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
0277-9536/

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

plunge with far-reaching implications, particularly for women and girls (Fotso et al., 2014).

Over a quarter of Kenyans, mainly women, currently live below the poverty line and suffer chronic hunger, malnutrition and deprivation. Most of these women suffer poor access to basic essentials and services, including family planning products and survive through livelihoods and relationships that expose them to violence, unwanted pregnancies and unsafe abortion (Izugbara et al., 2011; Njagi and Shilitsa, 2007). Termination of pregnancies resulting from sexual violence thus remains common in Kenya (Izugbara and Egesa, 2014; Ndunyu, 2013). Societal attitudes towards abortion are largely negative in the country, forcing many Kenyan women to seek it clandestinely, often with tragic sequelae. (African Population and Health Research Center, 2013; Marlow et al., 2013; H. Marlow et al., 2014; Ndunyu, 2013). Research has also documented the persistence of a longstanding practice among many Kenyan women and girls to induce their abortions outside formal facility settings or with the support of unqualified providers but to seek formal facility-based treatment for the attendant complications (African Population and Health Research Center, 2013; Gebreselassie et al., 2005; Ndunyu, 2013).

3. Literature

While abortion stigma continues to receive critical attention globally in studies on abortion safety and care-seeking practices (Herrera and Zivy, 2002; Major and Gramzow, 1999; McMurtrie et al., 2012; Orner et al., 2010; Shellenberg et al., 2011; Shellenberg and Tsui, 2012; Suh, 2014); little of the existing research has directly addressed lay perceptions of abortion safety in the context of abortion stigma. The focus of published research has been on models for measuring abortion stigma (Huntington et al., 1996; Kumar et al., 2009; Norris et al., 2011), the sites and spaces - medical discourses, government and political structures, institutions, communities and personal interactions-where abortion stigma is constructed (De Roubaix, 2007; Løkeland, 2004; O'Donnell et al., 2011; Scharwächter, 2008; Webb, 2000; Whittaker, 2002); women's experiences of stigma in the context of safe abortion and safe abortion providers' experiences of stigma (Freedman, 2010; Freedman et al., 2010; Joffe, 2009; Major and Cozzarelli, 1992; Major and Gramzow, 1999; Major et al., 1985; Major et al., 1998; O'Donnell et al., 2011). The role of stigma in men's relationship with and support for women with post-abortion complications has been studied in Uganda (Shellenberg et al., 2011). Research has also addressed the role of abortion stigma management strategies in fostering silence and isolation around abortion (Cockrill and Nack, 2013).

As a stigmatized practice that provokes or may be viewed as likely to provoke sanctions from the public, community, social networks and significant others, abortion raises critical privacy questions for women who procure it (Cockrill and Nack, 2013; Kumar et al., 2009). Goffman (2009) argues that information control is a major issue for those who are discreditable. Persons who engage in stigmatized behavior have to make a decision about whether "to display or not to display, to tell or not to tell, to let on or not to let on, to lie or not to lie; and in each case to whom, how, when and where" (Goffman, 2009:42). Stigmatized behaviors exclude individuals from full social acceptance as they are often attributes that are intensely discrediting. The stigma and potential repercussions associated with abortion mean that abortion-seekers face the continuing tasks of 'accepting it themselves and negotiating it in interactions with others who may view their character and behavior as incomprehensible, strange, or immoral' (Park, 2002). Thus, women's abortion-seeking behaviors may reflect an intention to evade stigma, negotiate structural challenges, manage information about one's actions, and deal with the tension between revealing and concealing critical private information about one's involvement in a tabooed practice (Heaton, 2012). The current study extends knowledge and theorization on stigma by illuminating how lay safety discourses can emerge among stigmatized people as they negotiate reputation, perceived illicit behavior, health, privacy, respect and support.

4. Materials and method

We conducted qualitative interviews with a convenience sample of 50 women treated for complications of unsafe abortion at six purposively-selected public facilities in Kenya (See Table 1 for details of participating facilities). The study was conducted in 2012–13 as part of a larger study on the incidence of unsafe abortion and magnitude of unsafe abortion complications in Kenya. The sampled facilities were two Level VI health facilities, two Level V public facilities and two Level IV public health facilities. According to Ziraba et al. (2015), a health care facility level is a description of functionality as defined by the Kenyan Ministry of Health. Level I is the lowest level of care, while Level VI is the highest level of health care in Kenya. These facilities were purposively-selected because they provide post-abortion care following unsafe abortion to women of different generations, socioeconomic status, and residential locations (African Population and Health Research Center, 2013). From Level VI health facilities, we interviewed 26 women (13 in each facility) and from the rest we interviewed 24 women (6 each from a facility). Respondents were women successfully discharged following treatment for complications of unsafe abortion in the sampled facilities. Participant recruitment continued until the sample size allotted to the particular facility was met. Interviews were only conducted with women among whom providers found evidence of interference with their pregnancies during general clinical examination and management; who acknowledged to providers that they had deliberately interfered with their pregnancy, and who upon discharge, consented to be interviewed for the research.

Interviewers carefully explained to the respondents that their responses were only for research purposes and will not be used for other causes. They were also unambiguously apprised that the interviewers were not acting for law enforcement agencies,

Table 1
Facility characteristics.

Facility level	IV	V	VI	Total
Sample size	2	2	2	6
Location of facility	Rural Urban	Rural Urban	All urban	NA
Respondent size	12	12	26	50
Interviewers' profession	Nurse, midwife	Nurse, midwife	Nurse, midwife	NA
Level of health services providers by facility	Secondary and primary care	Some tertiary, secondary, and primary care	Tertiary, secondary, and primary care	NA
No of women approached for interview	14	16	28	58

government units or judicial institutions. In Kenya, post-abortion care providers are not under obligation to report women presenting for post-abortion care to law enforcement agencies. This is unlike Senegal, Argentina, Bolivia and other settings where providers may be expected to report patients seeking treatment for complications of illegal abortion to criminal justice authorities (Gogna et al., 2002; Rance, 2005; Suh, 2014). In reality, the Ministry of Health, Kenya as well as other authoritative health bodies including the Kenya Obstetric and Gynecological Society (KOGS) and the Kenya Medical Association (KMA) currently emphasize confidential, respectful, stigma-free and compassionate treatment to women presenting for PAC at facilities (Ministry of Health (2003); not dated). Also, in many public health facilities in Kenya, PAC is currently offered as part of the government free maternal health care service package (Bourbonnais, 2013; Ndunyu, 2013).

