
Stephanie Dellicour, Liverpool School of Tropical Medicine
George Aol, Kenya Medical Research Institute
Peter Ouma, Kenya Medical Research Institute
Nicole Yan, Liverpool School of Tropical Medicine
Godfrey Bigogo, Kenya Medical Research Institute
Mary J Hamel, Centers for Disease Control and Prevention
Deron C Burton, Centers for Disease Control and Prevention
Martina Oneko, Kenya Medical Research Institute
Robert Breiman, Emory University
Laurence Slutsker, Centers for Disease Control and Prevention

Only first 10 authors above; see publication for full author list.

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Weekly miscarriage rates in a community-based prospective cohort study in rural western Kenya

Stephanie Dellicour,1 George Aol,2 Peter Ouma,2 Nicole Yan,1 Godfrey Bigogo,2 Mary J Hamel,3 Deron C Burton,3 Martina Oneko,2 Robert F Breiman,4 Laurence Slutsker,3 Daniel Feikin,3 Simon Kariuki,2 Frank Odhiambo,2 Gregory Calip,5 Andreas Stergachis,6 Kayla F Laserson,3 Feiko O ter Kuile,1 Meghna Desai3


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ABSTRACT

Objective: Information on adverse pregnancy outcomes is important to monitor the impact of public health interventions. Miscarriage is a challenging end point to ascertain and there is scarce information on its rate in low-income countries. The objective was to estimate the background rate and cumulative probability of miscarriage in rural western Kenya.

Design: This was a population-based prospective cohort.

Participants and setting: Women of childbearing age were followed prospectively to identify pregnancies and ascertain their outcomes in Siaya County, western Kenya. The cohort study was carried out in 33 adjacent villages under health and demographic surveillance.

Outcome measure: Miscarriage.

Results: Between 2011 and 2013, among 5536 women of childbearing age, 1453 pregnancies were detected and 1134 were included in the analysis. The cumulative probability was 18.9%. The weekly miscarriage rate declined steadily with increasing gestation until approximately 20 weeks. Known risk factors for miscarriage such as maternal age, gravidity, occupation, household wealth and HIV infection were confirmed.

Conclusions: This is the first report of weekly miscarriage rates in a rural African setting in the context of high HIV and malaria prevalence. Future studies should consider the involvement of community health workers to identify the pregnancy cohort of early gestation for better data on the actual number of pregnancies and the assessment of miscarriage.

BACKGROUND

Miscarriage is the most common adverse pregnancy outcome with aggravating emotional consequences for affected individuals and families. It is also a critical indicator of embryotoxicity and an important outcome for the study of embryotoxic effects of environmental, occupational and medication risks.1–3 Furthermore, it is a relevant end point to track the progress of reproductive health programmes and their impact on maternal health. Without accounting for miscarriage, maternal and reproductive health-related indicators miss a significant number of unreported pregnancies that are often not seen by the health system and are not recorded. For instance, indicators for antenatal care (ANC) coverage are based on the total number of women who had a live birth in a specific time period not accounting for up to 30% of pregnancies that are lost either to miscarriage or stillbirth.4 5 This may lead to unrepresentative estimates of access and utilisation of healthcare for high-risk pregnancies ending in miscarriage or stillbirth.

Strengths and limitations of this study

This study identified pregnancies early from the general population in a rural setting in western Kenya and refusal rate was low (6%).

The study is strengthened by the use of survival analysis with left truncation and the life table method to estimate weekly background rates and cumulative probability of miscarriage, respectively.

Misclassification between spontaneous and induced abortion cannot be ruled out, which is a limitation of the present study. Given estimates were within the expected range, and since known risk factors for miscarriages could be confirmed, this is unlikely to have had a substantial effect on the estimates.

