortion methods and sexual and reproductive health and who in the community would be the best source of that information, abortion providers used by women, and social and cultural norms that influence access to safe abortion services. The focus group guides were translated into Swahili and focus group participants were given a choice of whether the focus groups would be in English or Swahili. All focus groups were tape recorded, transcribed and where necessary translated into English.

The first author read all focus group transcripts together in English for initial code and theme identification. After reading the transcripts, a codebook was created with codes and their definitions, both from the guide and from the data. All focus group transcripts were uploaded in to NVivo 10 and coded by the first author. Codes and themes were then reviewed by the other authors. All focus group participants were asked the same questions, yet certain emergent themes were mentioned only by some groups and not others. Throughout the paper, we indicate the number of groups that mentioned the emergent themes. The quotes presented are representative of what was said about a particular theme, unless otherwise noted. The unit of analysis was the focus group. Matrices were used to pull out all the abortion methods mentioned by focus groups and to examine their frequency using an Excel spreadsheet.

Findings

Abortion methods and costs

Women in all of the focus groups discussed various methods they were aware of that women in their communities had used to induce abortion. The most commonly mentioned methods were tea leaves (9/10 groups), quinine (6/10 groups), detergent (6/10 groups) and undiluted fruit juice (6/10 groups). Other methods mentioned in five of ten groups included traditional herbs, a metal rod or wire inserted into the uterus through the vagina and overdoses of paracetomol. Methods discussed less frequently (in three or fewer of the ten groups) included: oral contraceptive pills, aspirin, sticks inserted through the vagina, cola, sisal juice, two antibiotics (flagyl or amoxicillin), alo vera, papaya, neem tree leaves, scissors, emergency contraception, beef bouillon, toothpaste, snake antidote, roots inserted through the vagina, baking soda, burnt bean ashes, gourd, Lifwafwa tree root, sintosis and a hot stone. The route of administration was not always clear from the women’s descriptions. Only one group mentioned Cytotec, the brand of misoprostol available in Kenya, and one group mentioned manual vacuum aspiration (MVA).

The cost of an abortion using the methods mentioned previously varied dramatically from as little as 60 Kenyan shillings (60 KSH ~ US$1) for quinine purchased at a pharmacy to 5,000 KSH (US$ 60) from a doctor. These costs are all from women’s self-reports and were not verified. In Trans Nzoia, a doctor was the most expensive option cited by women in all four focus groups. The cost was as high as 5,000 KSH, however, one focus group participant explained that the cost is negotiable:

FGD Facilitator: “Approximately how much does the doctor charge?”

P1: “It depends on your agreement with the doctor. If you speak with the doctor…he or she will even take two thousand.”

(FGD11, Trans Nzoia, Young/urban)

In all four focus groups in Trans Nzoia, women said that an abortion from a doctor at the public hospital cost 5,000 KSH or more. Women in the focus groups in Trans Nzoia reported that midwives and herbalists were significantly less expensive, charging 500–1,000 KSH (US $6–12) for methods such as herbs, drugs or induction.

FGD Facilitator: “How much do people in the village pay for abortion?”

P2: “5,000.”
P3: “500.”

FGD Facilitator: “Who charges 5,000?”
P2: “The doctor in the hospital charges 5,000.”
FGD Facilitator: “Who charges 500?”
As in Trans Nzoia, women from Bungoma said abortion services from herbalists were less expensive than doctors or services at the public hospital. In Bungoma, prices are also negotiable, and depend on the length of the pregnancy.

FGD Facilitator: “How much does traditional medicine cost?”
P1: “It depends on the agreement between [you and the herbalist].”
P2: “It does not have a fixed price.”
FGD Facilitator: “The most expensive herbs cost how much?”
P1: “500.”
FGD Facilitator: “And the cheapest?”
P1: “If the pregnancy is one month [it costs] 100, two months [then more]…”
(FGD16, Bungoma, Married/rural)

An abortion in the hospital cost between 1,500–2,000 KSH (US $17–23), according to women in three of the six focus groups in Bungoma, while a private doctor charged 3,000 KSH (US $35).

