



African Population and
Health Research Center

Quality of Post-Abortion Care in Kenya

Findings from a national survey

October 2020



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Foreword

In the past few decades, the Kenyan government has increasingly invested in efforts to address maternal mortality and morbidity. A considerable proportion of these illnesses and deaths result from complications of unsafe abortion. A nationwide study on the incidence of abortion in Kenya conducted by the African Population and Health Research Center (APHRC), in collaboration with the Ministry of Health (MoH) and other partners in 2012, revealed that most abortions in Kenya were unsafe and resulted in various complications that were treated in public health facilities. Quality post-abortion care is known to lower mortality and morbidity related to unsafe abortions, and to reduce future unwanted pregnancies by providing contraceptive services.

This follow-up study conducted by APHRC, examined the preparedness of public health facilities in Kenya to deliver post-abortion care to patients. In addition, the study sought to obtain an overview of patient experiences while seeking post-abortion care services within facilities. This report presents critical evidence and highlights gaps to guide programming towards the improvement of women's access to quality post-abortion care in the country.

Evidence presented in this report shows that the capacity to deliver essential elements of post-abortion care among primary and referral level facilities is relatively low because of the absence of staff trained on post-abortion care (PAC), as well as lack of post-abortion care equipment and supplies. Patients arriving in primary facilities are not fully guaranteed the recommended level of post-abortion care services, and due in part to weak referral mechanisms, they may experience delays in obtaining care with implications on health outcomes. Experiences of post-abortion care patients at health facilities may influence patients' uptake of PAC services.

Drawing from these findings, this report offers guidance to collaboratively push for reforms that strengthen health facility capabilities for PAC through training of health providers and provision of post-abortion care equipment and supplies across all facility levels. These efforts should include addressing unsafe abortions and improving access to family planning for all women.



List of Acronyms

APHRC	African Population and Health Research Center
CCC	Comprehensive Care Centers
EmOC	Emergency Obstetric Care
ERC	Ethics Review Committee
ERPC	Evacuation of retained products of conception
ESRC	Ethics and Scientific Research Committee
FP	Family planning
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
IUD	Intrauterine Device
IV	Intravenous
KEMSA	Kenya Medical Supplies Authority
KNH	Kenyatta National Hospital
MA	Medical Abortion
MoH	Ministry of Health
MUE	Medical Uterine Evacuation
MVA	Manual Vacuum Aspiration
NACOSTI	National Commission for Science, Technology & Innovation
NGO	Non-Governmental Organization
PAC	Post-Abortion Care
PDT	Pregnancy Determination Test
SRH	Sexual and reproductive health
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
VCAT	Values Clarification and Attitude Transformation

Executive Summary

Research indicates that nearly 464,690 induced abortions occur annually in Kenya. Majority of these are unsafe, resulting in a large variety of medical complications and about one in ten maternal deaths. Further, a considerable proportion of these complications require treatment and long-term admissions, in the absence of which, many women may experience permanent disabilities and/or death.

Post-abortion care (PAC) services offer treatment for incomplete abortions and provision of post-abortion contraceptive services. Provision of quality PAC is therefore essential for the reduction of unsafe abortion-related illnesses and deaths. In the last 15 years, the Kenyan government and its partners have pursued policies aimed at reducing maternal mortality, including those cases related to unsafe abortions. Currently, there is a paucity of data on the quality of PAC available to women and girls in public health facilities. This study contributes to addressing this gap through provision of evidence.

A cross-sectional nationally representative survey was conducted in 253 primary, secondary and tertiary health facilities in Kenya. We collected data using a facility assessment questionnaire in all the sampled health facilities and complemented this with 819 patient-exit interviews. One-hundred and twenty-six (126) in-depth interviews were also conducted with women treated for post-abortion complications, PAC providers and policy makers.

Findings showed a low capacity of primary and referral health facilities for provision of a range of PAC services. Barely 3% of primary facilities could deliver all designated PAC services consistent with this level, while just 29% of referral health facilities could provide the entire package of PAC services. Only 24% of primary facilities could deliver medical uterine evacuation and 27% could do the same surgically for first trimester pregnancies. The limited capacity to treat PAC cases among primary facilities was mainly due to the absence of trained providers (51%), and limited availability of necessary equipment and commodities for PAC services (78%). As a result, most primary facilities refer PAC patients to higher level facilities, even though the capacity for timely and effective referrals is limited due to lack of fueled vehicles or ambulances stationed at the facility. Further, over two-thirds of referral facilities lacked the capacity to deliver the full range of PAC services. For instance, only 64% and 62% respectively of Level 4 facilities reported capacity to deliver medical and surgical PAC for first trimester pregnancies. Similarly, blood transfusions and surgical procedures could only be done by 55% and 36% of Level 4 facilities respectively. The absence of trained providers, lack of equipment and PAC supplies and commodities were the main reasons for insufficient capacity to deliver PAC services within referral facilities in the country.

The majority of patients reported lack of privacy and confidentiality (64%), and a considerable proportion of these patients (43%) felt that the health facility environment was not conducive for care. Specifically, referral facilities often lacked dedicated MVA procedure rooms and had crowded wards or open spaces where examinations and treatment were conducted. More than half of PAC patients interviewed (59%) did not receive post-abortion contraceptive counselling before exiting the facility. However, transparency of payment (95.4%), stigma and discrimination (89.5%), dignity and respect (83.6%), trust (78.1%), autonomy in decision-making (77.8%), and patient-provider communication (77.2%) were rated highly across all facilities. In a few cases, patients reported instances of hostile providers, limited involvement in care decisions, sexual harassment, long waiting hours and complex referral processes.

Findings also revealed several multi-level barriers impeding access to and provision of quality PAC services. The initial withdrawal of the *Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya* left most PAC providers unsure of the full extent of care they are allowed to offer. Further, it disrupted training of providers on PAC and hindered supply of medical equipment and commodities. The limited dissemination of the standards and guidelines has created key gaps in quality of clinical care and staff capacity. In certain instances, lack of PAC guidelines created room for poor patient-provider interactions, with some providers denying services to patients, especially those suspected of inducing abortions.

Addressing the gaps and barriers reported in the provision of PAC could improve access as well as the quality of service delivered. To achieve this, there is need for reforms that strengthen PAC infrastructure, improve PAC service processes within the facility through training and ensuring access to PAC supplies. These reforms should also include updating PAC guidelines and wider dissemination of the same in addition to improving collaboration with communities and partners to reduce unintended pregnancies and unsafe abortions.

Background

Over 93% of women of childbearing age in Africa live in countries with restrictive abortion laws [1]. In Kenya, abortion is legally restricted and is permitted only to save a pregnant woman's life or to preserve her physical health [2]. As such, the vast majority of women in need of abortion in these contexts resort to clandestine, often unsafe interventions to terminate unwanted pregnancies [3]. These unsafe abortions often result in complications, severe disabilities and mortality [4]. Although complications arising from unsafe abortions vary in severity, a considerable proportion require treatment, long hospital stays, intensive care, and attendance by highly skilled - but often scarce - healthcare personnel [5]. Further, approximately 10% of maternal mortality cases in Kenya are linked to unsafe abortions [6].

While abortion is restricted in much of Africa, most countries in sub-Saharan Africa (SSA) are increasingly devoting significant resources to addressing abortion-related morbidity and mortality through post-abortion care (PAC) [7]. PAC focuses on treatment of incomplete abortion and provision of post-abortion contraceptive services [8]. The WHO definition of comprehensive PAC includes: treating complications, providing counseling and responding to emotional and physical concerns, providing contraceptive counselling and services, referrals to other sexual and reproductive health (SRH) services, and partnering with the community for prevention. One of the key interventions being introduced by countries in the region to enhance women's access to PAC is upgrading the capacity of mid-level providers and health facilities to provide emergency treatment as well as implementing misoprostol as a treatment strategy for complications of unsafe abortion [9].

Despite these efforts, many women in SSA lack timely access to critical PAC services within health facilities [10]. Several studies have interrogated the various barriers that impede access to PAC services. Most prominent among these barriers are structural and health system factors such as the existing legal restrictions on abortion, the lack of guidelines on PAC service provision, lack of trained staff within health facilities, limited in-service training, and inadequate medical equipment and supplies. In Kenya, for example, in 2013 the Ministry of Health withdrew the *Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion* [11], which are intended to guide the provision of appropriate PAC, with detrimental effects on women's access to PAC [12]. Equally important is abortion-related stigma, health providers' negative attitudes and behavior [13], as well as low levels of awareness and knowledge among women [14]. In the absence of quality PAC services, women are likely to have repeated unplanned pregnancies and unsafe abortions [15].



There is increasing interest in the quality of healthcare — the extent to which healthcare services advance patients’ desired health outcomes [16] — as a core pillar of health systems reforms [17]. Prior research outlines three core, connected ingredients for assessing quality of care: (i) structure (facility infrastructure, management and staffing), (ii) process (technical/technical quality and patient experience), and (iii) outcomes (patient satisfaction, return visits and health outcomes) [17-19]. So far, studies in Kenya have attempted to examine the general status of PAC such as its availability and access within the health system [10]. However none of these studies have quantitatively assessed the preparedness of facilities to deliver quality PAC services as well as patient experiences seeking PAC with a nationally representative sample [20, 21]. The scarcity of such evidence has continued to curtail attempts to increase investment and improve quality maternal health services to Kenyan women, a gap that this study seeks to address.

We examined the state of preparedness of public health facilities to deliver the full spectrum of PAC services in Kenya using key PAC indicators for health service delivery, such as staffing (including training), medical supplies and equipment, and reproductive health and abortion services provided. We also gathered data on patients’ experiences through exit interviews conducted in selected health facilities and in-depth interviews with both PAC patients and care providers. The study’s findings are expected to generate relevant evidence to inform programs and interventions.

Methods

Study design and population

We conducted a cross-sectional, mixed methods study involving service provision assessments and patient-exit surveys. Data were collected across a nationally representative sample of primary, secondary and tertiary health facilities in Kenya between November 2018 and February 2019, with each facility observed for 30 days. We also conducted qualitative interviews with purposively selected PAC patients, healthcare providers and policy makers.

Sampling and recruitment

The sampling of facilities was stratified by the different administrative jurisdictions (i.e. counties) as well as by facility levels of care. A master list of all public health facilities in the country was obtained from the Ministry of Health as at December, 2017. Sampling was conducted in two stages. In the first stage, a random sample of six counties was drawn from a list of all counties excluding Nairobi, the country's capital. Nairobi was purposively added to the list of already selected counties: Garissa, Kajiado, Kiambu, Laikipia, Mandera, and Migori. Nairobi was included to account for its strategic role in the provision of public healthcare services as it hosts the largest and oldest teaching and referral hospital in the country. Further, as the seat of the national government, it would provide a benchmark for comparing quality of PAC in other randomly sampled counties. At the second stage, a requisite sample of public health facilities was determined using the sample size formula for known populations using known estimates as shown below:
$$\Delta = z \sqrt{\frac{p(1-p)}{n}}$$

In this case, the known estimate (p) used as a sampling proportion was the proportion of facilities that could offer counselling and information on how to avoid contraceptive method failure, which was the lowest measure of quality of care from a recent survey [10]. Accounting for a response rate of 93%, which is based on the APHRC, MoH and partners 2012 abortion incidence study [4], the requisite sample size of facilities was determined as 259. Facilities eligible for this study were Levels 2, 3, 4, 5 and 6 facilities that could conduct deliveries. Psychiatric hospitals, rehabilitation facilities, and other facilities that offer specialized care as well as military and prison hospitals that do not offer services to the general public were excluded from the sample.