Estimates for the rate of miscarriage in early weeks of gestation were less precise due to the low numbers of pregnancies detected <6 weeks gestation.
Despite this being a significant reproductive health outcome, data on miscarriage rates in low-income and middle-income countries are scarce. Studies from industrialised countries report rates of miscarriage in clinically recognised pregnancies (ie, from 5 to 6 gestational weeks following the last menstrual period (LMP), the common gestational age for pregnancy recognition) that vary between 11% and 22%. When taking into account early miscarriage for pregnancies diagnosed by human chorionic gonadotropin or ultrasound before the appearance of fetal heart activity, the reported rates are closer to 30%.7

Miscarriage is a challenging end point to ascertain and accurate rates of miscarriage are difficult to estimate. There are methodological complexities of conducting studies to assess the miscarriage rate10 which relate to the difficulties in identifying a representative sample of pregnancies at the time of conception, the confirmation of suspected pregnancy and the determination of the exact timing of pregnancy loss. To accurately capture all pregnancy losses in a population, a study needs to be able to identify pregnancies from the time of conception and follow them prospectively. Early pregnancy losses, which occur before a pregnancy is usually recognised (ie, <5–6 weeks gestation), can only be detected by frequently repeated highly sensitive pregnancy tests.

Few studies have been designed to detect such early pregnancy loss and ascertained pregnancies close to the time of conception by enrolling participants who are planning to conceive and consent to regular pregnancy tests. Since a significant proportion of pregnancies are unplanned, data from these studies may have limited generalisability. Other studies recruiting women from antenatal clinics miss pregnancy loss occurring before initiation of ANC and may also be prone to selection bias as women presenting early for ANC may represent higher risk pregnancies than women presenting later. The assigned timing of miscarriage is usually based on the time of clinical recognition of pregnancy loss; however, fetal death may have occurred weeks before.

Studies of miscarriage in low-income and middle-income countries face additional challenges as most miscarriages occur without any contact with the formal healthcare system and are not registered. Since pregnant women usually present for ANC late in pregnancy (with an estimated 11–54% of women initiating ANC in the first trimester, and most presenting late in the second trimester), health facility-based recruitment and data collection strategies are inappropriate. In such settings, the study of miscarriage requires a community-based approach taking into account the different cultural and superstitious beliefs that may affect pregnancy disclosure and detection. Furthermore, reliable data on gestational age are difficult to obtain as ultrasound scans are rarely available and date of LMP may not be reliable in settings with limited literacy. There is also a higher risk of misclassification of induced abortions as spontaneous abortions as the former are illegal in most of these settings. The methodological constraints for measuring this outcome require early pregnancy detection and prospective follow-up from a population-based representative sample of all women of childbearing age (WOCBA) to minimise selection bias.

METHODS

Overview of study design

A prospective cohort of pregnant women was enrolled within a pharmacovigilance study to assess the risk of inadvertent first trimester exposures to artemisinin combination therapy (being reported elsewhere) between February 2011 and February 2013. Pregnancies were identified as early as possible through health facility and community-based strategies (described below), and followed prospectively (ie, before the pregnancy outcome was known) to document pregnancy outcome.

Study site

The study area was located in Siaya County, lying north-east of Lake Victoria in Nyanza Province, western Kenya. The cohort study was carried out in 33 adjacent villages under the Kenya Medical Research Institute-Centers for Disease Control and Prevention (KEMRI-CDC) Health and Demographic Surveillance System area (KEMRI-CDC HDSS). Nyanza Province has a high burden of disease and health indicators that are worse than the overall Kenyan national statistics. Malaria transmission is high with parasitaemia of 20% in over 14-year-olds (unpublished KEMRI-CDC data for 2010). Whereas the national HIV prevalence is 6.3% (4% for men and 8% for women), the prevalence for Nyanza Province is close to double, around 14% (11% for men and 16% for women). The total fertility rate in the area was 5.4 and around a third of currently married women aged 15–49 years used a modern contraceptive method according to a health and demographic survey in 2008–2009.