Women in six of the ten groups considered the cost of abortion from public hospitals or private providers to be prohibitive. As a result, they turned to less expensive options, such as traditional drugs and herbs. In FGD19 in a Bungoma group of married, rural women, they said most of the women used traditional drugs because of a lack of money to pay for the hospital to do it. Even where women knew about a potentially safe option for abortion, the cost was prohibitive and limited them to less expensive options.

“To have an abortion the right way is very expensive. It is not cheap. So how can you afford it? So most of the time we go for shortcuts. You hear people say, ‘I don’t know what to take.’ Quencher? Drinking tea leaves? Omo? [They take these things] so that when they reach the hospital, it comes out fast. But what you have to go through is a lot. Expelling the fetus from your body is painful.”
(FGD10, Trans Nzoia, Married/urban)

In a different focus group, one woman said that no matter what the cost, a woman would try to find a way to pay for it in order to obtain abortion services.

“If she wants to terminate the pregnancy, she wouldn’t mind, she would part with a lot of money to get the abortion.”
(FGD13, Trans Nzoia, Married/rural)

Women’s perceptions about how an abortion works

When women were asked about different methods used to induce an abortion in their communities, they reported that abortions cut the fetus up or that something was inserted into the uterus to “stir things up” and perforate the amniotic sac. In two cases, the perception was that tablets taken somehow cut the fetus, as described by young women in Trans Nzoia and Bungoma:

P5: “I heard that when you are pregnant and you go to hospital, doctors will give you tablets.”
P1: “How many tablets?”
P5: “Like three tablets.”
FGD Facilitator: “Where do you put [the tablets]?”
P5: “You swallow and then [they cut the child into pieces].”
(FGD12, Trans Nzoia, Young/rural)

In other focus groups, women discussed “stirring” the insides of a woman and perforating the amniotic sac to induce abortion. The stirring and perforating is by inserting metal rods or wires into the vagina or the use of herbs, roots and other substances to affect the amniotic sac and induce an abortion.

“I’ve heard that there are some people who abort in back rooms. They just take a piece of metal and insert it in your vagina. They insert [something] in the vagina and then they just stir there in your stomach. I am told they disconnect the kid from the mother and the attachment inside there. And then they also detach the wall and perforate the amniotic fluid sac, then the pregnancy is done away with.”
(FGD11, Trans Nzoia, Young/urban)

P3: “One woman uses a tree root. She inserts it inside [the woman’s vagina] and pierces the placenta and abortion occurs.”
P4: “What I heard is that that root has a poisonous juice, and when it reaches the placenta, it reacts with it and dissolves it, and [that is] why [the] abortion occurs.”
(FGD16, Bungoma, Married/rural)

Women’s stories of abortion-related deaths in their communities

In eight of ten focus groups, participants related stories of friends and family members in their communities who died from unsafe abortions. The deaths described were caused by taking different types of medications or herbal preparations or through “stirring” or perforating with sticks, metal or roots. In many cases, the actual medicine
given, whether herbal, prescription or over the counter, is unclear. It is also unclear, in some cases, whether the woman died directly from the method (from poisoning, for example) or later on from infection or haemorrhage from perforation and/or bleeding.

FGD Facilitator: “Are there young girls who have died during abortion?”
P1: “Yes.”

FGD Facilitator: “What happened?”
P1: “She took the medicine [to induce abortion], but she did not tell her mother. She started crying at night [and] her mother gave her painkillers, and she died.”

