Introduction

Unsafe abortion- the termination of a pregnancy by persons lacking the requisite skills, or in an environment lacking minimal medical standards or both- remains a major public health issue throughout the developing world (World Health Organization, 2003, 2011). The bulk of the estimated annual 22 million unsafe abortions and associated 47,000 annual deaths occur in the global south (Sedgh et al., 2012). In Kenya, unsafe abortion currently accounts for a quarter of all maternal deaths. In 2012, seventy-five percent of the estimated half a million abortions that occurred in Kenya were unsafe (African Population and Health Research Center, Ministry of Health [Kenya], Ipas, & Guttmacher Institute, 2013). Research in Kenya has concentrated on the incidence of unsafe abortion, its persistence, the magnitude of its complications, and health system implications (African Population and Health Research Center et al., 2013; Gebreselassie, Gallo, Monyo, & Johnson, 2005; Marlow et al., 2013; H. M. Marlow et al., 2014). 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 unsafe abortion patients have also been studied in Kenya (African Population and Health Research Center et al., 2013; Brookman-Amissah, 2004; Center for Reproductive Rights, 2010; Gebreselassie et al., 2005; Izugbara & Egesa, 2014; Izugbara, Ochako, & Izugbara, 2011; Izugbara, Otsola, & Ezeh, 2009; Johnson, Benson, Bradley, & Ordoñez, 1993; Marlow et al., 2013; Mitchell, Halpern, Kamathi, & Owino, 2006; Rogo, Solomon, & Oguttu, 1998).

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 et al., 2013; Hussain, 2012; H. Marlow et al., 2014; Ndunyu, 2013). Propositions linking this situation to differences 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 & Egesa, 2014; Ndunyu, 2013). Such research has been viewed as particularly valuable in the context of the 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. The questions addressed in the current study are: How, in the context of Kenya's current abortion law as well as severe abortion stigma in the country, do ordinary women constitute and understand abortion safety? And how do lay and public health discourses of abortion safety compare?

The global success of public health strategies in shrinking poor health outcomes has been considerably tempered by their limited attention to the social context and conditions of people's lives (Lang & 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). In the field of HIV for example, public health prevention and stigma reduction strategies, including condom distribution, free testing services, media campaigns and public education continue to deliver below expectation owing particularly to the neglect of the social reality of people's everyday life (Kippax & Stephenson, 2012; Piot, Bartos, Larson, Zewdie, & Mane, 2008), raising 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, Baum, & Ziersch, 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 efforts (Putland et al., 2011).

In this paper, we interrogate Kenyan women's perspectives on abortion stigma and safety as well as choice of pregnancy termination services. Findings have 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 environment of the procedure. While the conclusions reached in this paper are not incontrovertible, they have far-reaching salience for current efforts to 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 need for more reflections on the value of lay notions of safety in current public health responses to unsafe abortion. Lay abortion safety perceptions can inform efforts to save women's lives, cut 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 et al., 2013; Izugbara & Egesa, 2014).

Context

With an estimated population of 40 million people and a constitution that explicitly addresses abortion, Kenya offers a remarkable context for interrogating the social dimensions and meanings of abortion safety (Izugbara & 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. While the 2010 constitution presumably offers a new legal basis for women's access to safe abortion, a nationally-representative study conducted in 2012 estimated an annual incidence of nearly half a million induced abortions in Kenya, an induced abortion rate of 48 abortions per 1000 women of reproductive age, and an induced abortion ratio of 30 abortions per 100 births (African Population and Health Research Center et al., 2013).

Interestingly, the bulk of these abortions were among married women and women aged less than 25 years. 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 et al., 2013).

Currently, unsafe abortion is a leading cause of maternal morbidity and mortality in Kenya (Center for Reproductive Rights, 2010). The treatment of abortion complications also uses 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 to 33% in 1993, 39% in 2003, and to 46% in 2008-9 (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 2008-9, 42% of married women in Kenya reported their current pregnancies as unintended (Kenya National Bureau of Statistics (KNBS) & ICF Macro, 2010).