Community mobilisation and formative research

The acceptability of community-based pregnancy testing was unknown but important for this study. Community mobilisation activities included a series of meetings over several months with the District Medical Officer for Health, village chiefs, district officers and counsellors; the community advisory board was set up by KEMRI-CDC and community members to introduce and get feedback on the proposed study plans. ‘Baraza’ (community meetings) were held in all 33 villages within the study area. Study brochures were also distributed...
through the community meetings and at the central health facility. Formative research involving 10 focus group discussions was carried out with the aim of exploring the sociocultural context around pregnancy and to investigate the acceptability of proposed study procedures (reported elsewhere \(^{26, 29}\)).

**Recruitment of WOCBA and pregnancy detection**

Following community mobilisation, door-to-door enrolment was carried out to inform eligible WOCBA. All women aged 15–49 years, resident in households within the defined HDSS catchment area and participating in a population-based disease surveillance project (PBIDS) \(^ {30, 31}\) were eligible for enrolment. Women were excluded if they refused to participate, were unable to provide informed consent due to mental, physical or social inability or if they refused to be followed up to the end of pregnancy. Enrolment was active throughout the study period whereby newly eligible women (who turned 15 years of age during the study period or in-migrant joining PBIDS) were invited to join the study.

WOCBA who consented to participate were asked if they might be pregnant and offered a pregnancy test at the time of enrolment if they were not visibly pregnant and again approximately every 3 months from October 2011 onwards by village-based community interviewers. Any participant with a detected pregnancy was referred to the antenatal clinic at the referral health facility, Lwak Hospital, where trained study nurses confirmed the pregnancy through ultrasound or examination and auscultation for gestations >24 weeks and offered free ANC. Additionally, all pregnant patients presenting at Lwak Hospital ANC were assessed for study eligibility by a study nurse and enrolled if all selection criteria were met.

**Gestational age assessment**

Gestational age was assessed using multiple methods, including ultrasound scans at the first antenatal visit at Lwak ANC (for participants presenting before 24 weeks); reported first day of LMP; reported gestational age at the time of pregnancy loss; Ballard scoring for live births captured within 3 days of delivery; \(^ {32}\) and fundal height measurements recorded at ANC. Not all methods were available for all pregnancies since some were not seen at ANC (no fundal height or ultrasound measurement available) or were seen at ANC but beyond 24 weeks. The Ballard score was only available for live births seen within 3 days of delivery. Furthermore, some participants could not recall their LMP or, in some instances, had not resumed their menses since their previous pregnancy. For this analysis, gestational age was determined using the most accurate measurement available for each participant. Methods in order of decreasing accuracy were: ultrasound scan taken before 24 weeks gestation, Ballard estimates, LMP or reported gestation at time of pregnancy loss and lastly gestational age derived from fundal height assessment.

**Risk factors**

Obstetric history and ANC laboratory information collected routinely at antenatal booking (haemoglobin level, HIV and syphilis testing, and malaria microscopy) were extracted from the ANC records at Lwak Hospital or antenatal cards by study nurses. Demographic characteristics were collected through interviews at ANC or at the time of pregnancy outcome follow-up if the participant was not seen at ANC. Household-level wealth quintiles were obtained from data collected routinely through the HDSS (such as occupation of household head, primary source of drinking water, use of cooking fuel, in-house assets (eg, radio and television) and livestock), which were calculated as a weighted average using multiple correspondence analysis. \(^ {33}\)

**Pregnancy outcome**

Pregnancy outcomes were assessed using a combination of health facility and home-based follow-ups. The latter is particularly relevant for miscarriages, because the vast majority of these events occur in the community and not in the health facilities. Village-based staff received monthly lists of participants with estimated delivery dates in their respective catchment area. Study nurses were notified of pregnancy outcomes by village-based staff and follow-ups were carried out either at home or at the health facility. A detailed structured questionnaire about the delivery and outcome was administered face to face. Pregnancy outcomes captured included pregnancy losses (miscarriages, induced abortions and stillbirths), live births and major congenital malformations detectable at birth by surface examination. We defined miscarriage, also called spontaneous abortion, as a pregnancy that ends spontaneously before 28 weeks gestation as per the WHO definition of fetus viability. \(^ {34}\) A fetal death after viable gestational age is defined as a stillbirth.