During the survey implementation, certain facilities were dropped from the study due to insecurity and/or complete inaccessibility and replaced with similar facilities within the same locality. Except for facilities that declined to participate, all other sampled facilities that could not participate in the study were replaced with facilities of similar characteristics from the sampling frame. In total, 253 level 2, 3, 4, 5 and 6 health facilities were ultimately reached during the study with about 35 having been replaced for various reasons while six were not replaced. Four of the six facilities that did not participate in the study were in insecure locations or inaccessible due to flooding, while two declined to participate and it was not possible to replace any of these facilities because the data collection period had elapsed. In one case, there was no alternative replacement facility of the same level.

Based on the above 2012 study, about 7.6% of women treated with post-abortion complications were treated using medical uterine evacuation. The current study therefore drew a sample of PAC patients from the above facilities, with sufficient power for a stable estimation of 7.6% medical abortion cases to detect statistical difference in estimates with a 5% error. A sample of 108 women was thus needed for this study. Accounting for a patient-level response rate of 93.1% from the 2012 study, a sample of 117 patients was required per stratum. Given that we had seven (7) regions (counties), the final sample of patients required in the study was 117 (stratum sample) multiplied by the 7 counties resulting in 819 patients from all of the eligible facilities.

Data collection tools

Trained healthcare providers and research assistants collected data on PAC service indicators (signal functions) and conducted patient-exit interviews in sampled facilities in Kenya using structured survey tools. The facility survey tool was drawn from Healy and colleagues (2006) model [18] and updated to address country specificities (level, cadre of staff, equipment, supplies, etc.). This tool captured facility level data on staffing, reproductive health and post-abortion care services provided, hours of operation and available equipment and commodities. The patient exit tool was adopted from the frameworks developed to advance person-centered care for reproductive health equity by Sudhinaraset and colleagues [22]. Both tools were programmed in SurveyCTO and data collected using tablets. Qualitative interviews were guided by a semi-structured interview guide focusing on patients and providers experiences in seeking and providing PAC services.

Health facility survey for PAC services

This was a health facility assessment of all sampled facilities. Upon verifying eligibility of health facilities for participation, trained healthcare providers visited each facility and administered the signal function questionnaire. At large health facilities such as referral hospitals, the respondents were the heads of the obstetrics and gynecology department, or a key obstetrician-gynecologist working in the facility. Within lower level facilities, a nurse, midwife or clinical officer who was in a position to provide information on abortion care offered in that facility was interviewed. The data collection combined both interviews with relevant staff in the selected facilities and observation to confirm availability/functionality of identified items.

Patient-exit survey

To understand women's experiences while seeking or obtaining PAC, and to assess the quality of care received, we interviewed 820 women at discharge following receipt of PAC. All women treated for incomplete and/or spontaneous abortion in the selected health facilities and who agreed to participate were included in the study until the desired sample size was achieved for each county.

Prior to discharge, PAC providers introduced the women to the study and research assistants stationed at the facilities, with only those who consented to participate being interviewed. Data collection took place in facilities over a period of 30 consecutive days. Women were interviewed about their reproductive history, nature of post-abortion care received and perceived quality, post-abortion contraception and their wellbeing after clinical management.

Qualitative survey

Trained and experienced qualitative research assistants conducted in-depth interviews with PAC service providers (e.g. nurses, midwives, clinical officers, medical officers, obstetricians and gynecologists), policy makers and PAC patients. The interviews with policy makers aimed to document national-level efforts to improve PAC services and their perceptions of facility preparedness to offer PAC as well as the quality of the services provided. The interviews with PAC providers aimed to explore their experiences delivering PAC services, their perceptions of PAC and to understand how these perceptions influenced PAC provision. Providers and policy makers were purposively selected to capture variation by position and roles, experience in PAC provision, and location. Providers' and policy makers' socio-demographic characteristics are summarized in Table 1.

Table 1: Characteristics of PAC providers and policy makers (qualitative survey)

Characteristics		Frequency
Facility level	Primary	29
	Referral	20
	Missing	7
Health provider cadres	Nurse	36
	Clinical Officer	20
Location	Urban	29
	Rural	25
	Missing	2
Policy makers*		4

*Policy Makers- Two were practicing/consultant obstetrician and gynecologists who are involved in national PAC policy making processes, while another two were county coordinators of health

The interviews with PAC patients aimed to explore their experiences during PAC, their perceptions of PAC and how it informs their care seeking pathways and interactions with PAC providers. Patients were purposively selected to include women of varying ages, marital status, education level, occupation, and level of facility where they were treated. PAC patients' socio-demographic characteristics are summarized in Table 2.

Table 2: PAC patients' socio-demographic characteristics (qualitative survey)

Characteristic	Frequency (N=66)	
Age (Years)	14-19	6
	20-29	33
	30 and above	26
	Missing	1
Area of Resident	Urban	55
	Rural	11
Marital Status	Married/cohabiting	43
	Separated/divorced/widowed	2
	Single	15
	Missing	6
Occupation	Employed	44
	Unemployed	11
	Missing	11

In-depth interviews were supplemented with observations of PAC services provision in the targeted health facilities. While waiting to meet and interview the patients, the field workers observed interactions happening between PAC patients and healthcare providers, as well as the facility environments. These observations took place in waiting rooms, and during the patient's admission process.

Data analysis and management

Analysis was performed using Stata Statistical Software, Version 15. Exploratory analysis was done to summarize response rates of PAC patients and health facilities by levels and regions. We computed cross-tabulations to examine differences in key indicators (e.g., stigma and discrimination, autonomy, privacy and confidentiality, predictability of costs, communication, supportive care, trust, health facility environment and post-abortion counselling) by facility level and region. Based on the classification of facility levels, we generated proportions of facilities capable of delivering various components of post-abortion care.

Qualitative interviews were transcribed and translated into English (where needed). Researchers then developed a code-book from the interview guide and also by reviewing a few interviews. The code-book was applied to code a set of transcripts to ensure accuracy and capture missing codes. The code-book was then updated and the comprehensive version applied to all the transcripts using Nvivo version 12. Key emerging themes were identified and discussed with a focus on providers' perceptions of their capacity, and that of health facilities to provide PAC services, including reasons for not providing PAC, their interactions with PAC patients and their coping strategies. We focused equally on patients' experiences with PAC including decision-making processes, access to service, and perceptions of the quality of care received.

Table 3: Capacity to provide PAC services at primary and referral facilities

Expected functions for all levels of facilities	
1. Remove retained products of conception* 2. Administer parenteral antibiotics* 3. Administer parenteral uterotonics* 4. Administer intravenous fluids† 5. Provide at least one modern, short-acting family planning method at time of survey†	
Capacity to provide PAC functions expected of primary facilities	Capacity to provide PAC functions expected of referral facilities
6. Has vehicle with fuel to transport patients needing referral† 7. Has staff trained on PAC on duty or who are on call for 24/7	6. Administer a blood transfusion* 7. Undertake major abdominal surgery (proxied by provision of caesarean section) * 8. Provided at least one long-acting, reversible family planning method† or permanent method 9. Has staff trained on PAC on duty or who are on call 24/7
*Assessed on the basis of facility reporting if they had ever provided the service †Assessed on the basis of the availability and validity or functionality of a given item (drug or equipment) at the time of survey	

Ethical Considerations

The study protocol was reviewed and approved by the AMREF Ethics and Scientific Research Committee (ESRC) (AMREF-ESRC P429/2018), and the University of Nairobi/Kenyatta National Hospital Ethics and Research Committee (KNH-ERC/A/384) in Kenya. Permits to conduct the study were also obtained from the Kenyan National Commission for Science, Technology and Innovation (NACOSTI) and from each participating health facility. All participants provided signed informed consent before being interviewed by the data collectors. Girls below the age of 18 years were considered emancipated minors because of their pregnancy status [23]. Confidentiality, anonymity and privacy of all participants were maintained at all levels of this study by excluding all unique identifiers from all datasets and by limiting data access to the research team.

Findings

Preparedness of health facilities to deliver PAC: Facility Assessments

Distribution of health facilities and response rate

Of the 259 sampled health facilities across the seven counties, 253 responded to the PAC service assessment tool, giving an overall response rate of 97.7%. Study facilities mainly consisted of Level 2 (65%), Levels 3 and 4 (18.6% and 15.8% respectively) facilities (Table 4).

Table 4: Distribution of health facilities in the survey

County	Level 2	Level 3	Level 4	Level 5 & 6	Total (%)
Garissa	10	6	8	1	25 (9.9)
Kajiado	27	6	3	0	36 (14.2)
Kiambu	27	8	9	0	44 (17.4)
Laikipia	21	5	3	1	30 (11.9)
Mandera	15	7	3	1	26 (10.3)
Migori	38	5	9	0	52 (20.6)
Nairobi	26	10	3	1	40 (15.8)
Total n (%)	164 (64.8)	47 (18.6)	38 (15.8)	4 (0.8)	253 (100.0)

Description of the health system levels in Kenya: Level 2 and 3 facilities - Primary healthcare facilities; Level 4-6- Referral level facilities

Staffing in health facilities and operating hours

Forty-four percent of the facilities had midwives present every day for 24 hours (Table 5). Close to one in five (19.4%) facilities and about one in eight (12.3%) facilities had clinical officers and doctors respectively, present daily. In addition, 9.1% of the facilities had anesthetists and 6.2% had obstetrician/gynecologists present at the facilities daily. The Level 6 facility had all cadres of health staff, excluding clinical officers, while two of three Level 5 hospitals had all cadres of staff. One Level 5 hospital lacked doctor(s), clinical officer(s) and an anesthetist present for 24 hours daily.

Among Level 4 facilities, only one in four (28.2%) had an obstetrician/gynecologist present daily, while about half (48.7%) had an anesthetist present daily. More than 64% of Level 4 facilities had doctors and clinical officers (66.7%) every day, and almost all facilities at this level had midwives present daily (97.4%).

Fewer Level 2 (1.2%) facilities had doctors on a daily basis compared to Level 3 (4.3%) facilities. Just 4.9% of Level 2 facilities had clinical officers present daily, compared to more than a quarter (27.8%) of Level 3 facilities. While three in every four (78.7%) Level 3 facilities had midwives present every day, only one in five (20.7%) of Level 2 facilities had midwives.

Table 5: Availability and distribution of medical staff by facility level and cadre

Staff availability by Cadre					
Facility levels	Present daily*, n (%)				
	Obstetrician & Gynecologists**	Doctors**	Clinical Officers	Midwives	Anesthetist**
Level 2 (N=164)	2 (1.2)	2 (1.2)	8 (4.9)	34 (20.7)	1 (0.6)
Level 3 (N=47)	-	2 (4.3)	14 (27.8)	37 (78.7)	1 (2.1)
Level 4 (N=38)	11 (28.2)	25 (64.1)	26 (66.7)	38 (97.4)	19 (48.7)
Overall (N=253)	16 (6.2)	31 (12.3)	49 (19.4)	112 (44.3)	23 (9.1)

Level 6 had all cadres of staff, except clinical officers. Two level 5 hospitals had all cadres of staff. One level 5 hospital lacked doctor(s), clinical officer (s) and anesthetist present 24/7
 *Present for 24 hours 7 days a week, as at the time of study.
 **We understand that these cadres are not usually deployed at dispensaries. However, these may have been visiting healthcare providers that might have been reported as regular staff

In terms of operating hours and days, only a third (36%) of facilities were open 7 days a week for 24 hours. While all Level 5 and 6 facilities were open around the clock, just about 76% of Level 3 and 87% of Level 4 hospitals were open at all hours. Most Level 2 facilities (76.2%) were open for five days and for less than 24 hours. Overall, except for Level 5 and 6 facilities, less than 6% of the other facility levels were open around the clock to deliver contraceptive services with about one-quarter of Level 4 facilities (23.1%) open all the time to deliver this service. (Table 6).

