

## Facts on Abortion in Kenya

### CONTRACEPTION AND UNINTENDED PREGNANCY

- Behind nearly every abortion is an unintended pregnancy.
- More than 40% of births in Kenya are unplanned; among adolescents aged 15–19, 47% are unplanned.
- In 2007, one in four married Kenyan women had an unmet need for contraceptives; that is, they could become pregnant, did not want a child soon or at all, and were not using any method of contraception. This statistic has barely changed in more than a decade.
- Some 39% of Kenyan women use contraceptives; a third of users rely on a modern method.

### ABORTION ACCESS

- Abortion in Kenya is legal only when it is necessary to save a woman's life. It must take place in a hospital, with three medical practitioners certifying that the procedure is necessary.
- Each year, an estimated 316,560 abortions—both spontaneous and induced—occur in Kenya; that is 46 abortions for every 1,000 women of reproductive age, or about 29 for every 100 live births. In Eastern Africa as a whole, there are an estimated 20 abortions per 100 live births.
- Despite legal restrictions and the medical risks associated with clandestine procedures, Kenyan women obtain abortions from a wide range of providers, including doctors at private clinics,

midwives, traditional herbalists and other untrained providers; some women induce abortion themselves.

### ATTITUDES TOWARD ABORTION

- National-level information on Kenyans' attitudes toward abortion is lacking.
- A recent study in Nyeri District found that older women see abortion in pragmatic terms, as a response to the socioeconomic burden of having too many children or as a way to space births; older men generally view it as a way to conceal the consequences of premarital or extramarital sex.
- A 1990 study in Nairobi found that medical professionals were evenly divided in their support for liberalizing Kenya's abortion law but held generally negative attitudes about abortion.
- Almost half of nurses and nursing students surveyed in two Nairobi hospitals thought that emergency contraception was an abortifacient, and they were less likely to recommend it than those who did not hold this misperception.

### CHARACTERISTICS AND REASONS

- Women of all ages obtain abortions. A national study of women admitted to public health facilities for abortion-related complications found that 40% were aged 25–34, 12% were older than 34 and 16% were in their teens.
- In 2002, women seeking abortions had an average of three prior pregnancies.

- Sixty-five percent of women admitted to a Western Province hospital with postabortion complications were from rural areas; 59% were or had been married; and 71% were housewives or unemployed.

- Adolescents most frequently cite the stigma of childbirth outside of marriage, the inability to support a child and the possibility of having to quit school as reasons for having an abortion.

- Older and married women more commonly cite economic hardship and the desire to space the births of their children.

### POSTABORTION CARE

- An estimated 21,000 women are admitted each year to Kenyan public hospitals for treatment of complications from incomplete abortion; 28% experience severe complications, such as uterine perforation and shock.

- Abortions performed after the first trimester of pregnancy are generally riskier than those performed earlier; one-third of Kenyan women treated for postabortion complications are in the second trimester.

- Only 16% of facilities offering delivery services are equipped to perform vacuum aspiration, which uses suction to empty the uterus and is preferable to dilation and curettage (D&C) for the management of incomplete abortion. Just 14% are equipped to perform D&C procedures, recommended by the World Health

Organization when vacuum aspiration is not available.

- Women in rural areas have much less access to treatment for abortion complications than do women in urban settings.
- Private-sector facilities handle more than half of postabortion care cases, despite the fact that they charge patients about three times more than public-sector facilities do.
- In the 1990s, the Ministry of Health expanded postabortion care in district hospitals to include contraceptive services, after a study showed the effectiveness of family planning counseling and contraceptive use in preventing unsafe abortion. Years later, provision of these services in Kenya is still rated as middling by experts.

#### **COSTS OF ABORTION**

- One in 39 Kenyan women die from pregnancy-related causes. There are 560 maternal deaths per 100,000 live births.
- In Eastern Africa, in 2003, almost one in five maternal deaths were due to unsafe abortion. Even more common are long-term health problems, social stigma and infertility.
- In addition to the cost of the abortion procedure itself, further financial costs associated with abortion include time off from work, travel and postabortion care.
- Postabortion care costs an average of 1,130 Kenyan shillings per patient and accounts for an estimated 60% of public hospital expenditures.
- Abortions performed by a skilled provider are much more expensive than riskier proce-

dures performed by unskilled providers. Therefore, it is likely wealthier women obtain safer abortions than poorer women, who may only be able to afford to self-induce an abortion or seek the services of a dangerously unskilled provider.

#### **RECOMMENDATIONS**

- Concerted efforts must be made to reduce unintended pregnancies, since this is the most effective and cost-efficient way of reducing unsafe abortion.
- Comprehensive sex education should be provided in all secondary schools to ensure young people have the information they need to safeguard their reproductive health.
- The Ministry of Health prioritized strengthening family planning services in the 2007 Kenyan Reproductive Health Policy. It is crucial that the government follow through on its guarantee to make contraceptives available and train providers in sexual and reproductive health services.
- Family planning services should be integrated into the provision of postabortion care, since family planning has been shown to reduce unintended pregnancy and the abortions that often result.
- All health facilities that perform abortions and provide postabortion care should have the appropriate equipment and trained staff to ensure that quality care is consistently available at a reasonable cost.
- More research should be carried out, focusing on attitudes about abortion, the cost of postabortion care to the government, and the link

between poverty and unsafe abortion. Such data would help inform policies and programs that could increase well-being among women and families and reduce unnecessary illness and deaths.

*The data in this fact sheet are the most current available and are drawn from Unsafe Abortion in Kenya, In Brief, New York: Guttmacher Institute, 2008, No. 4.*



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