**Data analysis**

Analyses were performed using Stata V.12.1 (StataCorp LP, College Station, Texas, USA). Survival analysis with left truncation was used to estimate the miscarriage rate by gestational week to account for delayed pregnancy detection and the range in gestational ages at the time of pregnancy detection. Crude rate estimates (ie, dividing the number of miscarriages by the total number of pregnancies under study) are appropriate when it is possible to detect and enrol pregnancies from the time of conception. Most miscarriages occur early in pregnancy prior to clinical detection of pregnancy; \(^ {35}\) the rapidly decreasing risk of miscarriage across the first trimester of pregnancy highlights the influence of gestational weeks at time of pregnancy detection in study or programme settings on the estimated miscarriage rates. Therefore, rate estimates should account for left
truncation (early pregnancy) and, as far as it is possible, for the actual number of pregnancies under observation at each specific gestational week. Left truncation was used to account for survival bias as the average gestational age that pregnancies were detected was around 13 weeks and only pregnancies that survived the early weeks of gestation (the highest risk of miscarriage) were followed prospectively. The life table methods were used to calculate the cumulative probability of survival and cumulative probability of miscarriage. Standard methods were used to calculate probability of miscarriage by gestational week. In brief, the miscarriage rate during the specific week of gestation was converted to probability using the formula: (miscarriage rate)/(1+ (miscarriage rate×0.5)). The remaining risk of miscarriage by gestational week was calculated by subtracting the probability of surviving the remaining weeks from 1. The probability of fetal survival during the remaining weeks was the product of the probability of survival for week×and the probability of survival for week ×+1. Cox proportional hazard regression models with left truncation were fitted to estimate the effect of risk factors on miscarriage.

Ethical review and consent
Written informed consent or assent was obtained from each participant including consent to linking individual data to PBIDS and HDSS data.

RESULTS
Participant enrolment and study uptake
Between 15 February 2011 and 15 February 2013, 5536 (94% of 5911 WOCBA approached) consented to participate and 1453 pregnancies among these women were detected; about 10% of participants were detected as pregnant at the time of enrolment. Refusal to take part in the study was low at 6% of screened participants, as were refusals to take pregnancy tests during follow-up home visits (2%). Out of the 1453 identified pregnancies, 1134 (78%) were included in the data analysis for miscarriage; 319 were excluded because pregnancy detection occurred beyond 28 weeks gestation (219) or at the time of pregnancy outcome (33), owing to lack of information on gestational age (21), loss to follow-up immediately after pregnancy detection (41), or inconsistent pregnancy end dates (5; figure 1). The 1134 pregnancies involved a total of 1079 women, 55 of whom

Figure 1 Study participant flow diagram from screening to inclusion in data analysis for miscarriage. GA, gestational age.
had 2 pregnancies and 1024 who had 1 pregnancy during the study period. Figure 2 depicts the number of pregnancies detected by the different strategies. Overall, 62% of deliveries took place at a health facility, and 25% of identified miscarriages were cared for at a health facility. Sixty-seven per cent of pregnancy outcomes were captured <1 week after the end of pregnancy; however, for miscarriage, this proportion was only 20%. The median number of days between outcome and follow-up was 3 overall (range 0–755) and 24 (range 0–602) for miscarriage. This reflects the fact that follow-ups were arranged at the convenience of participants and to ensure a suitable amount of time between the event and home visit by study staff.