Table 6: Operation days and hours for general services and contraceptive services

	Level 2 (N=164)	Level 3 (N=47)	Level 4 (N=38)	Overall (N=253)
Operational days/time, n (%)				
7 days for 24 hours	17 (10.4)	36 (76.6)	33 (87.2)*	90 (35.6)
5 days, Less than 24 hours daily	125 (76.2)	5 (10.6)	1 (2.6)	131 (51.8)
Others	22 (13.4)	6 (12.8)	4 (10.3)	32 (12.7)
Days and time when contraceptive services are provided, n (%)				
7 days for 24 hours daily	3 (1.8)	3 (6.4)	9 (23.1)	15 (5.9)
5 days, Less than 24 hours daily	151 (92.1)	38 (80.9)	20 (53.9)	213 (84.2)
Others	10 (6.1)	6 (12.8)	9 (23.1)	25 (9.9)

#All Level 5 and 6 were open 7 days for 24 hours daily

*Level 4 facilities (hospitals) ~13% not open 24-7, were Level 3 facilities recently upgraded to Level 4 and were mostly in Migori County

Qualitative data highlighted information on facilities' staffing and operations. Providers interviewed were involved in a broad array of reproductive health services (including delivery, antenatal care, family planning, and PAC) within their respective health facilities. The providers (medical officers, clinical officers, nurses or midwives) worked in a rotation system. In this case, they rotated in different wards (antenatal care, gynecology, labor, etc.) following a particular schedule (on a weekly or monthly basis), based on the level of facility and management strategy. This allowed them to get familiar with all types of clients, including PAC patients.

Well, you know we rotate, so I would say that out of the two years, I have spent maybe one year in maternity, another six months in pediatrics. In any case, since we still cover the hospital on calls, we tend to cover the whole hospital. (Medical Officer, primary healthcare facility, Kajiado)

Health facilities have a shift system in place to reduce the risk of staff burn-out. Because of the staff rotations and shifts, the providers recognized that some PAC services may be unavailable at certain times, especially when trained service providers are off duty when a patient has been admitted. Such scenarios were reported in primary healthcare facilities as one of the reasons for referrals of PAC patients. Another consequence of the shifting and rotation is delay in care provision when only one provider is available and has to handle PAC patients together with other patients not seeking PAC services.

Staff training and availability of PAC equipment and supplies

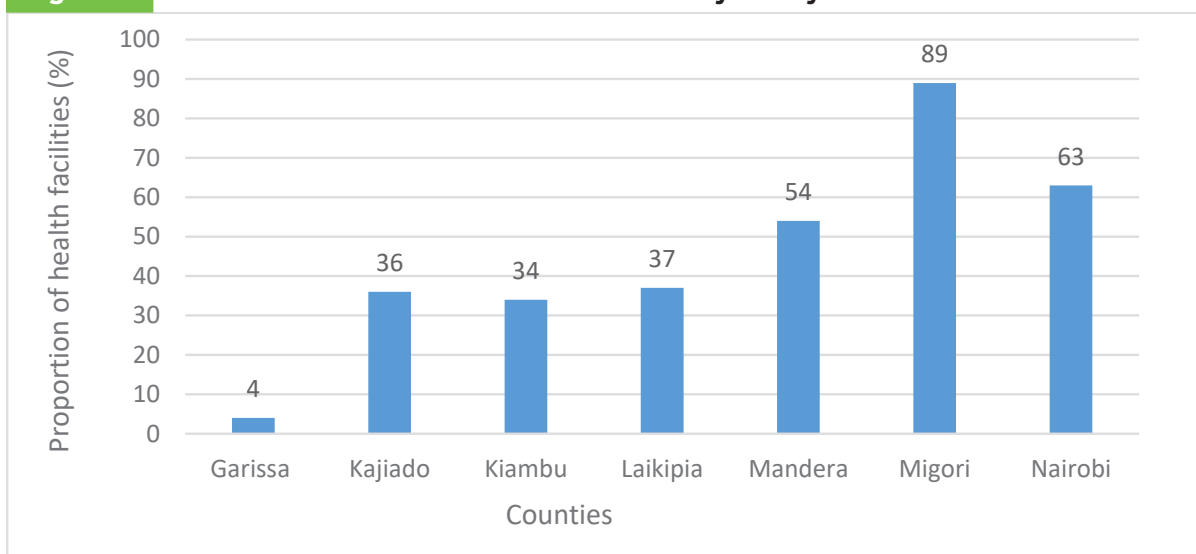
Slightly less than half of all facilities (49.4%) had staff trained on all the five components of PAC. Fewer Level 2 facilities (43%) had providers trained on PAC compared to about 60%, 64% and 75% of Levels 3, 4, 5 and 6 respectively. Nurses accounted for the majority of trained providers (49.0%) across all the facility levels, compared to clinical officers (18.6%) and doctors (6.3%) (Table 7). Generally, non-governmental organizations (NGOs) provided considerable support in training of health providers on PAC, and payment of salaries for some staff stationed in facilities on full time or part time basis, in addition to provision of various supplies and commodities.

Table 7: Proportion of health facilities with staff trained for PAC

Indicators	Level 2 (N=164) (%)	Level 3 (N=47) (%)	Level 4 (N=38) (%)	Overall (N=253) (%)
Staff stationed at facility trained on PAC	42.7	59.6	64.1	49.4
Doctor	0.0	4.3	30.8	6.3
Clinical Officers	9.2	31.9	41.0	18.6
Nurses	42.1	59.6	64.1	49.0

Looking at counties, most facilities in Migori (88.5%), Nairobi (62.5%) and Mandera (53.8%) had staff trained on all components of PAC, while Garissa had the fewest facilities (less than 5%) with trained staff, whereas the rest had about one third of facilities with staff trained on comprehensive PAC (Figure 1). Of those trained, the majority were nurses, with very few doctors and clinical officers. In Migori County, the high number of staff trained was attributed to the high presence of international NGOs who have partnered with public health facilities to train service providers on PAC and provide the facilities with the relevant commodities and supplies.

Figure 1: Health facilities with staff trained on PAC by county



Regarding essential PAC supplies and equipment, less than one fifth of health facilities had a functional operating theatre or an MVA room (16.6%). Only 3.7% of Level 2 facilities, one-quarter (23.4%) of Level 3, and half of Level 4 facilities (55.3%) reported having functional theatres or MVA rooms. Slightly less than one-third (28.5%) of facilities had backup generators in case of power blackouts (10.4% of Level 2 and 36.2% of Level 3), nonetheless a great proportion (90.5%) of the referral facilities had backup generators. Slightly more than half of the facilities (56.9%) had a functional landline or mobile phone for calls in case of emergency. Within the PAC treatment room, less than half of all facilities had specific suction tubes (20%), vacuum aspirator kits or syringes (36.4%), or a manual vacuum aspiration pack on hand (53.8%). Even so, majority of facilities ($\geq 98\%$) indicated having a private room for examining/counselling women and performing reproductive health procedures, an examination or procedure bed and clean running water source (Table 8).

Table 8: Equipment and supplies for PAC in facilities (reported available)

PAC supplies and equipment	Level 2; (N= 164)	Level 3 (N= 47)	Level 4 (N=38)	Total (N=253)
The following instruments, equipment, and supplies are needed for PAC, n (%)				
Vorsellum/Tenaculum	118 (72.0)	39 (83.0)	38 (100)	199 (78.7)
Sponge (ring) forceps	132 (80.5)	45 (95.7)	37 (97.4)	218 (86.2)
Vaginal speculums (Sims, Cusco, Auvard, Graves)	153 (93.3)	47 (100)	38 (100)	242 (95.7)
Needles and syringes	158 (96.3)	45 (95.7)	38 (100)	245 (96.8)
Manual vacuum aspiration pack	60 (36.6)	37 (78.7)	35 (92.1)	136 (53.8)
Examination light/ Light source or flashlight	92 (56.1)	39 (83.0)	35 (92.1)	170 (67.2)
Disposable latex gloves (surgical)	161 (98.2)	45 (95.7)	36 (94.7)	246 (97.2)
Hand-washing soap/liquid soap	147 (89.6)	47 (100)	35 (92.1)	233 (92.1)
The health facility or the treatment room should have the following furniture and equipment in working order, n (%)				
Functional operating theatre/MVA room	6 (3.7)	11 (23.4)	21 (55.3)	42 (16.6)
Examination/Procedure bed	160 (97.6)	47 (100)	38 (100)	249 (98.4)
Clean water Source	159 (97.0)	47 (100)	38 (100)	248 (98.0)
Electric/non-electric autoclave/dry heat sterilizer	143 (87.2)	45 (95.7)	38 (100)	230 (90.9)
Functional Landline/Mobile phone in the facility	78 (47.6)	32 (68.1)	31 (81.6)	144 (56.9)
Electricity (e.g. electricity grid, generator, solar)	137 (83.5)	47 (100)	38 (100)	226 (89.3)
Backup generator (in case of power outage)	17 (10.4)	17 (36.2)	34 (89.5)	72 (28.5)
A toilet (latrine) on premises (functioning)	152 (92.7)	45 (95.7)	38 (100)	239 (94.5)
Stethoscope	161 (98.2)	46 (97.9)	38 (100)	249 (98.4)
Blood pressure machines (sphygmomanometer)	162 (98.8)	47 (100)	37 (97.4)	250 (98.8)
IV fluid giving set (adult)	153 (93.3)	46 (97.9)	37 (97.4)	240 (94.9)
Ambu (ventilatory) bag	141 (86.0)	46 (97.9)	35 (92.1)	226 (89.3)
Suction catheter, 10, 12 Ch	91 (55.5)	39 (83.0)	37 (97.4)	171 (67.6)
Suction aspirator operated by foot or electronically	94 (57.3)	39 (83.0)	35 (92.1)	172 (68.0)
Vacuum aspirator kit/syringes	31 (18.9)	26 (55.3)	31 (81.6)	92 (36.4)
Private room for examining/treating/ counselling	162 (98.8)	47 (100)	37 (97.4)	250 (98.8)
Suction tube, 22.5cm, 23 French gauge	8 (4.9)	11 (23.4)	28 (73.7)	51 (20.2)
All (100%) Level 5 and 6 facilities (n=4) reported having all the listed items				

Virtually all referral facilities had all medicines available while relatively fewer Level 2 facilities had uterotonics (76.3%) and anticonvulsants (60.3%). Fewer Level 2 (44.5%) and 3 (68.1%) facilities had antiretroviral medicines on hand. Considering other non-pharmaceuticals, just about three quarters of Level 2 facilities (78.1% and 64.6%) could give IV fluids and plasma expanders compared to (87.2% and 83%) of Level 3 facilities respectively (Table 9).