The interviews were held in the sampled facilities or their environs, in spaces free of the attentive eyes, threat of sanctions, and pressure of non-participants. Interviewers were English and Swahili-speaking providers based in the sampled facilities. They were trained for 4 days on how to conduct qualitative interviews with patients. Interviewers were trained in qualitative interviewing by expert qualitative researchers.

The study guide was developed, reviewed and approved by an international group of qualitative abortion researchers. All interviewers were carefully trained on the study tools, best practices in qualitative research, instruments, and ethical protocols during and after fieldwork. Role-playing was used to develop interviewers' understanding and familiarity with the study tools. Training sessions covered the ethics of sensitive research, confidentiality, and how to ensure that respondents are not stigmatized. Interviewers were also clearly informed and prepared about the likelihood of general uncomplimentary remarks about providers and facilities. Over a one-week period, interviewers piloted the tool at the facilities where they work. The study team met at the end of the one-week pilot period to discuss experiences and issues emerging from the pilot and to further revise the tools. Data collection ran contemporaneously for one month in all the study facilities.

One expert translator-transcriber translated the interviews from Swahili to English. The transcripts were then meticulously compared to the taped interviews by two other expert translators. At first, the interview data were concurrently but independently coded by the lead author and an expert qualitative data coder, relying on Creswell's (2012) version of Glaser and Strauss' (2009) grounded theory. Following Izugbara and Egesa, (2014), the authors and coder met afterwards to review the coding outcomes, ensure intercoder concordance, and agree on a codebook that mirrored the thematic groupings of the interview questions and the key issues emerging from the data. Based on the jointly developed codebook, transcribed interviews were then finally coded with Nvivo (Izugbara and Egesa, 2014). A qualitative inductive approach involving thematic assessment of the narratives was adopted to understand the data. Higgins, Hirsch, and Trussell (2008) have suggested that this approach promotes the detection of overriding themes in qualitative data as well as the understanding of the meanings and messages of themes through the continual investigation of narrative data for categories, linkages, and properties. Word-for-word quotes are also used in the paper to focus attention on major responses and themes. The study was reviewed and approved by the Ethical Review Boards of the Kenya Medical Research Institute, the University of Nairobi/Kenyatta National Hospital, Moi University Teaching and Referral Hospital, Kenya, and Aga Khan University, Kenya. The Ministries of Public Health and Sanitation and Medical Services in Kenya and the Institutional Review Board of the Guttmacher Institute also reviewed and approved the study.

A limitation of this study is the considerable risk of stigmatization posed to the respondents by using providers as interviewers. Training sessions with the interviewers aimed to minimize this risk. Other limitations of this study include its restricted focus on women presenting at formal health facilities for treatment of unsafe abortion complications and the lack of comparative data on women who do not go to health facilities for post abortion care.

Future research needs to engage these gaps.

5. Respondents

As Table 2 shows, there was rich diversity in the socioeconomic and demographic characteristics of responding women. The women ranged in age from 16 to 42 years and had a median age of roughly 23 years. Most of the women were aged below 25 years. Majority of the women had only primary-level education and their mean years of completed formal schooling stood was 9. Responding women's marital backgrounds varied markedly: married (24%), single (64%), living together (10%) and widowed (2%). Students, the casually-employed, and women in petty businesses constituted the majority of respondents. Although, the sample mostly comprised nulliparous women, a substantial number of them were parous. Both urban and rural women as well as Christians and Muslims were represented in the sample. While some of the women lived in households that they headed, majority resided in households headed by others: husbands, fathers, mothers, brothers, uncles, and sisters. Some of the respondents reported previous abortions and very few of them disclosed consistent use of contraceptives.

The pregnancies terminated by the respondents were often reported as unwanted. As in Izugbara and Egesa (2014) and Izugbara et al. (2011), idealized notions of femininity and women's roles suffused responding women's perceptions of unwanted pregnancies. Overall, the unwantedness of the pregnancies derived from their occurrence in contexts that defied local notions of motherhood and proficient womanhood and of women as nurturers and wives. They were pregnancies perceived as not meeting local standards about 'proper' procreation or viewed as likely to reveal women's use of their sexuality in socially-disagreeable or culturally-unacceptable ways. Our data also underscored the

Table 2
Participants' socio-demographics.

Characteristics	Categories	F	%
Age	18 or less	12	24
	19–24	24	48
	25–30	11	22
	31–34	1	1
	35+	2	4
Education	Primary education	25	50
	Secondary	13	26
	Tertiary	12	24
Marital status	Married	12	24
	Never married	32	64
	Separated/divorced/deserted	5	10
	Widowed	1	2
Residence	Rural	10	20
	Urban	40	80
Parity	0	28	56
	1–3 children	19	38
	4–6 children	3	6
Occupation	Student	18	36
	Unemployed	7	14
	Casual employment	11	22
	In formal employment	2	4
	Private business	10	20
	House-wife	1	2
	Other	1	2

centrality of pregnancy to women's identity. One 31-year-old rural participant noted: 'It is women who bear children.' Another respondent, 28-year-old urban resident, Pina, averred: 'One cannot call herself a woman without being able to get pregnant. It is women's nature.' Yet another interviewee offered: 'Men do not give birth. That is women's role.' However, participants also noted that not all pregnancies were beneficial to women. Pregnancies that put women's identity at risk were reported as likely to be terminated. Pina (mentioned above) told us: 'As a woman, I know that pregnancy is important. But not all pregnancies are good for me. When a pregnancy will put you in trouble, you may have to terminate it.'

6. Abortion and abortion services

Responding women generally considered abortion to be widespread in Kenya. They also did not deem it as the particular problem of unmarried women and girls. It was reportedly common among rich and poor women, widows, married women as well as working and unemployed women. Nearly all the respondents expressed knowledge of at least two women or girls who had procured an abortion in the last two years. Respondents' typical comments while articulating the regularity of abortion in their communities and among their networks included: 'Many girls in my school have had an abortion.' 'Where I live, I know many girls and women who have terminated their pregnancies' 'It is common here … I know up to six of my friends who aborted last year.' The persons whose abortions respondents knew about were often close acquaintances: sisters, mothers, cousins, nieces, neighbors, classmates, sisters, and friends. In many instances, respondents also knew women and girls in their communities, families, workplaces or schools who had terminated more than one pregnancy in the last two years. They regularly noted that the abortions of their acquaintances and friends were usually self-induced or induced with the help of friends, chemist shop operators, neighbors, clinical officers, traditional birth attendants (TBAs) etc. One respondent reported that her cousin's abortion was induced by an elderly neighbor. Another disclosed escorting a girlfriend to procure an abortion from a local TBA. The TBA gave her friend a concoction to drink and also vigorously massaged her abdomen. Shortly afterwards, her friend began to vomit and bleed. The TBA discharged her after about six hours. There was also a respondent who knew a woman in her neighborhood who induced her own abortion by drinking a strong concoction of a particular malaria drug, a local alcoholic brew called *changaa* and other substances. Shortly after ingesting the concoction, the woman began to bleed profusely. Neighbors ultimately rushed her to a nearby hospital where she received post-abortion care. Doctors, midwives and nurses were other commonly-mentioned major abortion providers in Kenya.