### Participant characteristics and risk factors for miscarriage

The mean gestational age at time of pregnancy detection was 13.3 weeks (SD 6.9) and the median was 12.1 weeks. The mean gestational age at time of detection decreased over the study period with the introduction of three monthly home visits (figure 2). The mean maternal age was 26.1 years with women who miscarried being slightly older (29.5 (SD=8) years mean age vs 25.8 (SD=7) years; table 1). Overall, the vast majority were married (79%) and about half of the women had completed primary education, but few had completed secondary school, with no significant difference between the groups. Farming was the main income generating activity for a higher proportion of women who miscarried compared with those with other pregnancy outcomes. There was a statistically significant difference in wealth between groups, with women who miscarried being generally poorer than those with other pregnancy outcomes (table 1). A higher proportion of miscarriage cases occurred in multigravid women with four or more pregnancies and about 25% of cases reported having a previous miscarriage (compared with 13% for other pregnancy outcomes). Only 26% of women who miscarried had any history of ANC (compared with 98% in the other group), which may reflect the fact that most miscarriages occur before the average gestational age (21 weeks) when women initiate ANC in this area. Consequently, very few received any intermittent preventive treatment of malaria in pregnancy and an HIV test result was not available for over half of the miscarriage cases (since HIV tests are offered during the first ANC visit). However, among those with known HIV status (44), 30% of those who miscarried were HIV positive compared with 23% among those with other pregnancy outcomes.

### Cumulative probability of miscarriage and rate per gestational week

There were 89 (7.9%) miscarriages among the 1134 pregnancies included in the analysis. The mean gestational age at the time of miscarriage was 14.4 weeks (SD: 5.7) and the median was 13 weeks (range: 4.3–28); 75% of miscarriages occurred by 18 weeks. The cumulative
Table 1  Participants’ characteristics and risk factors for miscarriage