Poor access to family planning services and products, lack of comprehensive sexuality education, and fear of the side effects of contraceptives lead the causes of 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 is also out of the reach of several 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 also mainly found in urban areas (Agwanda, Khasakhala, & Kimani, 2009). Stigma related to contraceptive use and cultural pressure to have many children also inhibit the utilization of family planning services among women and girls in Kenya (Izugbara et al., 2011). Economic conditions in Kenya continue to plunge, and women remain the worst hit by the worsening economic situation in the country (Fotso, Izugbara, Saliku, & Ochako, 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 also 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 & Shilitsa, 2007). Termination of pregnancies resulting from sexual violence thus remains common in Kenya (Izugbara & Egesa, 2014; Ndunyu, 2013). Societal attitudes towards abortion are also largely negative in the country, forcing many Kenyan women to seek it clandestinely, often with tragic sequelae (African Population

and Health Research Center et al., 2013; Marlow et al., 2013; H. Marlow et al., 2014; Ndunyu, 2013).

Literature

While abortion stigma continues to receive critical attention globally in studies on abortion safety and care-seeking practices (Herrera & Zivy, 2002; Major & Gramzow, 1999; McMurtrie, García, Wilson, Diaz-Olavarrieta, & Fawcett, 2012; Orner, De Bruyn, Harries, & Cooper, 2010; Shellenberg et al., 2011; Shellenberg & Tsui, 2012); little of the extant research has directly addressed lay perceptions of abortion safety in the context of abortion stigma. The focus of extant research has been on models for measuring abortion stigma (Huntington, Mensch, & Miller, 1996; Kumar, Hessini, & Mitchell, 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, Weitz, & Freedman, 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, Landy, & Steinauer, 2010; Joffe, 2009; Major & Cozzarelli, 1992; Major & Gramzow, 1999; Major, Mueller, & Hildebrandt, 1985; Major, Richards, Cooper, Cozzarelli, & Zubek, 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 social silence and isolation around abortion (Cockrill & Nack, 2013).

As a stigmatized behavior 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 & Nack, 2013; Kumar et al., 2009). This confirms Goffman's (2009) thesis 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, 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 on stigma by illuminating how lay safety discourses can emerge among stigmatized people as they negotiate reputation, health, privacy, respect and support.

Materials and method

We conducted qualitative interviews with 50 women treated for complications of unsafe abortion at six purposively-selected public facilities in Kenya. The sample size of 50 women and the distribution of the respondents across the facility-types are arbitrary and motivated largely by time considerations and the need for analytical convenience. The sampled facilities were two Level 6 health facilities, two Level 5 public facilities and four Level 4 public health facilities. 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 et al., 2013). From Level 6 health facilities, we interviewed 24 women (12 in each facility) and from the rest we interviewed 26 women (6 each from a facility). Respondents were women successfully discharged following treatment for complications of unsafe abortion in the sampled facilities. Participants were only patients who acknowledged deliberately interfering with their pregnancy to the provider who attended to them. In some instances, the provider established further evidence of such interference through physical examination of the patient. Interviews were conducted by trained nurses and midwives in the sampled facility and who were fluent in English and Swahili. Interviewers were trained in qualitative interviewing by expert qualitative researchers. In each facility, the interviewing nurse or midwife approached every discharged post-unsafe abortion care patient with an interview request. They carefully explained to the respondents that their responses were only for research purposes and will not be used for other causes. Respondents were unambiguously apprised that the interviewers were not acting for law enforcement agencies, government units or judicial institutions. In Kenya, providers of post-abortion care are not under obligation to report women presenting for post-abortion care to law enforcement agencies. The process of recruiting participants continued until the sample size allotted to the particular facility was met. Interviews were only conducted with women who consented to the research. The interviews were held in the sampled facility or its environs, in spaces free of the attentive eyes, threat of sanctions, and pressure of non-participants. Interviewers were providers based in the sampled facilities and were trained for 3 days on how to conduct qualitative interviews with patients. Data collection for the study lasted one month. A total of 50 interviews were conducted in six facilities across the country. One transcriber was trained to translate the interviews from Swahili to English. The transcribed interviews formed the data and were coded thematically.