Responding women displayed rich knowledge of different abortion methods, diverse providers of abortion services, and various locations where abortion can be procured. Reportedly, women could terminate pregnancies by exercising forcefully and strenuously, jumping from high elevations, starving, energetically riding a bicycle etc. Special concoctions, including concentrated tea and coffee and overdoses of certain medicines were also considered effective abortifacients. Several of the patients also reported that there were modern medicines that terminate pregnancies. Having one's stomach roughly massaged or stepped on and drinking soot and bleach; concoctions of kerosene, petrol, and gasoline; stain removers; emulsions; and bleaching creams were also reported as methods of inducing abortions. The women knew several providers of abortion services in their communities: TBAs, chemist shop operators, pharmacists, doctors, nurses and midwives. Teachers, grandmothers and aunties were also mentioned as other people with knowledge of abortion methods and from whom women could obtain pregnancy termination services. One 27-year-old urban-based respondent noted: 'Where I live, women and girls know who to approach for help if they get pregnant accidentally. Even some of the teachers in the schools know how to help girls terminate a pregnancy.' Data also suggested that there were religious leaders and traditional healers with powers to terminate pregnancies through prayers, magical powers, chants and charms. Knowledge of women who had procured abortion from such mystic providers was widespread.

As earlier noted, respondents were women treated for complications of unsafe abortion. Essentially, their abortions were induced outside the facilities at which they were now presenting for post-abortion care. Responding women had used different means and providers to induce their abortions, including TBAs, chemist shop owners, pharmacists, clinical officers, and nurses. The bulk of the abortions for which the women were presenting for treatment were induced outside a formal health facility-setting. Some of the abortions were also induced at home by the patients themselves or with the help of others, particularly aunties, sisters, mothers, grandmother, friends, boyfriends and husbands. For instance, Akinyi, a 20-year old girl reported that she was assisted by her mother. After vigorously massaging Akinyi's abdomen for a long period of time, she gave her a very strong concoction to ingest. Shortly afterwards, Akinyi began to bleed. In her words: 'My mother told me that there was nothing to worry about as she (the mother) knew what she was doing. She told me that I only had do whatever she tells me and I will be fine.'

The TBA who helped Christie (27-year-old) to terminate her pregnancy inserted a mashed leafy substance into her vagina and also gave her some pills to ingest. In the case of another respondent, 24-year-old Myra, her boyfriend brought her pills which she ingested and later began to bleed copiously. There was also a respondent whose school friend directed to an abortion provider. She said: 'When I told my friend that I am pregnant and I cannot have the baby, she told me 'if you don't really want (to keep the pregnancy), I can tell my aunt to give you the medicine for abortion.' On the other hand, Mary's grandmother helped her abort by inserting an alcohol-smelling substance into her vagina. Mary (25-year-old) said: 'My grandmother told me that the pain will come in phases, on and off, gradually increasing and on the last day, the pain (will be) unbearable.' Another 30-year-old woman said she was referred by friends to a small informal health center. In her words: 'The provider at the health center inserted something like a pair of scissors into my private part and I felt a very sharp pain like he had cut something. He then told me to go home and that I should go to Kenyatta Hospital if the bleeding or pain became too much.' The account below, provided by another 26-year-old respondent, further illustrates the diversity of abortion sites and providers in Kenya:

Interviewer: But tell me more on how the medicine was administered by the aunt who helped you:

Nancy: She brought it for me in the house and I drank it. It was in a bottle and she told me to take everything and sleep then after three days, I will be rid of the pregnancy. I started bleeding on the third day but I was having a lot of pain in the abdomen.

Interviewer: Mhh, ehh …

Nancy: I was thinking that I might die.

Interviewer: Mhh …

Nancy: I tried to persevere but I could not move again and … was rushed to the hospital.

The women we studied generally viewed induced abortion as a problematic and morally-contentious issue that was not permissible in Kenya. They were also fully aware of the stigma surrounding it. One respondent offered: 'In Kenya, abortion is not viewed positively and you have to hide … it.' Another noted: 'Abortion is not

permitted here. It is viewed as bad … though many people do it.' Generally, participants felt that they had engaged in a deviant and problematic behavior by procuring an abortion. Bearers of stigma often concern themselves with what others think of them in relation to the stigmatized trait (Goffman, 2009). They also often internalize the social norms to which they fail to conform or are perceived to have failed to conform (Cockrill and Nack, 2013; Goffman, 2009; Major and Gramzow, 1999; McMurtrie et al., 2012; O'Donnell et al., 2011). In Kenya, according to respondents, women who terminate their pregnancy enjoy no respect, sympathy or support. In one poignant articulation of this view, a 30 year-old woman noted: 'In this country, HIV-infected people speak openly about their status and even attract sympathy and support. Abortion is the worst thing you can do as a woman. If you admit to it openly or if it is found out, you will lose every respect you have. People will call you bad names.' Another respondent also observed: 'In this country, it is not good for people to find out that you terminated a pregnancy. They will never respect you again. It is like the worst thing you can do as a woman in Kenya.'

7. Un/safe abortion narratives

Judging by the data, responding women did not use low quality abortion services out of ignorance. Rather, their use of such services followed a perceived insensitivity and inattentiveness of high-profile health facilities or well-known providers to the social safety needs of women. Of course, the women we worked with reported knowledge of qualified providers and well-equipped facilities and hospitals that offer abortion services. They also knew women and peers who had obtained pregnancy termination services from qualified providers and high-profile health facilities. For instance, 24-year-old Myra knew that her rich boss, a banker, procured abortion from a big and popular hospital in Nairobi. Another 30-year-old respondent affirmed knowing a girl whose wealthy parents assisted to procure an abortion at a popular high-class hospital in Nairobi. However, for the women we studied, there was more to abortion safety than the profile of the facility where it was procured and the qualification of its provider.