<table>
<thead>
<tr>
<th></th>
<th>Overall (N=1134)</th>
<th>Miscarriage (N=89)</th>
<th>Other pregnancy outcomes (n=1045)</th>
<th>HR (95% CI)</th>
<th>p Values</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gestational age at pregnancy detection in weeks (mean (SD))</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>13.3 (6.9; 0–27.9)</td>
<td>7.8 (4.4)</td>
<td>13.7 (6.9)</td>
<td>0.94 (0.88 to 1.01)</td>
<td>0.094</td>
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<tr>
<td><strong>Age in years (mean (SD))</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>26.1 (6.8)</td>
<td>29.5 (7.9)</td>
<td>25.8 (6.6)</td>
<td>1.08 (1.04 to 1.11)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Age categories</strong></td>
<td>286 (25.1)</td>
<td>14 (15.7)</td>
<td>271 (25.9)</td>
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<tr>
<td>15–20</td>
<td>287 (25.3)</td>
<td>14 (15.7)</td>
<td>273 (26.1)</td>
<td>0.9 (0.42 to 1.9)</td>
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<tr>
<td>26–30</td>
<td>255 (22.5)</td>
<td>16 (18.0)</td>
<td>239 (22.9)</td>
<td>1.14 (0.57 to 2.3)</td>
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</tr>
<tr>
<td>31–35</td>
<td>179 (15.8)</td>
<td>21 (23.6)</td>
<td>158 (15.1)</td>
<td>2.31 (1.2 to 4.44)</td>
<td></td>
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<tr>
<td>&gt;35</td>
<td>128 (11.3)</td>
<td>24 (27.0)</td>
<td>104 (10.0)</td>
<td>4.02 (2.08 to 7.76)</td>
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<td>None/primary not completed</td>
<td>495 (44.4)</td>
<td>38 (43.7)</td>
<td>457 (44.4)</td>
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<tr>
<td>Primary completed</td>
<td>533 (47.8)</td>
<td>44 (50.6)</td>
<td>489 (47.5)</td>
<td>1.07 (0.69 to 1.66)</td>
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<td>Secondary completed</td>
<td>88 (7.9)</td>
<td>5 (5.8)</td>
<td>83 (8.1)</td>
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<td>2</td>
<td>16</td>
<td>&lt;0.001</td>
<td></td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not working</td>
<td>379 (34.4)</td>
<td>22 (25.6)</td>
<td>357 (35.1)</td>
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</tr>
<tr>
<td>Farming</td>
<td>369 (33.5)</td>
<td>39 (45.4)</td>
<td>330 (32.5)</td>
<td>1.47 (0.88 to 2.45)</td>
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</tr>
<tr>
<td>Small business/skilled labour/salaried</td>
<td>335 (30.4)</td>
<td>19 (22.1)</td>
<td>316 (31.1)</td>
<td>0.88 (0.48 to 1.6)</td>
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<tr>
<td>Other</td>
<td>20 (1.8)</td>
<td>6 (7.0)</td>
<td>14 (1.4)</td>
<td>5.15 (2.15 to 12.34)</td>
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<tr>
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<td>2</td>
<td>16</td>
<td>&lt;0.001</td>
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<tr>
<td><strong>Marital status</strong></td>
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<td></td>
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</tr>
<tr>
<td>Single</td>
<td>240 (21.5)</td>
<td>22 (25.3)</td>
<td>218 (21.2)</td>
<td>1</td>
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<tr>
<td>Married</td>
<td>876 (78.51)</td>
<td>65 (74.7)</td>
<td>811 (78.8)</td>
<td>0.74 (0.46 to 1.2)</td>
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<tr>
<td>Missing</td>
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<td>2</td>
<td>16</td>
<td>&lt;0.001</td>
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</tr>
<tr>
<td><strong>Household wealth quintiles</strong></td>
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<tr>
<td>Poorest</td>
<td>105 (9.7)</td>
<td>18 (20.5)</td>
<td>87 (8.8)</td>
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<td></td>
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<tr>
<td>Very poor</td>
<td>158 (14.6)</td>
<td>9 (10.2)</td>
<td>149 (15.0)</td>
<td>0.33 (0.15 to 0.75)</td>
<td></td>
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<tr>
<td>Poor</td>
<td>220 (20.4)</td>
<td>16 (18.2)</td>
<td>204 (25.6)</td>
<td>0.4 (0.2 to 0.81)</td>
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</tr>
<tr>
<td>Less poor</td>
<td>269 (24.9)</td>
<td>22 (25.0)</td>
<td>247 (24.9)</td>
<td>0.47 (0.25 to 0.88)</td>
<td></td>
</tr>
<tr>
<td>Least poor</td>
<td>328 (30.4)</td>
<td>23 (26.1)</td>
<td>305 (30.8)</td>
<td>0.39 (0.21 to 0.74)</td>
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</tr>
<tr>
<td>Missing</td>
<td>54</td>
<td>1</td>
<td>53</td>
<td>&lt;0.001</td>
<td></td>
</tr>
<tr>
<td><strong>Gravidity</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Primigravid</td>
<td>219 (19.6)</td>
<td>17 (19.3)</td>
<td>202 (19.6)</td>
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<td></td>
</tr>
<tr>
<td>1–3 pregnancies</td>
<td>525 (47.0)</td>
<td>23 (26.1)</td>
<td>502 (48.8)</td>
<td>0.49 (0.26 to 0.91)</td>
<td></td>
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<tr>
<td>4+ pregnancies</td>
<td>374 (33.5)</td>
<td>49 (55.1)</td>
<td>325 (31.6)</td>
<td>1.63 (0.95 to 2.79)</td>
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</tr>
<tr>
<td>Missing</td>
<td>16</td>
<td>0</td>
<td>16</td>
<td>&lt;0.001</td>
<td></td>
</tr>
<tr>
<td><strong>Previous pregnancy loss</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Missing</td>
<td>160 (14.3)</td>
<td>22 (25.0)</td>
<td>138 (13.4)</td>
<td>2.23 (1.4 to 3.56)</td>
<td></td>
</tr>
<tr>
<td>ANC summary</td>
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<td></td>
<td>Missing n=1</td>
<td>Missing n=16</td>
<td></td>
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<tr>
<td><strong>Gestational age at first ANC visit in weeks (mean (SD))</strong></td>
<td>20.8 (7.8)</td>
<td>10.4 (4.9)</td>
<td>21.0 (7.7)</td>
<td>0.85 (0.79 to 0.91)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>range 1.7–41.0</td>
<td>missing n=71</td>
<td></td>
<td>missing n=227</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of ANC visit</strong></td>
<td>&lt;0.001</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>89 (8.1)</td>
<td>66 (74.2)</td>
<td>23 (2.3)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>90 (8.2)</td>
<td>18 (20.2)</td>
<td>72 (7.2)</td>
<td>0.17 (0.1 to 0.29)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>155 (14.2)</td>
<td>1 (1.1)</td>
<td>154 (15.3)</td>
<td>0 (0 to 0.03)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>244 (22.3)</td>
<td>3 (3.4)</td>
<td>241 (24.0)</td>
<td>0.01 (0 to 0.03)</td>
<td></td>
</tr>
<tr>
<td>4+</td>
<td>517 (47.2)</td>
<td>1 (1.1)</td>
<td>516 (51.3)</td>
<td>0 (0 to 0.01)</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
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Continued
The probability of miscarriage calculated through the life table method was 18.9%. Overall, the rate of miscarriage was 0.59 per 100 pregnancy-weeks (95% CI 0.47 to 0.73) calculated by survival analysis with left truncation. The weekly miscarriage rate declined steadily with increasing gestation (see figure 3 and table 2 for miscarriage outcomes).
<table>
<thead>
<tr>
<th>Gestational week</th>
<th>Pregnancies detected during week</th>
<th>Pregnancy-weeks at risk</th>
<th>Miscarriage</th>
<th>Induced abortion</th>
<th>Loss to follow-up and withdrawals</th>
<th>Weekly miscarriage rate per 1000 pregnancy-weeks (95% CI)</th>
<th>Probability of miscarriage per gestational week</th>
<th>Probability of survival per gestational week</th>
<th>Cumulative probability of survival</th>
<th>Cumulative probability of miscarriage</th>
<th>Remaining probability of miscarriage</th>
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<td>&lt;4</td>
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<td>4</td>
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<td>0</td>
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<td>0.956</td>
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<td>6</td>
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<td>0.925</td>
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<td>1</td>
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<td>2.08 (0.52 to 8.33)</td>
<td>0.002</td>
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<td>0.998</td>
<td>0.811</td>
<td>0.189</td>
<td>0.002</td>
</tr>
</tbody>
</table>