FGD Facilitator: “Where did she go for the medicines [to induce abortion]?”
P1: “The village.” (FGD15, Bungoma, Young/urban)

“There is a lady who was trying to help her daughter abort, so she took three different types of trees, mixed them and mashed them, and then mixed [it] with water, and gave it to her daughter. She reacted immediately and the girl died on the spot.” (FGD18, Bungoma, Young/urban)

“A woman used a stick to perforate the amniotic fluid of a lady in Mayanja. She inserted the stick and rotated it like this… the placenta came [out], but the girl died.” (FGD14, Bungoma, Married/urban)

“My friend, also my roommate, last year in January, left school and told me she was going to Kitale to pay her in-law a visit, yet she was going to abort. She sent me a message [that] all was not well. It was an old woman in the village who advised her on the method she used. After she used it, she bled and bled until she died.” (FGD11, Trans Nzoia, Young/urban)

“We don’t have anywhere to go for help. Some go for traditional medicines and die, others pass through difficult situations. We really suffer.” (FGD16, Bungoma, Married/rural)

Community perceptions of women who have had abortions

When women in both ages groups were asked how a woman known or thought to have had an abortion would be treated by her community, all the focus groups discussed how women are ostracized, labelled and stigmatized as killers or murderers, are perceived to be a bad influence on others, are called prostitutes and accused of being unfaithful to their husbands or boyfriends. Younger women are perceived to be poor candidates for marriage.

“The [community] will always uphold the person who gave birth with [more] respect than the person who aborted, who is deemed not to have morals. She is bad company and [the community] will advise [others] not to interact with [her].” (FGD11, Trans Nzoia, Young/urban)

“It’s like she has killed.” (FGD10, Trans Nzoia, Married/urban)

“When they see her with [other girls], they will say she will influence [them] and [the other girls] will also start having abortions. They discourage [other girls] from [interacting with her].” (FGD17, Bungoma, Young/rural)

FGD Facilitator: “And if a married woman aborts, what do people say about her?”
P1: “Some will say that the pregnancy was not from her husband and thus she decides to abort.”
P2: “Most do it secretly, so you [would not] know.”

FGD Facilitator: “If they knew that you were pregnant and you have abortion, what will they say?”
P3: “They will say that it was from outside [the marriage].” (FGD16, Bungoma, Married/rural)

Younger women in three of the Bungoma focus groups said that a young woman would not be able to get married, or would have to go to a different community to get married, if it was known or perceived that she had had an abortion. Participants in other focus groups did not mention this theme.

FGD Facilitator: “What will people say in your community if they know a girl who is not married has aborted?”
P1: “She will lose respect and [men] will not marry her.”
P3: “She can reach the stage of getting married and no one [will] marry her because they learned she aborted.” (FGD17, Bungoma, Young/rural)

Legality and secrecy surrounding abortion

Women in four of the ten focus groups thought abortion was illegal or weren’t sure whether it was legal or not. For this reason, they described the need for secrecy around seeking abortion, both on the part of the woman seeking abortion and on the part of the provider. Further, women
thought that abortion was not available at a public hospital, but that doctors from public hospitals would provide abortions in private settings if women agreed to keep it secret.

“[Women go] to private doctors, not midwives, private doctors who have private clinics. They do abortion. [Public] hospitals would not assist [with abortion] because it is illegal.”

(FGD14, Bungoma, Married/urban)

“[Abortion] services are not legal. If you go to a health centre for abortion, they will tell you: ‘We don’t do that’. And if they have to do it for you, it’s just back door. And the blame is on you. They will give you the medicine and tell you to go and sort yourself, or they will do it for you, and in case of any risk, they will say they were not part of it. And also in the health facility, they don’t offer safe abortion.”

(FGD11, Trans Nzoia, Young/urban)

The secrecy and perceived illegality of abortion as a stigmatized, illicit, back-door activity, keeps it out of the public purview.

P1: “He can assist but you, [but] you can’t just go openly to a doctor and tell him you have this issue [need an abortion].”

FGD Facilitator: “Why?”

P1: “That’s the norm… that you just can’t terminate a normal pregnancy. That’s why earlier on, we said if you want to consult a government doctor on this issue, you do it aside and he will do it for you, to get the money.”

FGD Facilitator: “So you can’t go to the hospital to get an abortion?”

P1: “No way. No way.”

(FGD13, Trans Nzoia, Married/rural)

Married women from Bungoma and Trans Nzoia discussed arranging an abortion as a negotiable financial transaction that depends on the demand on a given day and whether the woman looks like she has money.