Respondents consistently acknowledged high-profile health facilities and providers as potential sources of risk for women seeking abortion. In the apt words of a 30-year-old respondent: Those so-called high-profile health facilities and qualified providers can add to your trouble if you are a woman looking for abortion. When you go to those prestigious health facilities or well-known providers for abortion, you just don't know what will happen.'- Essentially, excellent facilities and providers were not all that women consider when seeking to make their abortions safe. Further, the respondents did not describe abortion safety merely in terms of physical health, but also in terms of women's social, reputational, relationship and economic security. One 29-year-old respondent drove this point home by noting that while high-profile health facilities may have all the equipment and good health providers, they do not often guarantee abortion patients' secrets. She says: 'They keep records of everybody who comes for treatment. But some providers do not keep records … ' Another respondent noted: 'You may have the best doctors and equipment there, but it is not safe because they will keep your file and everybody will know what you came to do … they also make you pay heavily even when you say you don't have money. That's why those places are not safe for abortion.' For responding women, safe abortion involved pregnancy termination procedures and providers that safeguard women's abortions secret and protect them from the law, were affordable, and identified through trusted social networks.

A major theme in responding women's construction of safe abortion was patients' social integrity and reputation. In one very clear and lucid articulation of this point, one 35-year-old respondent noted that an abortion is unsafe if it does not protect both the woman's health and social reputation. Among the women we interviewed, safe abortion connoted pregnancy termination procedures that safeguard and shield women from both poor health and negative social outcomes. Essentially, a safe abortion provider or facility safeguards women's abortion secret and protects their social reputation. One respondent explained it thus: 'If you help me terminate my pregnancy successfully but end up exposing me to people I would ordinarily not want to know about it, then it is not safe for me.' Another participant maintained: 'A good and safe abortion service and provider will ensure that people do not hear or know that I have had an abortion.'

Evidently, the narratives we elicited strongly indicated women's lack of faith in high-profile health facilities and providers to meet their privacy needs in relation to abortion. One respondent observed: 'It is not safe to use those big hospitals for abortion. They expose women's secrets and everybody will know what you came for.' Park (2002) and Goffman (2009) suggest that persons involved in stigmatized behavior actively conceal their actions from those who are likely to condemn them. In the study, women expressed concerns that in some facilities, their abortion secrets would be divulged which would hurt their reputation, livelihoods, life chances, support systems and networks. One of the clearest articulations of this point was by 28-year-old Lucy who noted that: 'If people hear about a woman's abortion, they would use it against her by telling people she does not want to know about it. They could tell her husband, father, boyfriend, family members, church, community and friend. This can just tarnish her and make her suffer for many years.'

People share their secrets with those they perceived would be supportive, avoiding people they think will stigmatize them or give them away (Cain, 1991; Cowan, 2014; Goffman, 2009; Petronio et al., 2006; Vangelisti and Caughlin, 1997). Revealing private information indiscriminately makes people vulnerable. Boundary coordination, which involves gauging how much and to whom one wants to tell and the timing of disclosure is critical (Heaton, 2012). Women in the study managed the boundaries of their abortion secrets through their choice of abortion service sites and providers. One respondent offered: 'I went to a TBA because she had helped some people I know and she keeps secrets. I did not even know she provides abortion services to women. It was a friend that she helped who directed me to her. If I'd gone to a hospital, many people would know what I came for.' Secrets are key to the maintenance of reputation (Cowan, 2014; Goffman, 2009; Heaton, 2012). Unguarded disclosure of a stigmatizing behavior can be damaging and unsafe (Bok, 1989; Cowan, 2014; Heaton, 2012). For instance, in speaking about the risks inherent in seeking abortion services from big health facilities and well-known providers, some unmarried young women in the study maintained that hospitals were not safe for abortion because they felt their parents or guardians may be contacted by providers. Consequently, TBAs and other informal providers who presumably keep women's abortions secret were reported as sources of safer abortion services. They do not request parental consent or approval before offering abortion service. In such settings reportedly, married women presenting for abortion are also not asked to bring their husbands. Other women spoke about how high-profile facilities retain copies of abortion-seekers' IDs in files, making women easily traceable and identifiable.

Another prevalent notion among the women was that abortion safety can be guaranteed by utilizing abortion procedures and providers identified through dependable social networks. One respondent asserted. 'You will know from friends that a particular provider or facility is good, will not disclose your secret, does not engage in formalities, and respects women. These make you feel

safe to use it. It is not safe to use a provider without recommendation from people you trust.' Hospital-based providers were reportedly condemnatory and judgmental towards women seeking abortion. They reportedly gossiped about women among themselves, called them names and even publicized their abortion. One woman noted: 'Providers in these big formal facilities make women feel very bad. They would tell women "when you were having sex, did you not know that you will get pregnant." Another respondent observed: 'I considered it safer to go to that particular woman (TBA) because she had helped several of my friends without problems and my friends directed me to her.' The chemist shopkeeper from whom 25-year-old Jane procured an abortion medication was recommended by a friend who had also previously used him. Jane said: 'He does not judge you; he just gives you what you need … tells you what to expect and tells you to go home … he just helps you'. The shopkeeper simply told Jane that many people come to him for the same service and that she should not feel alone or ashamed. The TBA who induced Martha's abortion was introduced to her by a friend. The TBA also told Martha that she has helped many women and that she (Martha) had nothing to fear. Basically, providers and facilities that act as accomplices and coconspirators with the women were considered key to abortion safety. In their quest for a network of dependable supporters, people at risk of stigmatization create and relate differently with knowers and non-knowers of their secret (Bok, 1989; Cowan, 2014; Heaton, 2012). Women's reliance on trusted friends and networks to select their abortion methods and providers channeled their secrets away from individuals viewed as having negative attitudes toward abortion and who are likely to stigmatize them. This resonates with Goffman's (2009) contention that there are great rewards in being considered normal.