Table 9: Facilities with medicines and commodities

Medicines and commodities available	Level 2 (N=164) (%)	Level 3 (N=47) (%)	Level 4 (N=38) (%)	Overall (%)
Drugs				
Antibiotics	96.3	97.9	100.0	97.2
Uterotonics*	76.2	89.3	97.4	82.2
Anticonvulsants**	60.3	83	87.2	69.2
Antiretrovirals	44.5	68.1	94.9	57.3
Anesthetics***	99.4	97.9	100	99.2
Non-pharmaceuticals				
IV fluids****	78.1	87.2	89.7	81.8
Colloids/Plasma expanders	64.6	83	97.4	73.5
All (100%) Level 5 and 6 facilities (n=4) reported having all the medicines and commodities available *Mifepristone & misoprostol combination, Misoprostol alone, other abortifacient, injectable uteronic ** Magnesium sulphate injection, other anticonvulsants ***Halothane, Ketamine, Lignocaine/Lidocaine 2% or 1% ****IV fluids Dextrose 5%, 10%, 50%, Dextran 70%, Glucose Infusion 5%				

As reported previously, NGOs play a central role in availing essential PAC equipment and supplies. About one-quarter of health facilities (22%) reported receiving relevant equipment (such as manual vacuum aspiration (MVA) kits) and/or medical commodities as donations from NGOs supporting PAC provision in public health facilities. This was mainly to supplement government supplies and to address the challenge of stock-out. Facilities that benefited from such donations were Levels 4, 5 and 6, while very few Level 2 facilities had benefited. (Table 10)

Table 10: PAC supplies by NGOs

Indicators	Level 2 (N=164) (%)	Level 3 (N=47) (%)	Level 4 (N=38) (%)	Overall (N=253) (%)
Facilities with PAC equipment/commodities provided by NGOs	15.9	23.4	41	21.7
Manual Vacuum Aspiration Kit	11	23.4	33.3	17.4
Delivery set & beds	1.8	0	7.7	2.4
Family planning supplies*	5.5	0	5.1	4.4
Other equipment and drugs**	1.8	2.1	5.1	2.4
Three of four Level 5 and 6 facilities received PAC equipment/commodities from NGOs *IUCD, Implanon, Emergency contraceptive pills **Examination lamps, Doppler's, autoclave, speculum, forceps, cytotec;				

Provision of Other Reproductive Health Services

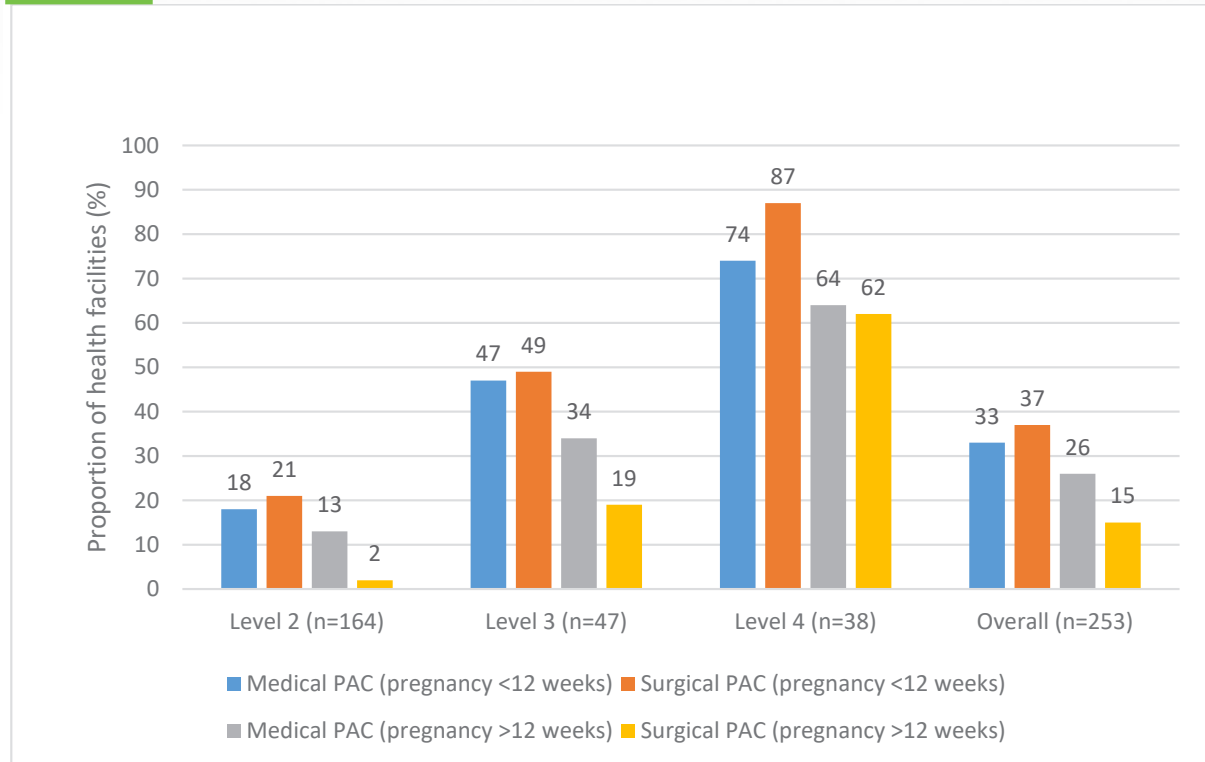
More than half (58.5%) of the health facilities had laboratory services present. Level 2 facilities had the least number of laboratories (37.8%) while all the referral level facilities (Levels 4, 5 and 6) had laboratory services present. A greater proportion of facilities 99.6% offer HIV counselling and testing, whereas 90.5% could provide STI screening. Hepatitis B screening was the least provided service (32.4%) and also the least provided across all the facility levels except in Level 5 and 6 facilities (Table 12).

Table 11: Availability of Laboratory services

Laboratory procedures	Level 2 (N=164)	Level 3 (N=47)	Level 4 (N=38)	Overall (N=253)
Laboratory present in the facility	37.8	93.6	100	58.5
HIV counselling and testing services	99.4	100	100	99.6
Hepatitis B screening	15.2	44.7	84.6	32.4
STI screening**	85.4	100	100	90.5
*All Level 5 and 6 facilities had all the laboratory procedures				
**STIs including Chlamydia, Gonorrhoea, Trichomoniasis, Candidiasis, and Genital herpes				

Evacuation of retained products of conception (ERPC) by facility levels

Overall, 32.8% and 37.2% of the all the health facilities could perform medical and surgical PAC for first trimester pregnancies respectively. The lowest capability was recorded in primary level facilities as only 17.7% and 20.7% Level 2 facilities could provide medical and surgical PAC for first trimester pregnancies respectively. About half of Level 3 facilities could provide medical (47%) and surgical PAC (49%) services. Most referral facilities had capacities to deliver both medical and surgical PAC for first-trimester pregnancies. About 74.4% and 87.2% of Level 4 facilities could provide medical and surgical PAC procedures for first trimester pregnancies (Figure 2).

Figure 2:**Proportion of facilities providing surgical and medical PAC for 1st and 2nd trimester pregnancies by facility level**

*All Level 5 & 6 facilities were capable of providing surgical and medical PAC for pregnancies below and above 12 weeks.

Drawing from the perceptions of providers and policy makers, the capacity to provide PAC was dependent on both personal skills and facility resources (PAC equipment and medical supplies). Participants considered the presence of well-trained providers and well-equipped facilities as complementary to providing quality PAC. The absence of either was viewed as lack of capacity. According to them, for facilities to be described as capable of providing PAC, they must have both the equipment and the personnel to utilize and manage them. Some of the narratives obtained highlight this.

The question of capacity comes with the knowledge and skills and then it also comes with equipment. If one is missing, you will definitely not be able to take care of patients. (Nurse, primary healthcare facility, Migori). Basically, we usually face a lot of challenges because as for me actually, I am very equipped. You know I've gone to school, where I was working actually, I was practicing a lot of it [PAC] because it was a level five facility, (...); but when I came to this facility, which is a level three, you find there are so many constraints in terms of the infrastructure. We don't have the tools to do even MVA, we don't even have a ward to keep a patient for observation as much as possible, we would love to... Majority of us we have the knowledge, a lot of it from school or from where we have worked and practiced ... but now we can't be able to deliver the quality that we expect. (Clinician, primary healthcare facility, Kiambu).

According to healthcare providers, training allows them to assess the clinical condition of PAC patients, make a diagnosis, and decide on which treatment protocol to administer. Policy makers also indicated that training would enhance health providers' attitudes by enabling them to understand how their personal values may influence their actions (values clarification) and improve how they relate with and handle PAC patients.

It all depends on trainings, if these people are not trained so that they can be able to clarify their values, they are not able to differentiate their own values from professionals. (Senior MoH official, County level, Nairobi).

However, there are assorted challenges linked to training and facility resourcing. The question of training centered on pre-service and in-service training. Some participants also discussed the lack of training on performing certain key PAC services including MVA and prescription of medical abortion (MA) drugs. Pre-service training (i.e. basic emergency obstetric care (EmOC) training) was cited by providers as inadequate and in-service training was seen as infrequent, even though the situation was more pronounced in primary health facilities. These views are illustrated in the following quotes from two providers in Kajiado and Kiambu counties:

I think I'm not that good at offering PAC because I'm not able to do the MVA, I haven't undergone that training. (Nurse, primary healthcare facility, Kajiado). Personally I'm not trained on PAC, post-abortion care and I believe that it involves MVA and the rest, so, and I believe also...we are three nurses and we are not trained on that so it's almost...I cannot say zero because we can give some treatment but we cannot do much. Sometimes we need an MVA (so we) refer and sometimes we want the persons who are trained and were given MVA kits... I don't know whether it [MVA] can be effectively done here. (Nurse, primary healthcare facility, Kiambu)

The frequency of the training opportunities was also reported to be irregular and far between. Most participants reported that a long time had elapsed since they were trained on PAC, insisting on the need for refresher training to ensure that they were up to date on evolving technologies and protocols used to treat PAC such as medical abortion drugs. Refresher training was noted to be particularly important in contexts where providers have limited opportunities to perform PAC because of a low caseload or lack of equipment as this would ensure that they updated their skills.

As highlighted in the foregoing quote, healthcare providers who are only able to offer basic care, including examining the patients to make a diagnosis, have to refer all patients whose conditions require uterine evacuation using MVA or MA to another facility. Some facilities did not have a trained provider while others had a limited number of trained personnel relative to the caseload in the facility. In such situations where a limited number of providers had training, the participants reported delays in care provision or referral in those instances when patients were admitted and the trained staff were not available.

Both policy makers and healthcare providers noted that staff transfers impede PAC services. A healthcare provider in Migori County, for example, explained that they had a colleague who was trained to provide PAC but the person was transferred to another facility. As a result, they had to refer their PAC patients although they had the equipment to offer the services:

We have the facilities but the staff is an issue, of late the staff is not there. There was a time we used to do that strictly here without a problem. But now we refer because that person is no longer here. (Nurse, primary healthcare facility, Migori).

Policy makers also cited frequent staff turnover within facilities, with trained and experienced PAC providers exiting as new ones joined the service. Coupled with restrictions on the training of providers that emanate from controversies surrounding abortion, staff turnover was noted to pose a major challenge on the provision of PAC services as the remaining staff may not be trained and may be unable to offer the services or provide poor quality services.

Yes, that I've already explained to you earlier, we are not at zero. Already, we have people who were trained, but there are not many because some have already exited. Therefore, if this person who was trained ... is the one who is on duty today, and they are offering the services, this person will offer the quality service, but come tomorrow if this person is not in, and the person who is there is not trained, that is where you hear things like maybe the attitude, that judgment and such. (Senior MoH official, County level, Nairobi).

The lack of training for PAC providers was also blamed on inconsistent policies or unclear implementation frameworks. One of the participants reported, for instance, that the withdrawal of the *Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion* had consequences on providers' training:

You know initially we used to have the guidelines on the post-abortion care but somewhere from twenty twelve (2012), there was a circular that came from the DMS [Directorate of Medical Services] that cancelled all those things such that we cannot even train the healthcare providers. (Senior MoH official, County level, Nairobi).