“It depends, it’s negotiable, and it’s also a business. If the day’s business is low, he won’t turn her away just because she doesn’t have any money. For students, it’s her pocket money, so he is helping her. He can’t lose the money since it is business. For other women, he looks at you, [and] if you look like you have money, he will ask for ten [thousand KSH] since you don’t want your husband to know, you have to pay more.”

(FGD14, Bungoma, Married/urban)

Abortion is perceived to be safer at higher gestational ages

In half of the focus groups, women said that abortion is safer at high gestational ages.

FGD Facilitator: “What is the best stage for [pregnancy] termination?”

P1: “They say when you terminate at one month you can die, but more than a month, they can cut, and [it is] safe.”

FGD Facilitator: “At how many months?”

P2: “Six… five months, just there.”

(FGD10, Trans Nzoia, Married/urban)

In half of the focus groups, women described the concept that a “ripe fruit” was easier to pick than one that is small and difficult to see. For this reason, women believed that removing the fetus, through cutting into the uterus or other methods to remove the fetus vaginally, was safer because the entire, formed fetus could be removed. There was trepidation about pieces of the fetus being left behind and that that could cause bleeding and infection. Many women believed that abortion works by cutting up the fetus, so to them, removing the fetus whole, if possible, was safer than leaving any part behind.

Perceptions that no abortion is safe

In half of the focus groups, women and young women from Bungoma and Trans Nzoia said that they did not know of any safe abortion methods.

FGD Facilitator: “What are some safe abortion methods?”

P1: “I don’t think there are any safe abortion methods.”

(FGD18, Bungoma, Young/urban)

Women in three other focus groups said that whether seeking abortion services from local providers, at home or in the hospital, all abortion methods were risky and may lead to death.

“When you look at all the local means used to abort at home, you may end up dying. The same thing when you go to the hospital, those processes may bring you complications. I have heard [that they use] piercing materials – a metal – that may harm you, and cause complications. There are no safe means of abortion.”

(FGD17, Bungoma, Young/rural)

“It is not safe in the hospital. I think it’s risky. If you [go] to the hospital for instance, they will
insert the metal, perforate the fluid, and after it flows out, the baby should come. In [the] hospital, you are told to go home. The abortion may occur that day or the following day, or even after four days.” (FGD11, Trans Nzoia, Young/urban)

It was unclear exactly what method was used in the hospital that the young woman was describing and whether it is an actual method used at the hospital, but her perception was that the method used in the hospital is not safe.

Perceptions of poor treatment at public health facilities

In three of the five focus groups with younger women, they believed they would be treated poorly at the health facility due to their age. Young women reported feeling discouraged and reluctant to go to health facilities because of this.

FGD Facilitator: “Are there reasons why a young woman might not go to a health facility in this community to get help if she has a pregnancy that she does not want?”

P1: “Yes.”

FGD Facilitator: “Would she be treated poorly?”

Participants: “Yes.” (In unison)

P2: “If at that time you are under 18 they will abuse you.”

(FGD15, Bungoma, Young/urban)

When young women did go to health facilities and were treated poorly, they were discouraged and contemplated going elsewhere. A young woman describes this:

“They do insult patients. You can go to the hospital and then the doctors start talking ill about you, so this discourages you so much, and you decide to leave.” (FGD12, Trans Nzoia, Young/rural)

Married women perceived that they would be insulted by doctors at the public hospital too, particularly if they were high parity and pregnant. They reported fear of being shamed for presenting with multiple pregnancies and for not using contraceptives to prevent the pregnancy.

“[People] say the doctors are bad, so you fear going [to the hospital]. Sometimes when you go, and are pregnant, [the doctor] will insult you.”