There was also broad consent among the women we studied that affordability is a key dimension of abortion safety. Unaffordable abortion procedures and providers were considered unsafe for women. Such services were also said to expose women to stigma, mistreatment and ridicule. Their providers also reportedly pressure women seeking abortion to keep their pregnancies. One 28-year-old woman reported that her friend once tried to use a high-profile hospital in Nairobi for abortion but was chased away when they discovered she could not foot the bill. In her words: 'When my friend said she did not have the kind of money they were asking for, they threatened to call the police on her, they only let her go after she promised she was no longer interested in the abortion.' The bulk of women who seek abortion services were reportedly desperate. One woman noted: 'No woman keeps money waiting for when she will abort … it is not always something you plan for. Sometimes, you just find out that you are pregnant and have to abort. May be you don't even want the man to know.' It was believed that abortion services needed to be cheap and affordable for women. Pregnancy termination in hospital settings and by high-profile providers was considered very costly and often out of the reach of the poor. Women and young girls may not often have the resources to pay providers in these facilities to keep their abortions secret. Articulating her reasons for seeking an inexpensive but unsafe provider, one woman observed: 'For me, I sought a provider that was inexpensive. I was looking for a service within my reach. I know facilities where you can get an abortion, but you have to pay a lot in those places. Such places are not good for women like me. You will be detained and humiliated since you cannot pay and they will make your secret known to everybody.' Well-equipped facilities and providers were considered out of the financial reach of most abortion-seekers and thus expensive to use. Driving this point further home, another respondent observed: 'I didn't have enough money. In the hospital, I was told to bring 6000 shillings and … I had only 1000 shillings. So with the traditional doctors you find that they don't ask much that is why many people go there. They make it easier and safer to procure an abortion.' There was also a respondent who noted: 'Hospitals that offer abortion services charge very high. They can make you sell something or borrow just to get an abortion. They detain you if you cannot pay and everybody will then know … '

Respondents also generally believed that abortion is illegal in Kenya, mentioning the Kenyan media, religious leaders, health providers, family, friends, and schools as sources of their information on the criminality of abortion. Given the presumed illegality of abortion in Kenya, safe abortion was also understood in terms of procedures and providers that shielded women from the law and arrest. Seeking abortion from high-profile providers and facilities reportedly put women at risk of being reported to the police, imprisoned, or forced to call their parents, husbands, schools, and guardians. Thirty-year Mercy asserted: 'The things that can happen when you seek abortion in high-profile facilities are just too many. They can call the police to arrest you. I know girls who were threatened into keeping their pregnancies at big facilities. Some of them gave birth and ultimately dropped out school or were disowned by their parents.' Stories of women coaxed by providers in formal facilities into keeping their pregnancy were common. Evident in these stories was that formal providers pay little mind to the negative consequences for women of being forced to keep pregnancies they desire to terminate. One respondent noted that high-profile facilities and providers respect the law and their work more than they respect women's needs and feelings, which makes it unsafe to seek abortion from them. She declared: 'We are told that doctors and nurses can be arrested and their hospitals closed if they perform an abortion, so they are careful about what to do. If you are poor and go to them for an abortion, they will hand you over to the police.' This particular interlocutor noted that her friend presented for abortion at a government-owned facility and was threatened with police arrest until she agreed to phone her mother to come to where she was. Of course, her friend did not want the parents to know. Another respondent knew a woman who went to a government health facility for abortion and ended up getting connected to a pastor who counselled her on 'the sin of abortion'. Similarly, there was a respondent who noted that before using a chemist shopkeeper to induce her abortion, she had sought help in a clinic. At the clinic, she was told that abortion services were very costly and that she should carry the pregnancy to term. They also told her that abortion was illegal and she could be arrested. When she insisted that she did not want to keep the pregnancy, the nurses shouted at her, called her names and threatened to hand her over to the police. She fled the clinic and consulted a friend who directed her to the particular chemist shop operator where she procured her abortion.

8. Discussion and conclusion

The social dimensions and meanings of abortion safety remain poorly explored in the literature. We studied notions of unsafe abortion and pregnancy termination practices among women treated for unsafe abortion complications. Despite the silence and confusion surrounding abortion in Kenya, lay knowledge related to it remains rich among women. The Kenyan women we studied knew a range of methods for inducing abortion as well as diverse types of abortion providers. Knowledge of other women who had procured abortion and where they received the service was also widespread among the participants. Schuster (2005) shows that in exceedingly pronatalist contexts, the need for women to manage unwanted and socially-contested fertility, often leads them to cautiously arm themselves with critical information about how to cope with unwanted pregnancy and terminate it without detection.

In Cameroon, Johnson-Hanks (2002) found that despite pervasive condemnatory attitudes toward abortion, women practiced it with some regularity but without much detection. Stigma associated with mistimed entry into recognized motherhood therefore situated abortion in Cameroon within a local culture of gendered honor and social politesse. Knowing where to obtain abortion, without discovery and detection, thus became important for Cameroonian women with unintended pregnancy. Similar findings have been reported in Ghana and Burkina Faso (Bleek 1981; Rossier 2007).

In the current study, women primarily terminated unwanted pregnancies. Generally, pregnancies were considered unwanted when they occurred in contexts that did not reinforce standard ideas of motherhood and competent womanhood, were incompatible with local beliefs about 'proper' procreation or had the potential to expose women's use of their sexuality in culturally-objectionable ways. In Izugbara et al. (2011), women considered pregnancies to be unwanted when they occurred in contexts that do not reinforce traditional notions of consummate motherhood and of women as nurturers and wives; were incompatible with customary beliefs about 'proper' reproduction; and divulged their use of their sexuality in culturally unacceptable ways. Kendall et al. (2005) found a deep recognition among women and girls that particular forms of fertility, such as single parenthood can be socially and economically-demanding. Geronimus (2003) also argued that the planning of fertility was a gendered tactic among women for countering their structural susceptibility. Women's reference to gender norms to explain unwanted pregnancy demonstrates the critical circumscription of reproductive choices and behavior by traditional views of fertility and sexual expression (Izugbara et al., 2011; Jones et al., 2007).

From a public health perspective,well-trained health personnel and equipped facilities equate safe abortion. But the women we interviewed espoused an alternative perspective of abortion safety. For them, the basis of abortion safety is providers and facilities identified through critical social networks and able to safeguard women's abortion secret, act as accomplices and coconspirators to women, and offer them affordable services. Put simply, only abortion procedures and providers that are sensitive to the social implications of women's participation in a stigmatized and illegal practice were safe for women.

In Kenya, little reprieve exists for women-seeking abortion in formal health settings (Ndunyu, 2013). As in many other countries, the stigma and discrimination that Kenyan women who seek abortion face in the rest of society are regularly reproduced in formal health care settings (see Gogna et al., 2002; Rance, 2005; Suh, 2014). The views of the abortion patients we studied are therefore not irrational (Popay and Williams, 1996). According to Pill et al. (2001), patients' ideas of safe help-seeking have a reasoned basis. In the wider imaginary of Kenyan women and girls, the protection of patients from abortion stigma is beyond the remit and competence of high-profile facilities and providers (Ndunyu, 2013). Currently, hospital-related folklore in Kenya recounts tales of providers and health facilities that surrender abortion-seekers to the police, pro-life counsellors, religious leaders, family and community (Izugbara and Egesa, 2014; Ndunyu, 2013). Yet, protection from stigma and guarantee of the secrecy of one's abortion are important for women seeking abortion services.