A qualitative inductive approach involving thematic assessment of the narratives is used to interrogate the data. According to Higgins, Hirsch, and Trussell (2008), this method supports the unearthing of key issues in qualitative data as well as the untangling of the meanings and messages of leitmotifs in narrative data for categories, linkages, and properties (Izugbara et al., 2011). 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.

Respondents

(Table 1 about here)
As Table I 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. The bulk of the women were aged below 25. Majority had only primary-level education and their mean years of completed formal schooling stood roughly at 9. Responding women's marital backgrounds varied markedly: married (24%), single (64%), living together (10%) and widowed (2%) etc. Students, the casually-employed, and women in petty private 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 husbands, fathers, mothers, brothers, uncles, and sisters. Some of the respondents also reported previous abortions. Very few of the women disclosed consistent use of contraceptives.

The pregnancies terminated by the respondents were often reported as unwanted. Redolent of Izugbara and Egesa (2014) and Izugbara, Ochako and Izugbara (2011), idealized notions of femaleness and women's roles suffused responding women's perceptions of unwanted pregnancies. Overall, the unwantedness of the terminated pregnancies derived from their occurrence in contexts that defied local notions of motherhood and proficient womanhood and of women as nurturers and wives, conflicted with local beliefs about 'proper' procreation or divulged women's use of their sexuality in socially-disagreeable ways. Our data also underscored the centrality of pregnancy to women's identity. 'It is women who bear children.' One interlocutor noted. Another respondent, 28-year-old Pina averred: 'One cannot be a woman without getting 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 helpful to women. Pregnancies that put women's identity at risk were reported as likely to be terminated. Putting this point in perspective, Pina (mentioned above) told us: 'As a woman, I know that pregnancy is important. But not all pregnancy is good for me. When a pregnancy will put you in trouble, you may terminate it.'

Abortion and abortion services
Responding women considered abortion to be widespread in Kenya and did not deem it a problem of unmarried women and girls only. It was reportedly common among rich and poor women, widows, married women as well as working and unemployed women. It was also seen as frequent among married 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 largely close acquaintances: sisters, mothers, cousins, nieces, neighbors, classmates, sisters, and friends. In several 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. Respondents regularly noted that the abortions of their acquaintances and friends were often 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 confirmed 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. Before long, 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 had rich knowledge of different abortion methods, diverse providers of abortion services, and various locations where abortion can be procured. Reportedly, women could dislodge 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 knew about modern medicines that terminate pregnancies. Having one's stomach roughly massaged or marched 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 good knowledge of abortion methods and from whom women could obtain pregnancy termination services. One respondent put it thus: 'In the estate where I live, women and girls know who to approach if they get pregnant accidentally. Even some of the teachers in the schools know how to help girls terminate a pregnancy.' Narratives suggested that there were also 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. The women had used different means and providers to induce their abortions. TBAs, chemist shop owners, pharmacists, clinical

officers, nurses and other hospital workers topped the list of the providers used by the women. Essentially, 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 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 own words, 'my mother told me that there was nothing to worry about as she knew what she was doing. She told me 'the only thing is for you to do whatever I tell you and you will be fine.'

The TBA who helped Christie to terminate her pregnancy inserted a mashed leafy substance into her vagina and also gave her some pills to swallow. In the case of another respondent, Myra, her boyfriend brought her pills which she ingested and later began to bleed copiously. There was also a respondent whose school friend linked 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 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 woman was referred by friends to a small informal health center. She said 'The provider inserted something like a pair of scissor 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 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 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

Among the women we studied, abortion was constituted as a problematic and morally-contentious issue that was not permissible in Kenya. They were also fully aware of the stigma surrounding it. 'In Kenya, abortion is not viewed positively and you have to hide …it.' One woman offered. 'Abortion is not permitted here. It is viewed as bad… though many people do it.' Another maintained. Generally, participants felt that they had engaged in a deviant and pilloried 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 & Nack, 2013; Goffman, 2009; Major & 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 sentiment, a 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 woman observed: 'In this country, it is better to die than 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.'