(FGD13, Trans Nzoia, Married/rural)
“Nowadays, giving birth to five or six children can be shameful for you, because when you go to the hospital, you are asked how many kids you have. If you say five or six, the nurses will laugh at you and ask why you don’t know about family planning. This can deter you from going to the clinic or hospital.” (FGD16, Bungoma, Married/rural)

Discussion
An important aim of this study was creating interventions to increase women’s awareness about the difference between safe and unsafe methods for abortion. A majority of methods that women described are not only unsafe but potentially life-threatening. We also found a lack of understanding about how an abortion works. Because of this lack of understanding women feared abortion and believed that the fetus was cut into pieces and that those pieces could cause an infection or haemorrhaging. Women related stories of deaths of friends and family members who died due to unsafe abortion and a majority of women believed that there was no such thing as a safe abortion. Women and young women mentioned many of the same methods. Interventions to inform women in both Bungoma and Trans Nzoia about the dangers of many of the methods being used are greatly needed, along with education that there are safe abortion methods, how they work, and that they are available at public health facilities in their communities.

The higher cost of a safer abortion, from a doctor in a hospital or a private clinic, was an important barrier to women accessing services. Abortion services in public facilities cost between 1,000–2,000 KSH (US$ 11–23). Most women in western Kenya earn less than 220 KSH (US$ 2.50) per day, so a procedure that costs 950–2,000 KSHs, is prohibitively expensive. We did not verify the cost of the services at the hospitals, however, women perceived that they are too expensive, and that perception in and of itself is a deterrent to women seeking safe abortion care. Instead, we found that women utilized herbalists and midwives because they charged less for services. Women and young women reported similar costs of abortion services in their communities and both sought less expensive options. Other studies in Kenya have found that women turned to less expensive abortion options because of the high cost of safe abortions.16,18

Women’s knowledge of safe abortion methods and services was limited by the providers who intentionally misled women to think that abortion was illegal under all circumstances and took advantage of their lack of knowledge about the law to overcharge them for services. Further, providers varied the price of the abortion based on whether the woman looked as if she could pay more, the length of the pregnancy and the level of secrecy. Younger and older women all reported that the provider varied the amount that they charged for their services. In in-depth interviews with women who had abortions in Mombasa and Kilifi districts in Coast province, Ndunyu also found that abortion costs depended on the provider and the length of the pregnancy.18 Women did not know what a fair price for an abortion was nor whether they were being taken advantage of. There is a need for pricing transparency at public health facilities, so that women know they are being charged the right price for the procedure.

The social and cultural environments in Bungoma and Trans Nzoia were not supportive of women who had abortions and prompted women seeking abortion to keep it secret to avoid stigma, accusations of infidelity or becoming poor candidates for marriage. For older, married women, they were often accused of infidelity if known or perceived to have had an abortion, whereas younger women found it difficult to find marriage partners. Other research in Kenya has found that young people are socially stigmatized for being sexually active outside of marriage, are barred from attaining their educational goals if pregnant and are considered poor marriage partners if found to be sexually active, pregnant or known to have had an abortion.17,18 The social sanctioning of women and young women seeking abortion limits their ability to find support and to access important information about safe abortion, as well as safe abortion services.

Conclusion
We used our findings to develop a multi-faceted, community-based intervention to improve women’s and community members’ knowledge about the legality of abortion, the safe abortion methods available in their communities, to address some of the misconceptions about abortion and to reduce the stigma associated with abortion. To increase women’s and young women’s knowledge about safe and unsafe abortion methods, how abortion works within a woman’s body and its safety, and referrals to trained providers, we developed an educational
outreach program to women in women’s groups, churches and their homes with the support of trained community-based organization staff and community health workers. To reach young women, we trained a cadre of peer educators in sexual and reproductive health education, safe abortion and referrals to safe abortion facilities with trained providers. We also conducted outreach to schools through trained community-based organization staff to educate young people about sexual and reproductive health and abortion.

We also educated community members of all ages and genders to sensitize them about the abortion experience for women, so that stigma, ostracism and labeling of women can be addressed. We used ongoing community dialogue meetings and forums to discuss topics such as the legality of abortion, safe abortion, family planning and sexual and reproductive health. We trained Chiefs and other opinion leaders to become champions of sexual and reproductive health and safe abortion in their communities. We implemented community based theater programs and street-based theater to spark debate about abortion at the community level and engage community members in discussion about abortion stigma. We also worked with men’s groups to educate them about safe abortion, family planning and sexual and reproductive health.