The changes and inconsistencies with PAC guidelines as reported above were also noted to have affected supply of equipment. Kenya Medical Supplies Authority (KEMSA), which equips the facilities with MVA kits, stopped stocking kits and supplying facilities due to the withdrawal of the guidelines in 2013, as explained by one of the policy makers interviewed:

Yes, and no. No in the sense that if a client comes who requires the services, for example in a public facility and they have the commodities, the equipment that are required to do so, they will offer the services but now you will notice that with this [withdrawal of guidelines in 2013], even the kits are no longer with the KEMSA. So they have skills to do so but we don't have the equipment. (Senior MoH official, County level, Nairobi).

Participants emphasized that the concern around equipment or commodities was more pronounced in primary level facilities, where providers lacked MVA kits or rooms, ultra-sonographers, observation rooms, blood banks and other equipment. In some facilities, MVA kits were never supplied, while in others restocking was delayed leaving such facilities in "a sorry state", as described by one provider in Migori:

I don't know when it was supplied, because there are those cannulas [tubing inserted into a vein or body cavity to aid in administering medication or fluids, drain fluid, or insert surgical instruments], they are color-coded, the smallest being the yellow one. It is not here, so it means you have to use the larger ones. So sometimes I have challenges. Actually, I've never used it from the time I reported here. (Clinician, primary healthcare facility, Migori).

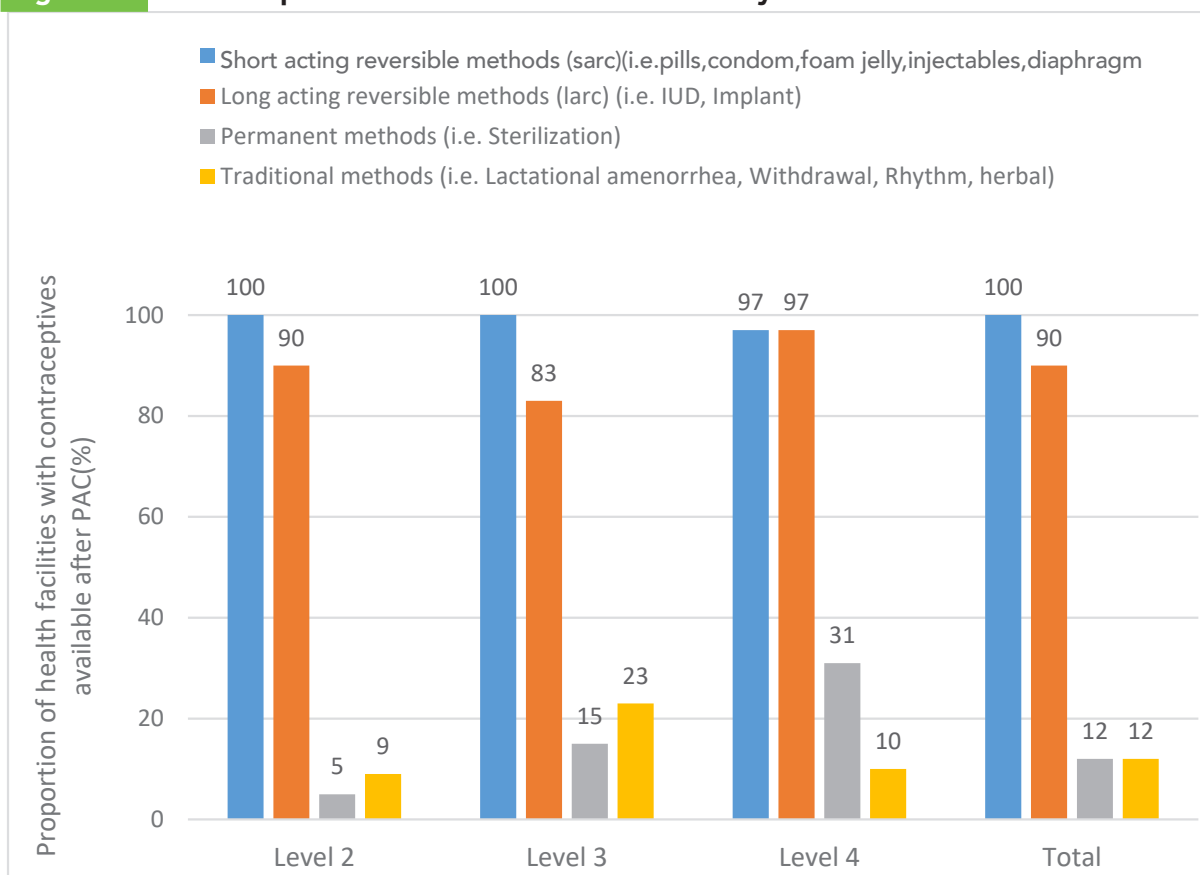
Observations in health facilities revealed cases of referral level hospitals being unable to deliver PAC for prolonged periods (up to two weeks) because of broken MVA kits (such as cannula loss, broken syringes, etc.). Therefore, although they had well-trained providers, they had to refer their patients to other facilities resulting in delays in care and additional costs for patients

Availability of contraceptive services after PAC

All primary level facilities (Level 2 and 3) could provide at least one short-acting contraceptive. Similarly, a high proportion of Level 2 (90%) and 3 (83%) could provide at least one long-acting reversible contraceptive method. As for the referral facilities, nearly all (97%) could provide short- and long-acting contraceptives following PAC. Just 50% of Level 5 and 6, and 31% of Level 4 facilities could provide permanent contraceptives (Figure 3).

Various contraceptives are typically available to women after PAC. Most facilities had combined oral contraceptive pills (91.3%), progestin-only contraceptive pills (84.6%), progestin-only injectable contraceptives (79.5%), implants (77.1%) and male condoms (75.5%). Overall, the least available contraceptives were combined injectable (1.6%), vasectomy (8.7%), and bilateral tubal ligation (BTL) (10.3%).

Figure 3: Contraceptives available after PAC across facility levels



Healthcare providers interviewed in the qualitative survey indicated that post-PAC counseling is a requirement before discharge of a patient. Post-PAC counselling was noted to include educating patients about the need for contraception, what contraceptive methods were available and how they work, the causes of spontaneous abortion, the consequences of induced abortion, and sexually transmitted infections (STIs), among other topics. PAC providers were noted to tailor their counselling to the identified cause(s) of abortion (induced or spontaneous), personal circumstances (married or single) or sexual activities (for instance those who are abstaining from sexual intercourse either as a choice or because their partners were unavailable). Participants also reported a few facilities that have comprehensive care centers (CCC) or HIV testing services (HTS) with dedicated counselors to whom patients are referred for counselling on contraceptives and other SRH needs. These services were either offered within or outside the facility.

Counselling is mainly provided after treatment, when the patient's condition is stable and/or when being discharged. However, providers acknowledged that not all patients receive counselling. As explained by one of the providers in Laikipia county, one reason why some patients did not receive counselling was because the patient was treated when the counselor was unavailable (e.g., at night or over the weekends):

Yeah, sometimes because we get these clients at night and maybe he [counsellor] is not available and maybe he is gone; maybe sometimes on the weekend he is not also available so most of these services they don't get, the counseling part. (Clinician, referral healthcare facility, Laikipia).

Heavy caseloads and understaffing were also noted to hinder providers' ability to provide counselling to all PAC patients. Indeed, one of the participants pointed out that their caseload is often high which makes it difficult to offer counselling to all PAC patients.

Mostly, time need is the major constraint because as I told you, we really receive a lot of patients so we have very minimal time to have adequate interactions with specific patients... But in a scenario where we have time to ourselves, and the patient also has time to themselves, we do provide the ultimate care of the counseling and also provision of the family planning methods. (Nurse, referral healthcare facility, Nairobi).

Sending patients to CCC counsellors was described as a solution given provider's inability to provide the counselling. However, some providers noted that CCC counselors could also be busy, and patients may decide not to follow through with the referral. As some providers further indicated, in cases of induced abortions, police officers were sometimes called when the treatment was completed to "threaten" patients. This was the case where a particular facility was recording a high number of induced abortions, and involving the police was thought to be a useful measure (despite implications on the code of medical ethics) to reduce the number of cases by interrogating the patients to identify the clandestine abortion providers while threatening the patients.

And we transfuse them and then discharge and then we send most of them for family planning and then also we involve the police. Since (we) started involving the police, we noticed that the number of cases has reduced. (Clinician, referral healthcare facility, Kajiado).

Regarding the availability of and access to contraceptives, most of the providers interviewed in referral facilities reported the availability of all types of methods that patients may need. This is explained by one of the providers:

Almost ... not even almost, we have all the methods; we have the implant, the injection for three months, we have the Norplant, we have the NST [injectable] that is, all the methods that are supposed to be there are always available at any particular time. (Nurse, primary healthcare facility, Garissa).

Participants also indicated that contraceptives are provided for free in line with government subsidized fees for gynecologic and obstetric conditions.

The fortunate thing in our facility is maternity PAC services, all (gynecological), obstetric conditions are free, so at one point we don't go to cash for that. The government supplements for that amount as long as it's in the report, it's supplemented for. (Nurse, primary healthcare facility, Kajiado).

In a few facilities, patients were able to access contraceptive methods in the patient treatment wards. In most cases, however, patients had to be referred to a different unit, such as a family planning clinic, for contraceptive counseling and products. Even so, the respondents recognized that not all patients follow through with the referral to the family planning clinic as the majority exit the facilities without any method. In the particular case of induced abortion, one provider explained that patients “don't get there- they disappear. It's downstairs, it's not like it's in a different place, (it) is a part of the hospital, it's like (the) pharmacy. It's just that I think the stigma [brings about] the desire to just disappear” (Clinician, primary healthcare facility, Kajiado).

Though this provider did not link such situations with the element of police presence to threaten PAC patients, it is possible that these practices may have instilled fear that pushes patients to escape from the health facility.

Overall capacity to provide post-abortion care in Kenya

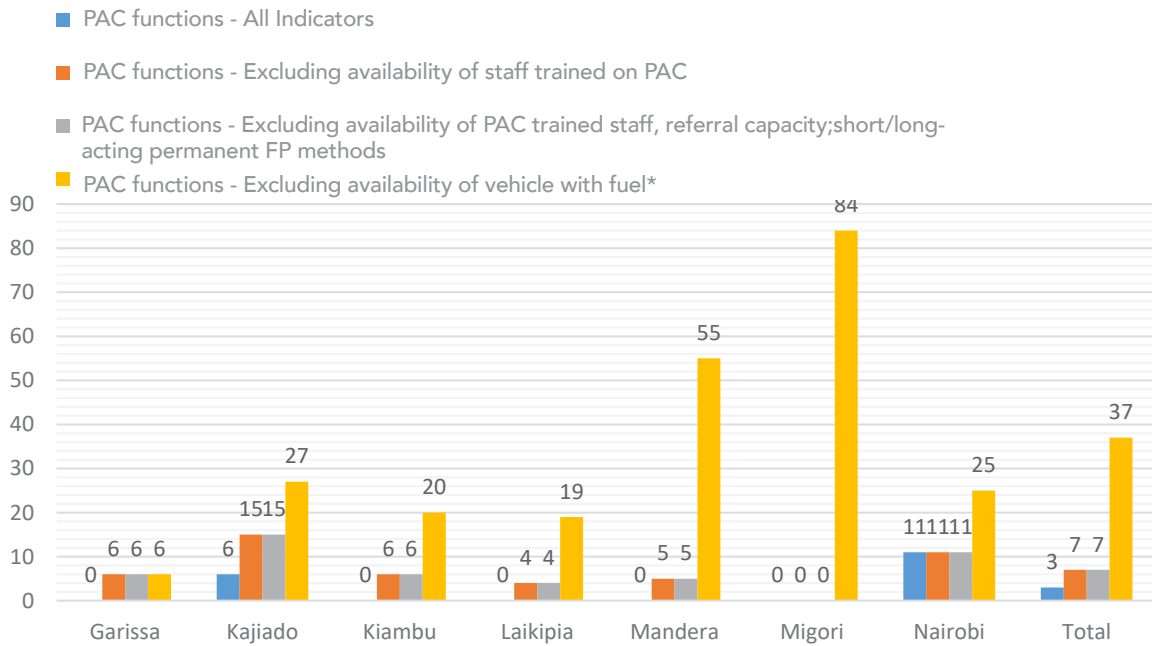
Capacity to provide PAC in primary-level facilities

Only 2.8% of primary health facilities had the capacity to deliver all the essential elements of PAC services, which include: treatment of complications, family planning counselling and contraceptive services, ability to refer (through availability of vehicle with fuel to transport patients needing referral), and staff trained on PAC (Figure 4). Few facilities in Nairobi (11.1%) and Kajiado (6.1%) counties could deliver all PAC services expected of primary facilities. None of the primary facilities in Garissa, Kiambu, Laikipia, Manderu and Migori counties could deliver on all essential indicators for PAC service package.