were con-

from 10% to 22%. Known risk factors for miscarriages

et al

Dellicour S,

et al

McGready

Figure 4 Miscarriage Kaplan-Meier survival curve by
gestational week.

weekly rates and probabilities) until approximately
16–20 weeks, after which it remained steady at approxi-
mately 0.3 per 100 pregnancy-weeks. Figure 4 shows the
cumulative pregnancy survival probabilities per gestation
week.

DISCUSSION

This study provides the first description of the miscar-
riage rate in this rural Kenyan population in the context
of high malaria and HIV prevalence; there are very little
data on miscarriage background rate for sub-Saharan
Africa in general. The cumulative probability of miscar-
riages by 28 weeks gestation accounting for a staggered
pregnancy detection in our study population was 18.9%,
and the probability by week declined from 16 weeks
onward. The true rate is likely to be higher as informa-
tion from very early pregnancies (eg, <6 weeks gestation)
was not captured and the average gestational age of
pregnancy detection was 13.3 weeks, which meant that
only 57% of pregnancies were detected during the
highest risk period for miscarriage (the first trimester).
However, this represents a more accurate estimate of the
risk of miscarriage than the crude prevalence of 7.9% as
pregnancies were not observed from the time of concep-
tion and entered the study at different gestational
ages.6 10 15 The rate of 19% is similar to that reported by
McGready et al69 from the Thai-Burmese border
(20%) and consistent with that observed in other pro-
spective studies in non-malarious areas, which ranges
from 10% to 22%. Known risk factors for miscarriages
were confirmed in this population, including older
maternal age,40 more than three previous pregnancies,41
having a previous pregnancy loss,42 HIV infection,43 44
occupation,2 3 and lower household wealth.45