In addition to community-based interventions, we trained and equipped providers in local public health facilities to provide safe abortions. Provider training included a Values Clarification and Attitude Transformation (VCAT) training to improve their understanding of the law in Kenya and to sensitize them to supporting women requesting abortion services. Providers also received clinical trainings in manual vacuum aspiration (MVA) and medical abortion and facilities were upgraded and provided with equipment and materials needed to perform safe abortions. Providers, health facility staff, community-based organizations and community health extension workers met to discuss the findings from this research and ensure that community members are well received and encouraged to access safe abortion services.

References

Résumé
Au Kenya, l’avortement à risque est l’une des principales causes de morbidité et mortalité maternelles. En octobre 2012, nous avons tenté de comprendre les méthodes que les femmes mariées âgées de 24 à 49 ans et les célibataires âgées de 20 ans et moins utilisaient pour avorter, les prestataires auxquelles elles allaient et les normes sociales, économiques et culturelles qui influençaient l’accès des femmes aux services d’avortement sûr dans les comtés de Bungoma et Trans Nzoia au Kenya occidental. Nous avons réuni cinq groupes thématiques avec des jeunes femmes et cinq avec des femmes mariées dans des communautés rurales et urbaines de chaque comté. Nous avons formé des animateurs locaux pour gérer les groupes en swahili ou anglais. Toutes les discussions des groupes ont été enregistrées, transrites, traduites, informatisées et codées pour l’analyse. L’avortement en dehors des structures de santé publique a été fréquemment mentionné. Tenues au secret pour éviter une condamnation, ignorant la loi et jugeant que le coût des méthodes d’avortement sûr était plus élevé, les femmes demandaient des avortements à risque à un prix plus modique à des sages-femmes communautaires, des vendeurs de médicaments et/ou des prestataires non formés. Beaucoup de groupes pensaient que l’avortement était moins risqué à un âge gestationnel plus avancé, mais qu’il n’existait pas de méthode sûre. Notre but était de guider la conception d’une intervention communautaire sur l’avortement sûr pour les femmes. Il faut lever les obstacles à la demande de services sûrs mentionnés par les deux groupes d’âge, tels que le coût élevé, l’illégalité perçue et la peur des insultes et de la maltraitance dans les centres publics.

Resumen
El aborto inseguro es una causa principal de morbimortalidad materna en Kenia. En octubre de 2012, buscamos entender los métodos que utilizaban las mujeres casadas entre 24 y 49 años de edad y las jóvenes solteras de 20 años de edad o menores, para inducir un aborto, los prestadores de servicios a quienes acudían y las normas sociales, económicas y culturales que influían en el acceso de las mujeres a los servicios de aborto en los condados de Bungoma y Trans Nzoia, en Kenia occidental. Realizamos cinco discusiones en grupos focales con mujeres jóvenes y cinco con mujeres casadas, en comunidades rurales y urbanas de cada condado. Capacitamos facilitadores locales para que realizaran las discusiones en grupos focales en swahili o inglés. Todas las discusiones en grupos focales fueron grabadas, transcritas, traducidas, computarizadas y codificadas para análisis. El aborto fuera de las unidades de salud pública fue mencionado con frecuencia. Debido a la necesidad de mantener todo en secreto para evitar condena, la incertidumbre en cuanto a la ley y la percepción de mayor costo de los métodos de aborto más seguro, las mujeres buscaban abortos inseguros a menor costo de parteras comunitarias, vendedores de medicamentos y/o prestadores de servicios no capacitados. Muchos grupos creían que el aborto era más seguro a edades gestacionales más avanzadas, pero que no existe tal cosa como un método de aborto seguro. Nuestro objetivo era influir en el diseño de una intervención comunitaria sobre aborto seguro para las mujeres. Se debe abordar las barreras que enfrentan ambos grupos etarios para buscar servicios seguros, tales como costo elevado, ilegalidad percibida y temor de recibir insultos y maltrato en unidades de salud pública.