Lay resistance to and disagreement with public health notions of risk and safety is widespread and well-documented (Hughner and Kleine, 2004; Nations et al., 1997; Patten, 2015; Tinoco-Ojanguren et al., 2008). Such resistance often emerges from people's rational response to life circumstances informed by their lay understanding and experiences of particular health issues (Lawlor et al., 2003). In many contexts, lay resistance takes the form of collective social critique of public health strategies that occurs in the form of rumor, gossips and hearsay. In their study of abortion among poor and powerless Brazilian women, Nations et al. (1997) found that through popular culture, women asserted their shared opposition to the official opinion about the criminality and immorality of induced abortion and lack of family planning services. In the current study, women's abortion safety notions underscored their anxieties, struggles and concerns as everyday people negotiating both an intensely stigmatizing behavior as well as an unsympathetic health system.

Among other things, the views of participating women offer a powerful commentary on the limits of current public health discourses of safe abortion which disregard the complex social, economic and cultural forces that circumscribe induced abortion. Tensions between lay and public health definitions of abortion safety offer an opportunity to provide more robust and holistic understanding of contemporary health problems. As Lang and Rayner (2012) argue, for public health to be effective in the 21st century, it needs to connect more rigorously with the everyday lives and existential realities of individuals, groups, communities and societies; focus actions on the multifaceted determinants of health; and prioritize the production and sustenance of the manifold conditions that enable good health to thrive.

Acknowledgments

This study was primarily funded by the UK Department (Grant No: AG 5055 ARIES 113656) for International Development. Core support provided to APHRC by Sida and the William and Flora Hewlett Foundation assisted the authors in developing the study and writing up this paper. The study team also received support from the Safe Abortion Fund (SAAF). We also acknowledge the support of the STEP UP (Strengthening Evidence for Programming on Unintended Pregnancy) Research Programme Consortium, funded by UK aid from the UK Government (Grant SR1109D-6). We are immensely grateful to the women who accepted to be interviewed for this study and to the providers who supported the fieldwork as interviewers. By reading and critiquing our drafts and encouraging us to engage more with our data, our anonymous reviewers helped raised the quality of the paper.

References

African Population and Health Research Center, Ministry of Health [Kenya], Ipas, & Guttmacher Institute, 2013. Incidence and Complications of Unsafe Abortion in Kenya: Key Findings of a National Study. African Population and Health Research Center, Nairobi, Kenya.

African Population and Health Research Centre, 2009. Socioeconomic and Demographic Indicators in the Nairobi Urban Demographic Health Survey Sites. African Population and Health Research Centre, Nairobi.

Agwanda, A., Khasakhala, A., Kimani, M., 2009. Assessment of Family Planning Services in Kenya: Evidence from the 2004 Kenya Service Provision Assessment Survey.

Bok, S., 1989. Secrets: On the Ethics of Concealment and Revelation: Random House LLC.

Bourbonnais, B., 2013. Implementing Free Maternal Health Care in Kenya: Kenya National Commission on Human Rights (Nairobi).

Brookman-Amissah, E., 2004. Woman-centred safe abortion care in africa. Afr. J. Reprod. Health/La Revue Afr. Santé Reprod. 8 (1), 37–42. http://dx.doi.org/10.2307/3583303.

Bleek, W., 1981. Avoiding shame: the ethical context of abortion in Ghana. Anthropol. Quart 203–209.

Cain, R., 1991. Stigma management and gay identity development. Soc. Work 36 (1), 67–73.

Center for Reproductive Rights, 2010. In Harm's Way: The Impact of Kenya's Restrictive Abortion Law. Center for Reproductive Rights, New York.

Cockrill, K., Nack, A., 2013. "I'm not that type of person": managing the stigma of having an abortion. Deviant Behav. 34 (12), 973–990.

Cowan, S.K., 2014. Secrets and misperceptions: the creation of self-fulfilling illusions. Sociol. Sci. 1, 466–492.

Creswell, J.W., 2012. Qualitative Inquiry and Research Design: Choosing Among Five Approaches. Sage.

De Roubaix, M., 2007. Ten years hence—has the South African choice on termination