While applying less restrictive criteria (that is excluding the availability of staff trained on PAC), only 6.6% of primary facilities across all study counties could deliver the whole package of PAC services. Similarly, excluding availability of staff trained on PAC as well as availability of short/long acting and permanent family planning methods slightly improved the proportion of primary level facilities with capacity to provide PAC services across counties to about 6% in Garissa and Kiambu counties, 11% in Nairobi and 15% in Kajiado. Further, when excluding availability of a vehicle with fuel (for transporting patients during referral) from the criteria, close to two in five (37%) primary facilities

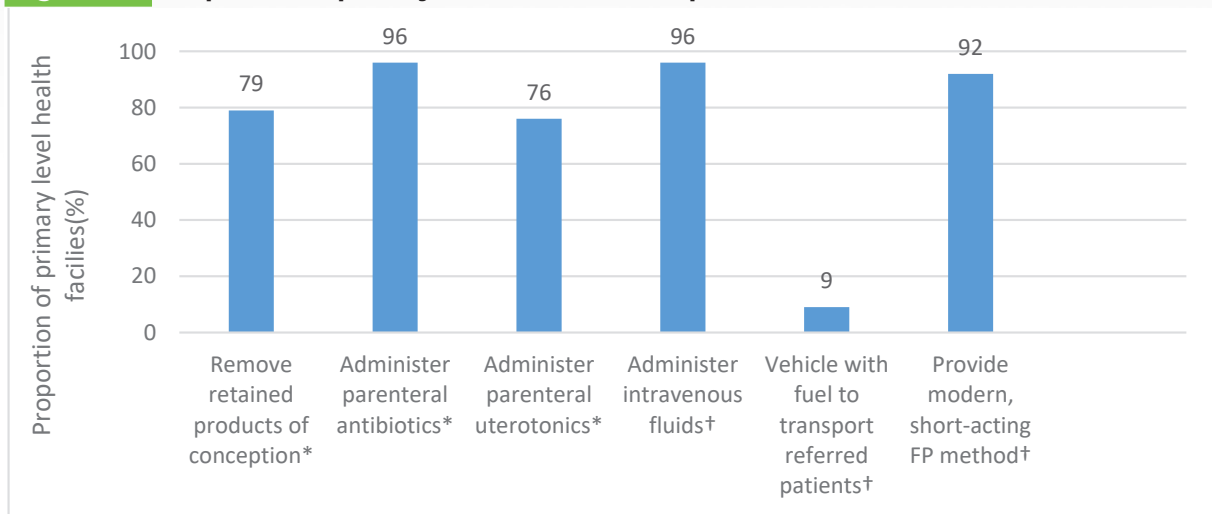
could deliver all other essential PAC services, with 84% of facilities in Migori, 55% in Mandera, 27% in Kajiado and 25% in Nairobi showing capacity for PAC provision. Notably, excluding the vehicle with fuel for referrals did not change the proportion of primary facilities that could deliver PAC in Garissa County (Figure 4).

Figure 4: Primary level facilities capacity for basic PAC provision



Capacity to provide specific PAC services among primary-level facilities

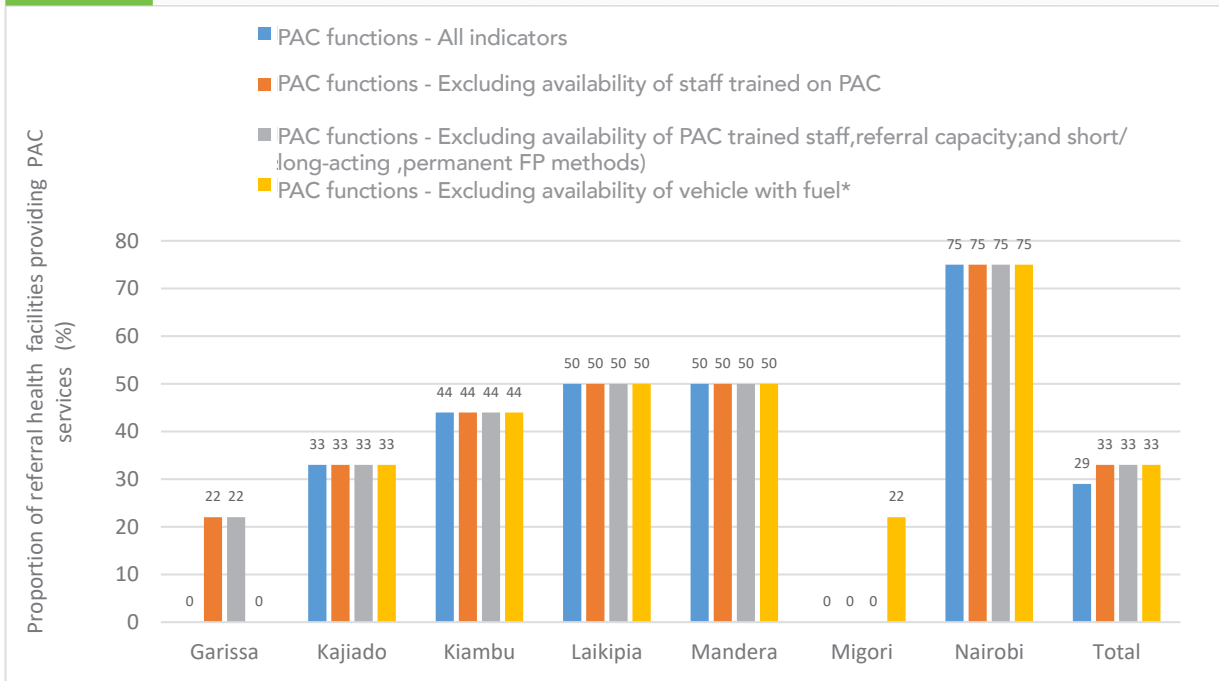
More than three-quarters of primary level facilities (78.7%) could remove retained products of conception while nearly all facilities could administer parenteral antibiotics as well as intravenous fluids (96.2%). Similarly, three in four primary facilities (76.3%) could administer parenteral uterotonics with most facilities capable of providing at least one modern, short-acting contraceptive method (91.5%). Only 8.5% of the facilities had fueled vehicles to facilitate referral of patients (Figure 5).

Figure 5: Proportion of primary level facilities with specific PAC services

Capacity to provide PAC services in referral facilities

Barely one in three referral facilities (28.6%) was capable of providing the entire package of essential PAC services, which include: treatment of complications, family planning counselling, short- and long-acting contraceptive services, blood transfusion, major abdominal surgery (proxied by provision of caesarean section), vehicle with fuel to transport patients needing referral and staff trained on PAC. Among these facilities, most were in Nairobi (75%), compared to 50% in Laikipia and Mandera counties, and none in Garissa and Migori Counties (Figure 6). While using a less restrictive criteria for PAC services in referral facilities (that is excluding availability of staff trained on PAC and availability of short and long-acting or permanent family planning methods), the capacity to deliver all essential elements of PAC services for this levels of health facilities did not considerably change the proportion of referral facilities, except in Garissa county. Once the requirement of having a fueled vehicle at the facility is excluded, 33.3% of referral facilities could deliver PAC services, with the highest change in capacity observed in Migori County (22.2%).

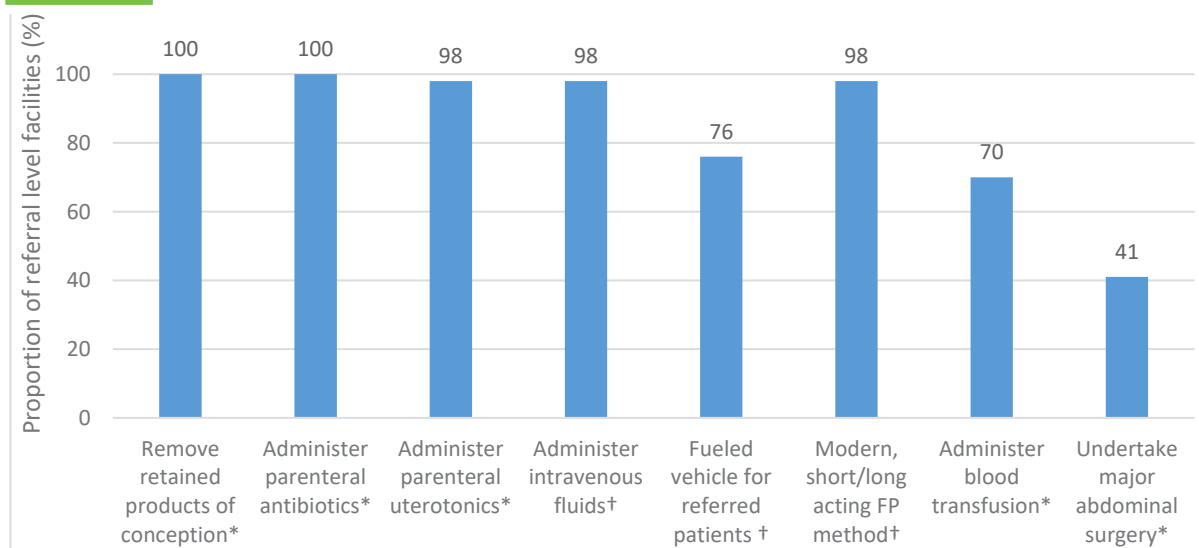
Figure 6: Availability of PAC services in referral facilities



Capacity to provide specific PAC services for referral level facilities

All referral level facilities (100%) had the capacity to remove retained products of conception and administration of parenteral antibiotics to women. Virtually all (97.6%) had the capacity to administer parenteral uterotonics, intravenous fluids as well as provide modern short- or long-acting family planning methods. Barely three in four referral facilities (76.2%) had fueled vehicles to facilitate the referral of patients to or from the facility, and about seven in ten (70%) could administer blood transfusions. Only two in five (40.5%) referral facilities could undertake major abdominal surgeries (i.e., exploratory laparotomy) (Figure 7).