Acceptability of pregnancy testing was surprisingly
high and refusal to take a pregnancy test following
enrolment remained around 2% throughout the home-
based surveys. Women in this setting are usually reluc-
tant to disclose their pregnancy status due to cultural
and superstitious beliefs about pregnancy disclosure.
This has been recognised as one of the reasons for delay
in seeking ANC.19 21 Women are worried about gossip,
witchcraft (particularly in the early stage of pregnancy),
being accused of boastfulness and embarrassment in case
of later pregnancy loss. For unmarried and/or young girls,
pregnancy is not disclosed due to fear of social repercusions. Before initiation of the study, no
information was available on the acceptability of preg-
nancy tests in a similar rural community; our formative
research indicated that very few women were even aware
that such tests existed. In this community, engaging
trained village-based staff to offer pregnancy tests
through regular home visits worked well, as reflected by
the high acceptance rate (94%) and low loss to follow-up
(8%). Since the initiation of this study, other studies
have used trained fieldworkers (both male and female)
to do pregnancy detection and reported similar success.
For future studies of miscarriage, we recommend
working with the community to identify the most suit-
able approach to identify early pregnancy. Community
health workers now being deployed in many sub-Saharan African countries46 could play a key role in
early pregnancy detection, thus providing better data on
the actual number of pregnancies for programmatic
planning and monitoring as well as referring pregnant
women to initiate ANC in the first trimester.

A few limitations should be noted. Despite our best
efforts to capture pregnancy early, the relatively low
numbers of pregnancy detected before 12 weeks gesta-
tion (508) generate moderately imprecise estimates and
wide CIs particularly in early (<6 weeks) gestation.
Depending on the gestational age ascertainment
method used, there could have been more or less mea-
surement error leading to misclassification of the time at
entry and exit in the cohort and, therefore, miscarriage
rate in a specific gestation week. There could have been
error in the estimation of gestation at the time of mis-
carrige since this was largely self-reported, sometimes
months after the event. There is risk that induced abor-
tions were misclassified as miscarriage or as lost to
follow-up. Kenya has strict laws on induced abortion,
and it is only permitted if, according to a trained health
professional, there is a need for emergency treatment,
or the life or health of the mother is in danger, or if
permitted by any other written law. Owing to restrictive
laws and stigmatisation, underreporting is common.
Nine induced abortions (<1%) were reported in this
study, which is much lower than a reported expected
ratio of 30 abortions per 100 births for Kenya.47
However, it is probable that women consenting to par-
ticipate in the study would be at lower risk of seeking
induced abortion by accepting to be followed up
through pregnancy. This could lead to selection bias but
the refusal rate was low at 5%, and therefore this is
unlikely to affect estimates substantially. Lastly, as HIV
and malaria are known risk factors for miscar-
riage43 44 46 and are highly prevalent in this area, this
may influence the generalisability of study findings to
areas with different disease burden.
CONCLUSION
This prospective cohort study in WOCBA provides the first estimates of weekly miscarriage rates in a rural African setting in the context of high HIV and malaria prevalence. This information should be valuable to researchers and programme managers for resource planning, to monitor trends and impacts of interventions as well as to clinicians in gauging miscarriage rates at a given gestational week. We have demonstrated the feasibility of conducting a community-based pregnancy cohort in a resource-constrained setting for analysing the outcome of pregnancies with respect to miscarriage risk.

Author affiliations
1Liverpool School of Tropical Medicine, Liverpool, UK
2Kenya Medical Research Institute Centre for Global Health Research, Kisumu, Kenya
3Centers for Disease Control and Prevention, Atlanta, Georgia, USA
4Global Health Institute, Emory University, Atlanta, Georgia, USA
5Pharmacy Systems, Outcomes and Policy Department, University of Illinois at Chicago, Chicago, Illinois, USA
6Departments of Pharmacy and Global Health, Schools of Pharmacy and Public Health, University of Washington, Seattle, Washington, USA

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REFERENCES


Weekly miscarriage rates in a community-based prospective cohort study in rural western Kenya

Stephanie Dellicour, George Aol, Peter Ouma, Nicole Yan, Godfrey Bigogo, Mary J Hamel, Deron C Burton, Martina Oneko, Robert F Breiman, Laurence Slutsker, Daniel Feikin, Simon Kariuki, Frank Odhiambo, Gregory Calip, Andreas Stergachis, Kayla F Laserson, Feiko O ter Kuile and Meghna Desai

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