of pregnancy Act, Act 92 of 1996, realised its aims? A moral-critical evaluation. Med. Law 26 (1), 145–177.
East Africa Center for Law and Justice, 2012. Abortion in Kenya. Retrieved July 21, 2014, from. http://eaclj.org/about-us/7-fida-and-kclf-landscaped-comparison.html.
Fotso, J.C., Izugbara, C., Saliku, T., Ochako, R., 2014. Unintended pregnancy and subsequent use of modern contraceptive among slum and non-slum women in Nairobi, Kenya. BMC Pregnancy Childbirth 14 (1), 224.
Freedman, L., 2010. Willing and Unable: Doctors' Constraints in Abortion Care. Vanderbilt University Press.
Freedman, L., Landy, U., Steinauer, J., 2010. Obstetrician-gynecologist experiences with abortion training: physician insights from a qualitative study. Contraception 81 (6), 525–530.
Gebreselassie, H., Gallo, M.F., Monyo, A., Johnson, B.R., 2005. The magnitude of abortion complications in Kenya. BJOG: Int. J. Obstet. Gynaecol. 112 (9), 1229–1235. http://dx.doi.org/10.1111/j.1471-0528.2004.00503.x.
Geronimus, A.T., 2003. Damned if you do: culture, identity, privilege, and teenage childbearing in the United States. Soc. Sci. Med. 57 (5), 881–893.
Glaser, B.G., Strauss, A.L., 2009. The Discovery of Grounded Theory: Strategies for Qualitative Research. Transaction Publishers.
Goffman, E., 2009. Stigma: Notes on the Management of Spoiled Identity. Simon and Schuster.
Gogna, M., Romero, M., Ramos, S., Petracci, M., Szulik, D., 2002. Abortion in a restrictive legal context: the views of obstetrician–gynaecologists in Buenos Aires, Argentina. Reprod. Health Matters 10 (19), 128–137.
Heaton, R.L., 2012. Abortion as a Taboo Topic: A Network Text Analysis of Abortion Disclosure Decisions and Boundary Coordination. The University of Utah.
Herrera, A.A., Zivy, M.R., 2002. Clandestine abortion in Mexico: a question of mental as well as physical health. Reprod. Health Matters 10 (19), 95–102. http://dx.doi.org/10.1016/S0968-8080(02)00019-8.
Higgins, J.A., Hirsch, J.S., Trussell, J., 2008. Pleasure, prophylaxis and procreation: a qualitative analysis of intermittent contraceptive use and unintended pregnancy. Perspect. Sex. Reprod. Health 40 (3), 130–137.
Hughner, R.S., Kleine, S.S., 2004. Views of health in the lay sector: a compilation and review of how individuals think about health. Health 8 (4), 395–422.
Huntington, D., Mensch, B., Miller, V.C., 1996. Survey questions for the measurement of induced abortion. Stud. Fam. Plan. 155–161.
Hussain, R., 2012. Abortion and Unintended Pregnancy in Kenya. Guttmacher Institute, New York.
Ikamari, L., Izugbara, C., Ochako, R., 2013. Prevalence and determinants of unintended pregnancy among women in Nairobi, Kenya. BMC Pregnancy Childbirth 13 (1), 69.
Izugbara, C.O., Egesa, C., 2014. The management of unwanted pregnancy among women in Nairobi, Kenya. Int. J. Sex. Health 26 (2), 100–112.
Izugbara, C.O., Ochako, R., Izugbara, C., 2011. Gender scripts and unwanted pregnancy among urban Kenyan women. Cult. Health Sex. 13 (9), 1031–1045.
Izugbara, C.O., Otsola, K.J., Ezeh, A.C., 2009. Men, women, and abortion in central Kenya: a study of lay narratives. Med. Anthropol. 28 (4), 397–425.
Joffe, C.E., 2009. Dispatches from the Abortion Wars: The Costs of Fanaticism to Doctors, Patients, and the Rest of Us. Beacon Press.
Johnson-Hanks, J., 2002. The lesser shame: abortion among educated women in southern Cameroon. Soc. Sci. Med. 55 (8), 1337–1349.
Johnson, B.R., Benson, J., Bradley, J., Ordoñez, A.R., 1993. Costs and resource utilization for the treatment of incomplete abortion in Kenya and Mexico. Soc. Sci. Med. 36 (11), 1443–1453.
Jones, R.K., Frohwirth, L.F., Moore, A.M., 2007. I would want to give my child, like, everything in the world: how issues of motherhood influence women who have abortions. J. Fam. Issues 29, 79–99.
Kendall, C., Afable-Munsuz, A., Speizer, I., Avery, A., Schmidt, N., Santelli, J., 2005. Understanding pregnancy in a population of inner-city women in New Orleans—results of qualitative research. Soc. Sci. Med. 60 (2), 297–311.
Kenya National Bureau of Statistics, 2015. Ministry of Health, National AIDS Control Council, Kenya Medical Research Institute, & National Council for Population and Development. Kenya Demographic and Health Survey 2014: Key Indicators. Kenya National Bureau of Statistics, Nairobi.
Kenya National Bureau of Statistics (KNBS), & ICF Macro, 2010. Kenya Demographic and Health Survey 2008-09. KNBS and ICF Macro, Calverton, Maryland.
Kenya National Commison on Human Rights, 2012. Reproductive Health Rights in Kenya: A Myth or Reality. Kenya National Commison on Human Rights, Nairobi, pp. P40–P41.
Kippax, S., Stephenson, N., 2012. Beyond the distinction between biomedical and social dimensions of HIV prevention through the lens of a social public health. Am. J. Public Health 102 (5), 789–799.
Kumar, A., Hessini, L., Mitchell, E.M., 2009. Conceptualising abortion stigma. Cult. Health & Sex. 11 (6), 625–639.
Lang, T., Rayner, G., 2012. Ecological public health: the 21st century's big idea? BMJ 345, e5466 5461–5465.
Lawlor, D.A., Frankel, S., Shaw, M., Ebrahim, S., Smith, G.D., 2003. Smoking and ill health: does lay epidemiology explain the failure of smoking cessation programs among deprived populations? Am. J. Public Health 93 (2), 266–270. http://dx.doi.org/10.2105/AJPH.93.2.266.
Løkeland, M., 2004. Abortion: the legal right has been won, but not the moral right. Reprod. Health Matters 12 (24), 167–173.
Magadi, M.A., 2003. Unplanned childbearing in Kenya: the socio-demographic correlates and the extent of repeatability among women. Soc. Sci. Med. 56 (1), 167–178.
Major, B., Cozzarelli, C., 1992. Psychosocial predictors of adjustment to abortion. J. Soc. Issues 48 (3), 121–142.
Major, B., Gramzow, R.H., 1999. Abortion as stigma: cognitive and emotional implications of concealment. J. Personal. Soc. Psychol. 77 (4), 735.
Major, B., Mueller, P., Hildebrandt, K., 1985. Attributions, expectations, and coping with abortion. J. Personal. Soc. Psychol. 48 (3), 585.
Major, B., Richards, C., Cooper, M.L., Cozzarelli, C., Zubek, J., 1998. Personal resilience, cognitive appraisals, and coping: an integrative model of adjustment to abortion. J. Personal. Soc. Psychol. 74 (3), 735.