Un/safe abortion narratives

Judging by the data, responding women's 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, respondents knew qualified doctors and well-equipped facilities and hospitals that offer abortion services. They also knew of women who had obtained pregnancy termination services from qualified providers and high-profile health facilities. For instance, Myra knew that that her rich boss, a banker, procured abortion from a big and popular hospital in Nairobi. Another respondent affirmed knowing a girl whose wealthy parents assisted to procure an abortion at a popular exclusive 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 that high-profile health facilities and skilled providers could put women seeking abortion at grave risk. 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 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 trying to make their abortions safe. Further, abortion safety was not just described in terms of the physical health of the woman, but also in terms of her social, reputational, relationship and economic security. One 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 guarantee patients' secrets. 'They keep records of everybody who comes for treatment. But some providers do not keep records or know what to keep record of and abortion is not one of those things.' Another 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 the women we studied, safe abortion was constituted in terms of pregnancy termination procedures and providers that

safeguard women's abortions secret and protect them from the law, were affordable, and decided on through dependable social networks.

A major theme in responding women's construction of safe abortion was patient's social integrity and reputation. In one clear and lucid articulation of this point, a respondent noted that an abortion is safe if it does not protect both the woman's health and social reputation. Among the women we interviewed, safe abortion connoted 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. 'If you help a woman terminate her pregnancy successfully but end up exposing it to people she would ordinarily not want to know about it, then the abortion is not safe.' Explained a respondent. Another participant put it thus, 'A good and safe abortion service and provider will ensure that people do not hear or know that a woman has had an abortion.' At closer look and probe, the narratives we elicited strongly indicated women's lack of faith in high-profile health facilities and providers to ensure the privacy needs of abortion-seeking women. 'It is not safe to use those big hospitals for abortion. They expose women's secrets and everybody will know what you came for.' A respondent observed. Park (2002) and Goffman (2009) suggest that persons who engage in stigmatized behavior actively conceal their actions from potentially stigmatizing people. 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. '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, 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 (Cain, 1991; Cowan, 2014; Goffman, 2009; Petronio, Caughlin, Braithwaite, & Baxter, 2006; Vangelisti & 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, unmarried young women in the study maintained that hospitals were not safe for abortion because their parents or guardians may be contacted by providers. TBAs and other informal providers were reported as sources of safer abortion services. They would not request for parental consent or approval before offering abortion service. Married

women would also not be asked to bring their husbands if they presented to informal providers and settings for abortion. Other women spoke about how high-profile facilities retain copies of patients' IDs in files, making women easily traceable.

Another prevalent notion among the women was that abortion safety can be guaranteed by utilizing abortion procedures and providers decided on through the wisdom, experience and recommendations of dependable social networks. 'You will just know from friends that a particular provider or facility is good, will not disclose your secret, and does not engage in formalities, respects woman and these make you feel safe to use it. It is not safe to use a provider without recommendation from people you trust.' Asserted one respondent. Interestingly, narratives suggested that highly-skilled providers and high-profile facilities are hardly recommended as safe for abortion-seeking women. Hospital-based providers were reportedly condemnatory and judgmental towards women seeking abortion. They talked behind women, called them names and even publicized their abortion. One woman noted: 'Providers in these big formal facilities make women feel very bad. They would say, when you were having sex, did you not know that you will get pregnant.' Another 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 Jane procured an abortion medication was recommended by a friend who had also previously used him. '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.' Jane told us. The shopkeeper simply told her that many people come to him for the same service and that she should not feel alone. 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 despise women who engage in abortion. This resonates with Goffman's (2009) contention that there are great rewards in being considered normal.