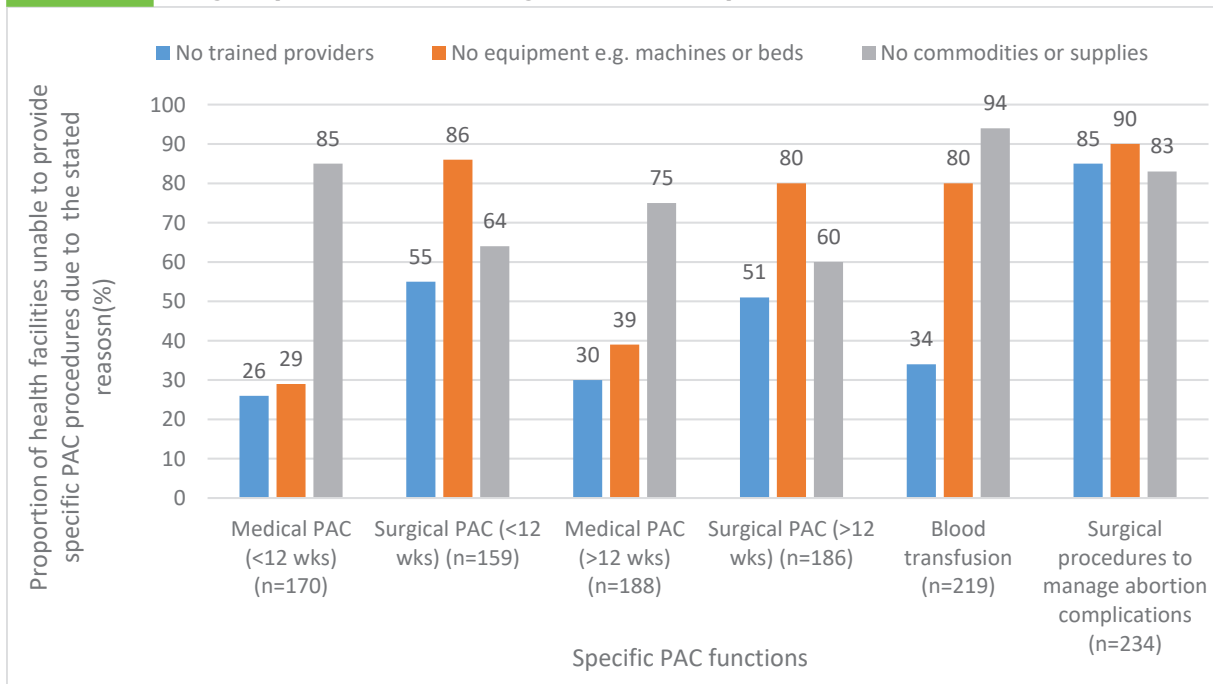
Figure 7: Proportion of referral level facilities with specific PAC services



Reasons for lack of PAC services

The lack of trained providers, equipment and commodities or supplies were cited as the most common reasons for the absence of basic and comprehensive PAC services in public health facilities. The main reasons cited for not providing surgical procedures to manage abortion complications included: lack of trained providers (85%), lack of equipment (89.7%) and absence of commodities and supplies (82.9%). The greatest gap was reported in Levels 2, 3 and 4 in that order (Figure 8). Similarly, performing blood transfusion was prevented by the lack of blood supplies in 94% of health facilities, while 79.5% were due to lack of equipment such as blood banks (Figure 8). Surprisingly, some facilities that were unable to administer IV fluids indicated that it was against their hospital policies. Several respondents also cited some services as against the providers' moral and ethical standing such as delivering medical PAC.

Figure 8: Main reasons for non-provision of medical/surgical PAC, blood transfusion and surgical procedures to manage abortion complications



More specific PAC services were also largely impeded by lack of training for providers, as well as absence of equipment/supplies. Though rare, providers from primary health facilities reported the absence of PAC patients as a reason for not providing PAC services, even though they had been trained and facilities were well equipped. One of the providers in a dispensary explained:

I think I can do post- abortion. I think I can treat them, I can give them antibiotics, we even have some disposable MVA kits but the cases are not there, unfortunately we don't have clients for now (Clinician, primary healthcare facility, Kajiado).

Provider-related personal choices and values were also raised as a hindrance to the provision of PAC services. As illustrated in the following quote, respondents described cases of their colleagues not offering PAC for reasons related to their religious beliefs. In these situations, these providers opted to refer their patients to colleagues or other facilities, thus delaying care and increasing the risk of complications. Some facilities resolved such challenges by relocating those specific staff to other wards where they would not need to handle PAC patients.

... except one or two staff who have a religious issue, relating to general FP and PAC issues, generally the others are okay. It affects in one way because, one she will not be able to provide the PAC service meaning it becomes a problem to the client because that client will be told wait for so and so to come so that (they) are able to (receive) the service and remember in PAC that delay would also not be good for the patient. (Nurse, primary healthcare facility, Kajiado).

Referral of PAC patients

Given the limited capacity of most primary level facilities to deliver PAC, the majority of these facilities tend to refer PAC patients to other facilities. There are existing guidelines for the referral process. These guidelines emphasize task shifting, which involves the delegation of duties from highly skilled doctors down to the clinical officers, nurses and community nurses. The guidelines also describe how a service provider evaluates a patient's condition and refers the patient in cases that cannot be managed at a lower level facility.

It is very clear in the guidelines that if you cannot do it either because of lack of equipment, lack of a facility to do it then of course you refer to the next facility where what you are lacking [exists]. (Senior MoH official, national level, Nairobi).

There was consensus among participants that an ambulance is the appropriate means of transport during referral, especially where the patient is in critical condition. Therefore, most facilities reported regular use of an ambulance whenever it was available on site and operational. However, participants noted that most primary level facilities have no ambulance and relied on "satellite ambulances" which are often managed by the sub-county administration. As such, ambulances are not always available or may take a long time to come to facilities located in distant areas.

About the referral system, previously it was like good because we had our own ambulance in the sub-county but right now we still don't strain so much because now we liaise with the sub-counties with the ambulances, we also have the number of emergency services in Kiambu... but if you have to source from the other sub-counties at times it takes long and during that time maybe the client is bleeding much, you have to give the fluids and you see you might reach a certain level that you do not give any more fluids. (Clinician, primary healthcare, Kiambu).

Providers explained that when the patient's condition allows it, they ask or allow them to use private means of transport when the patients are referred. However, providers noted that some patients had to use private transportation even when their condition was severe because the ambulance was delayed or unavailable and access to care was urgent to avoid deterioration of the patient's condition.

...we call the ambulance and in the meantime we also work together with the relatives, you know a patient cannot die because you are waiting for the ambulance to come from the sub-county hospital. If the relatives are able to get a vehicle to the hospital, well and good. (Nurse, primary healthcare, Kiambu).

According to providers, PAC referrals were primarily linked to facilities' limited capacity to deliver services, especially due to lack of training, commodities, and supplies, and providers' personal values. They also noted that a patient's condition plays a key role in the decision to refer. For example, providers pointed out cases where the referral was due to delay in care seeking by the patient resulting in complications that could not be managed in the facility.

No, what happens is, most of the referrals we get from the community and mostly it's let's say self-referral or from our community health workers, so they come to the facility after trying one or two [remedies] at home... and when they are defeated at home is when they come to the facility. So at most times if you get them at an early stage, you are able to deal with them. Sometimes you get them when it's complicated, a lot of bleeding has taken place, and you are forced to refer because we don't offer transfusion services. So when it's a little late we refer. (Nurse, primary healthcare facility, Kajiado).

After making the diagnosis, some facilities immediately refer the patients because they lack the competencies to provide the care needed per the Ministry of Health guidelines. Nurses, for instance, reported that they are trained to, and allowed to manage or handle abortions that occur within the first trimester. One of the nurses interviewed explained that she always immediately refers later term cases:

So basically any miscarriage that's below three months, we can handle or, personally, I handle. But something like intrauterine fetal death or inevitable abortion above three, four months, which is supposed to be inducted, we don't do it here so we refer. From the ministry's referral system, you only refer to a level three or four hospital. (Nurse, primary healthcare facility, Nairobi).

Policy makers also asserted that complications are classified in guidelines as either acute or chronic. Therefore, service providers at lower level facilities are to evaluate and refer clients based on the severity of each case.

Based on the background that this service is supposed to be task shifted, task shared to the level of a nurse, we know that a good proportion of these cases are becoming complicated and so the nurse cannot handle them. So part of the guideline is to prepare the nurse to pick out patients who may have near misses or whose complications are such that the nurse cannot manage and [must] refer to the next level who is a doctor working in a hospital. For example, if one [patient] has bled so much and would require blood transfusion, we know we don't transfuse blood in a health center or dispensary, so she has to refer for correction in a hospital set up... In addition, nurses are not supposed to manage [sepsis]. (Senior MoH Official, National level, Nairobi).

Some facilities, especially the lower level with trained personnel and some equipment such as MVA, would still opt to refer because of the uncertainty surrounding PAC cases. Providers explained that PAC requires many resources that go beyond simple MVA such as the availability of blood for transfusion, surgery, and in-patient services. They noted that a seemingly simple case can quickly become complicated thereby requiring unavailable resources. To avoid any risk of last-minute surprises, they referred PAC patients to higher level facilities.

If the cases are not complicated, sometimes we do the minor procedures and then give them the drugs and if it's complicated we refer them because we can't afford to have them. We don't have inpatients and also beds and maternity as well...so we refer them to referral hospitals for further management. (Nurse, primary healthcare facility, Mandera).

Providers' descriptions of cases that were "not complicated" differed considerably from one provider to another. To some providers, these cases included conditions where the evacuation could be done manually, or cases without heavy bleeding after uterine evacuation, anemia, infections, or cases not requiring surgery. According to some providers, mostly in rural areas, there were instances where they resorted to manage patients' even when they lacked the capacity to do so because the patient could not afford care in a higher level facility.

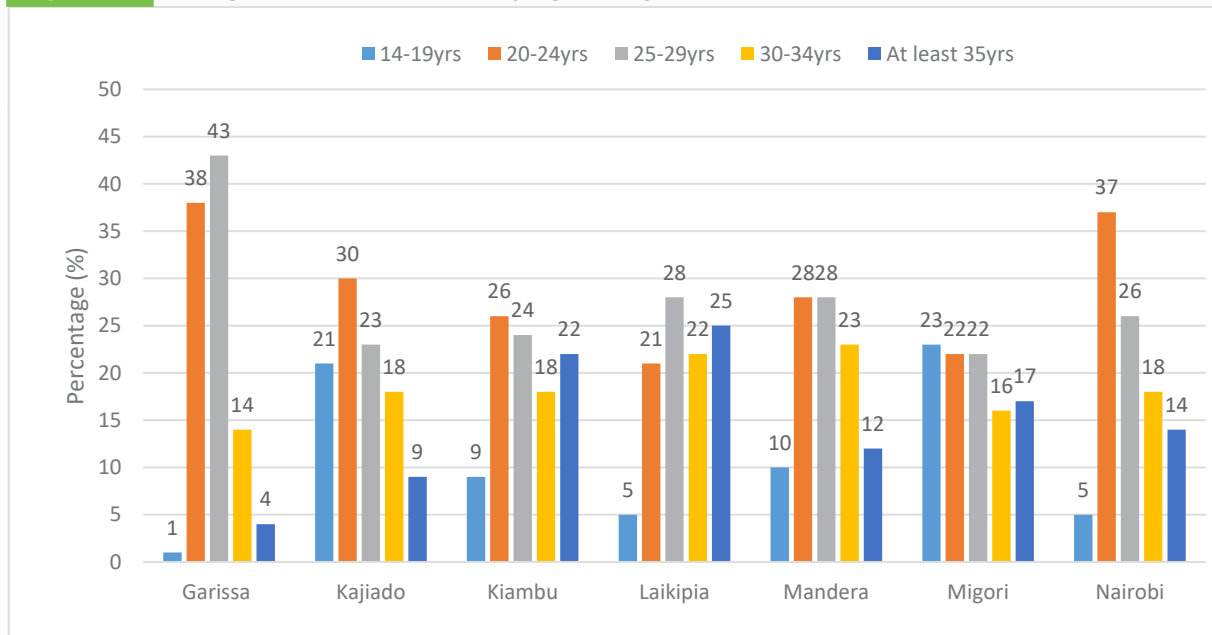
... The equipment is not effective but you have to do it, and you have to do it because even if you refer, they may not go; they tell you if there is something you can do, do it. We work in a community where the economic state is also low therefore referring somebody either to the county referral hospital or to a private hospital of their choice is like you are exposing them to expenses which they would have not been ready for. (Clinician, primary healthcare facility, Migori).