Marlow, H., Wamugi, S., Yegon, E., Fetters, T., Wanaswa, L., Msipa-Ndebele, N., 2013. The abortion context in Western Kenya: women's perspectives from the Bungoma and Trans Nzoia. Contraception 88 (3), 447. http://dx.doi.org/10.1016/j.contraception.2013.05.068.
Marlow, H., Wamugi, S., Yegon, E., Fetters, T., Wanaswa, L., Msipa-Ndebele, S., 2014a. Women's perceptions about abortion in their communities: perspectives from western Kenya. Reprod. Health Matters 22 (43), 149–158. http://dx.doi.org/10.1016/S0968-8080(14)43758-3.
Marlow, H.M., Wamugi, S., Yegon, E., Fetters, T., Wanaswa, L., Msipa-Ndebele, S., 2014b. Women's perceptions about abortion in their communities: perspectives from western Kenya. Reprod. Health Matters 22 (43), 149–158.
McMurtrie, S.M., García, S.G., Wilson, K.S., Diaz-Olavarrieta, C., Fawcett, G.M., 2012. Public opinion about abortion-related stigma among Mexican catholics and implications for unsafe abortion. Int. J. Gynecol. Obstetrics 118, S160–S166.
Ministry of Health, 2003. Kenya National Post Abortion Care Curriculum: Trainer's Manual, vol. 1. Ministry of Health (Kenya), Nairobi.
Ministry of Health. (not dated). National Guidelines for Quality Obstetrics and Perinatal Care. Nairobi: Ministry of Health.
Mitchell, E.M., Halpern, C.T., Kamathi, E.M., Owino, S., 2006. Social scripts and stark realities: Kenyan adolescents' abortion discourse. Cult. Health Sex. 8 (6), 515–528. http://dx.doi.org/10.1080/13691050600888400.
Nations, M.K., Misago, C., Fonseca, W., Correia, L.L., Campbell, O.M.R., 1997. Women's hidden transcripts about abortion in Brazil. Soc. Sci. Med. 44 (12), 1833–1845. http://dx.doi.org/10.1016/S0277-9536(96)00293-6.
Ndunyu, L.N., 2013. Women's Experiences of Induced Abortion in Mombasa and Kilifi Districts, Kenya. (PhD). University of Kwa-Zulu Natal, Kwa-Zulu Natal.
Njagi, J., Shilitsa, J., 2007. Kenya: 'Poverty to blame for spread of HIV'. Daily Nation. Poverty News. http://allafrica.com/stories/200712030129.html.
Norris, A., Bessett, D., Steinberg, J.R., Kavanaugh, M.L., De Zordo, S., Becker, D., 2011. Abortion stigma: a reconceptualization of constituents, causes, and consequences. Women's Health Issues 21 (3), S49–S54.
O'Donnell, J., Weitz, T.A., Freedman, L.R., 2011. Resistance and vulnerability to stigmatization in abortion work. Soc. Sci. Med. 73 (9), 1357–1364.
Orner, P., De Bruyn, M., Harries, J., Cooper, D., 2010. A qualitative exploration of HIV-positive pregnant women's decision-making regarding abortion in Cape Town, South Africa. SAHARA J J. Soc. Asp. HIV/AIDS Res. Alliance 7 (2).
Park, K., 2002. Stigma management among the voluntarily childless. Sociol. Perspect. 45 (1), 21–45.
Patten, S., 2015. Medical models and metaphors for depression. Epidemiol. Psychiatr. Sci. 1–6.
Petronio, S., Caughlin, J.P., Braithwaite, D., Baxter, L., 2006. Communication privacy management theory: understanding families. Engag. Theor. Fam. Commun. Mult. Perspect. 35–49.
Pill, R., Prior, L., Wood, F., 2001. Lay attitudes to professional consultations for common mental disorder: a sociological perspective: depression and public health. Br. Med. Bull. 57 (1), 207–219. http://dx.doi.org/10.1093/bmb/57.1.207.
Piot, P., Bartos, M., Larson, H., Zewdie, D., Mane, P., 2008. Coming to terms with complexity: a call to action for HIV prevention. Lancet 372 (9641), 845–859.
Popay, J., Williams, G., 1996. Public health research and lay knowledge. Soc. Sci. Med. 42 (5), 759–768. http://dx.doi.org/10.1016/0277-9536(95)00341-X.
Putland, C., Baum, F., Ziersch, A., 2011. From causes to solutions - insights from lay knowledge about health inequalities. BMC Public Health 11 (1), 67.
Rance, S., 2005. Abortion discourse in Bolivian hospital contexts: doctors' repertoire conflicts and the saving women device. Sociol. Health Illn. 27 (2), 188–214.
Rogo, K., Solomon, O., Oguttu, M., 1998. Preventing unsafe abortion in western Kenya: an innovative approach through private physicians. Reprod. Health Matters 6 (11), 77–83. http://dx.doi.org/10.2307/3775524.
Rossier, C., 2007. Abortion: An Open Secret? Abortion and Social Network Involvement in Burkina Faso. Reprod. Health Matters 15 (30), 230–238. http://dx.doi.org/10.1016/S0968-8080(07)30313-3.
Scharwächter, P., 2008. Abortion decision making by focusing: a preliminary study. Eur. J. Contracept. Reprod. Healthc. 13 (2), 191–197.
Schuster, S., 2005. Abortion in the moral world of the Cameroon grassfields. Reprod. Health Matters 13 (26), 130–138.
Shellenberg, K.M., Moore, A.M., Bankole, A., Juarez, F., Omideyi, A.K., Palomino, N., Tsui, A.O., 2011. Social stigma and disclosure about induced abortion: results from an exploratory study. Glob. Public Health 6 (Suppl. 1), S111–S125.
Shellenberg, K.M., Tsui, A.O., 2012. Correlates of perceived and internalized stigma among abortion patients in the USA: an exploration by race and hispanic ethnicity. Int. J. Gynecol. Obstet. 118, S152–S159.
Suh, S., 2014. Rewriting abortion: deploying medical records in jurisdictional negotiation over a forbidden practice in Senegal. Soc. Sci. Med. 108, 20–33.
Tinoco-Ojanguren, R., Glantz, N.M., Martinez-Hernandez, I., Ovando-Meza, I., 2008. Risk screening, emergency care, and lay concepts of complications during pregnancy in Chiapas, Mexico. Soc. Sci. Med. 66 (5), 1057–1069.

United Nations, 2010. The Millennium Development Goals Report 2010. New York.
Vangelisti, A.L., Caughlin, J.P., 1997. Revealing family secrets: the influence of topic, function, and relationships. J. Soc. Pers. Relat. 14 (5), 679–705.
Webb, D., 2000. Attitudes to 'Kaponya Mafumo': the terminators of pregnancy in urban Zambia. Health Policy Plan. 15 (2), 186–193.
Whittaker, A., 2002. 'The truth of our day by day lives': abortion decision making in rural Thailand. Cult. Health Sex. 4 (1), 1–20.
Winikoff, B., Sheldon, W., 2012. Use of medicines changing the face of abortion. Int. Perspect. Sex. Reprod. Health 164–166.
World Health Organization, 2003. Safe Abortion: Technical and Policy Guidance for Health Systems. World Health Organization, Geneva.
World Health Organization, 2011. Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008, sixth ed. World Health Organization, Geneva.
Ziraba, A.K., Izugbara, C., Levandowski, B.A., Gebreselassie, H., Mutua, M., Mohamed, S.F., Kimani-Murage, E.W., 2015. Unsafe abortion in Kenya: a cross-sectional study of abortion complication severity and associated factors. BMC Pregnancy Childbirth 15 (1), 34.