There was also broad consent that affordability is a key dimension of abortion safety. Unaffordable abortion procedures and providers were considered unsafe for women. They reportedly exposed women to stigma, mistreatment and ridicule. They also sometimes pressure women seeking abortion to keep their pregnancies. One 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 turned around and 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 poor, unemployed, and desperate. Abortion services need to be cheap and affordable for such 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. '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. 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. One respondent drove this point home thus: 'I didn't have enough money and in the hospital, I was told it is about 5000 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.' Another respondent noted thus: 'Hospitals that provide abortion charge very high. They can make you sell something or borrow just to get an abortion. They keep you if you cannot pay and everybody will then know…'

Respondents generally believed that abortion is illegal in Kenya and mentioned 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 constituted in terms of procedures and providers that shielded women from the law. 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. '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.' Declared 30-year-old Mercy. Stories of women cajoled by providers in formal facilities into keeping their pregnancy were common. Evident in these stories was that women made it clear that some providers pay little mind to the negative consequences for women of being forced to keep pregnancies they have made up their mind 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 asserted: 'you know 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, we hear that they will mess you up and hand you over to the police.' This particular interlocutor noted that her friend who she presented for abortion at a government-owned facility was threatened with police arrest until she phoned her mother and told her where she was. Of course, her friend did not want the parents to know. Another respondent knew a woman who went to a big government facility for abortion but ended up getting connected to a pastor who counselled her on the sin of abortion.

Similarly, one respondent 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. The process of choosing abortion methods and providers involves making critical choices regarding what is safe for a women engaging in a taboo behavior. As secret-keeping is key and beneficial in image management and reputation protection among women in a context where abortion is stigmatized (H. Marlow et al., 2014; Ndunyu, 2013), resort to particular, often unsafe abortion services and procedures that promise safety from the law, invariably enables women to manage the perceived social risks surrounding abortion.

Discussion and conclusion

The social dimensions and meanings of abortion safety remain poorly explored in the literature. We studied women who underwent unsafe abortion complications for their notions of unsafe abortion and their choice of pregnancy termination services and practices. From a public health perspective, well-trained health personnel and equipped facilities equate safe abortion. But the women we interviewed espoused a different perspective on abortion safety. For them, abortion safety is a function of providers and facilities able to safeguard women's abortion secret; act as accomplices and coconspirators to women, offer affordable service, and decided on through critical social networks. Put simply, only abortion procedures and providers that are sensitive to the social implications of women's participation in a stigmatized and illegal behavior were safe for women. In Kenya, little reprieve exists for women-seeking abortion in formal health settings (Ndunyu, 2013). The stigma and discrimination they face in the rest of society are regularly reproduced in formal health care settings. The views of the abortion patients we studied are therefore not irrational (Popay & Williams, 1996). According to Pill, Prior, & Wood (2001), patients' ideas of safe help-seeking have a reasoned basis. In the wider lay 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 in Kenya, hospital-related folklore recounts tales of providers and health facilities that surrender abortion-seekers to the police, pro-life counsellors, religious leaders, family and community (Izugbara & 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 & Kleine, 2004; Nations, Misago, Fonseca, Correia, & Campbell, 1997; Patten, 2015; Tinoco-Ojanguren, Glantz, Martinez-Hernandez, & Ovando-Meza, 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, Frankel, Shaw, Ebrahim, & Smith, 2003). In some contexts, lay resistance takes the form of "hidden transcripts" that critique public health strategies. In their study of abortion among poor and powerless Brazilian women, Nations *et a*l (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 concerns as everyday people negotiating both an intensely stigmatizing behavior as well as an unsympathetic health system. Their views offer a powerful commentary on the limits of current public health framing of safe abortion which disregards 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 more holistic understanding of contemporary health problems. As Lang & 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.

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Table 1: ***Participants' socio-demographics***

Characteristics		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