Patients experience of PAC

Socio-demographic characteristics of study participants

More than half (56%) of the patients who participated in the exit interviews was between 20 and 29 years, while one in every three (33.9%) was 30 years and older. Thirty-nine percent were younger than 25 years. There were differences in age across counties with about one in five patients interviewed in Kajiado and Migori counties being between 14-19 years compared to other counties where fewer than 10% of women were in this age group (Figure 9). Moreover, nearly half of these teenagers (44%) were seen at the primary level facilities.

Figure 9: PAC patients' distribution by age categories across counties



Exit interview participants' sociodemographic characteristics are summarized in Table 12. Although just a slight majority indicated they were residing in an urban setting (53.8%), most of those seen at the primary level facilities were rural residents (77.3%) while close to a third of those seen at referral facilities were urban residents. Majority of the PAC patients had attended school (83%) with at least two in five (40.9%) having completed primary level education, while 40.6% had reached secondary level education. Close to one in five women (17.8%) had achieved tertiary level education. More than half of the patients treated for post-abortion complications (57.9%) were unemployed. Among those employed, about one in four (26.8%) was earning KES 5000 (approximately 50 US dollars) or less per month, while a third (33.8%) earned between KES 5,000 to KES 10,000 per month and another one in three earned above KES 10,000. Unemployment or lack of income among PAC patients was greatest in Mandera County (92.9%), Garissa (87.5%), Kajiado (61.2%) and Migori (56.5%). A slight majority of PAC patients in Kiambu (58.8%), Laikipia (59.8%) and Nairobi (56.7%) were employed.

Most of the PAC patients were Christians (74.5%) with Protestants comprising 36.9% of the total sample and Catholics, 18.3%. Twenty-five percent of the patients were Muslims. Majority of PAC patients were married or cohabiting (72.8%), while 16.5% were single (Table 12).

Table 12: Patients' socio-demographic characteristics

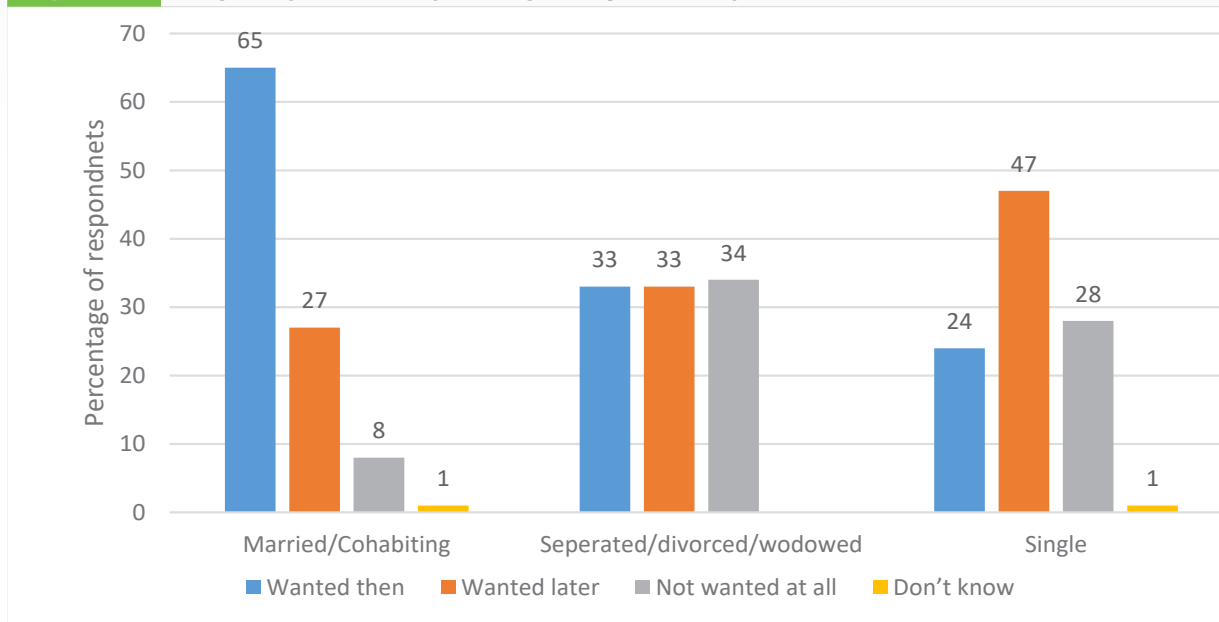
Characteristic		Primary level: N=172; n (%)	Referral level: N=647; n (%)	Overall: N=819; n (%)
Age (years)	14-19	32 (18.6)	47 (7.3)	79 (9.7)
	20-24	38 (22.1)	199 (30.8)	236 (28.9)
	25-29	42 (24.4)	184 (28.4)	226 (27.6)
	30-34	33 (19.2)	119 (18.4)	152 (18.6)
	At least 35	27 (15.7)	98 (15.2)	125 (15.3)
Area of residence	Rural	133 (77.3)	245 (37.9)	378 (46.2)
	Urban	39 (22.7)	402 (62.1)	441 (53.8)
Ever attended school		111 (64.5)	569 (87.9)	680 (83)
Highest level of education*	Primary	62 (55.9)	216 (38.0)	278 (40.9)
	Secondary	33 (29.7)	243 (42.7)	276 (40.6)
	Tertiary	15 (13.5)	106 (18.6)	121 (17.8)
Main economic activity	Employed	45 (26.2)	300 (46.4)	345 (42.1)
	Unemployed	127 (73.8)	347 (53.6)	474 (57.9)
Monthly income (KES)	≤5000	23 (52.3)	69 (23.1)	92 (26.8)
	5000-10000	11 (25.0)	105 (35.1)	116 (33.8)
	10001-15000	1 (2.3)	39 (13.0)	40 (11.7)
	>15000	9 (20.5)	86 (28.8)	95 (27.7)
Religion*	Catholic	21 (12.2)	129 (19.9)	150 (18.3)
	Protestant	37 (21.5)	265 (19.8)	302 (36.9)
	Other Christian	30 (17.4)	128 (19.8)	158 (19.3)
	Islam	84 (48.8)	121 (18.7)	205 (25.0)
Marital status	Married/cohabiting	140 (81.4)	456 (70.5)	596 (72.8)
	Separated/divorced	10 (5.8)	78 (12.1)	88 (10.7)
	Single	22 (12.8)	(7.5)	135 (6.5)

*These indicators had an additional category of "others" with less than 1%

Pregnancy desirability

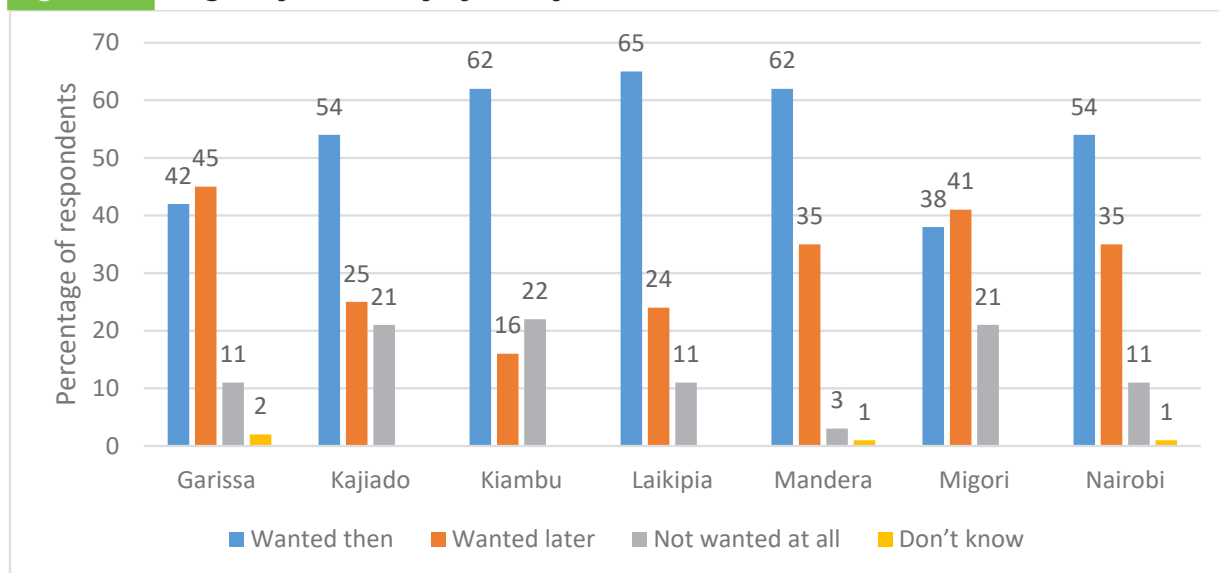
The index pregnancy of close to half of PAC patients (45%) was unintended. About one in three married patients (34.6%) did not want the pregnancies then. Moreover, majority of those who were single (75.5%), divorced or widowed or separated (67.1%) did not want their pregnancies (Figure 10). Close to one in every five patients (17.1%) treated for their abortion-related complications had considered terminating the pregnancy.

Figure 10: Pregnancy desirability among PAC patients by marital status



Considering preference for pregnancy by county, the vast majority of patients in all counties reported that they wanted the pregnancies then, except for Migori and Garissa counties where the proportion of women who indicated that the pregnancy was unwanted exceeded that of women who indicated that the pregnancy was wanted (Figure 11).

Figure 11: Pregnancy desirability by county



Reasons given for pregnancy being unintended included contraceptive failures (29%), financial constraints (26%), and concerns about school and/or career progression (14%). A greater proportion of women in Mandera (76.7%) and Garissa (45%) reported that the unwanted pregnancy resulted from contraceptive failure, while among women in Kiambu (26.6%), Laikipia (35.3%) and Nairobi (39.5%) counties, financial constraints dominated. School and career progression concerns were most common in Migori (29.3%) and Kajiado (27%) counties.

Perceived quality of PAC services

Qualitative interviews described patients' perceptions of what they considered as "good care" and/or "bad care" based on their previous experiences in health facilities. In their description of "good care", we noticed the recurrence of expressions such as friendliness, lack of harassment, respect and empathy in the context of their interactions with service providers, as well as absence of queues (or presence of short queues) and low cost of care. Some patients considered receiving the right treatment or feeling better when leaving the facility as good care. As one woman explained, "bad care", on the other hand, was associated with harsh or rude providers, long queues, and lack of empathy:

For bad care... the doctors and nurses are harsh [when] they talk to people. That is why I don't go to a hospital. They are so rude. They can shout at you, they can even beat you because you did something, they don't care how you feel. In good care, you feel your patients' pain as your pain. (25 years old, single, business, urban, Nairobi).

Patient's decision to seek PAC services in a particular facility was guided by perceived good experiences of previous care, the cost of service and their resources. This is explained by one of the patients:

I wanted to come here because it is cheap, it's not the same with the other hospitals because it depends on your earnings, and you can go to an expensive one or a cheap one. So I decided according to my means, I should be brought here. (23 years old, single, unemployed, urban, Kajiado).

However, many of those who opted for primary level facilities based on their previous experiences of good care while seeking treatment for a different medical issue, ended up being referred because the facility chosen could not offer the service needed. Patients expressed their PAC experiences using several key constructs including dignity and respect, autonomy, stigma and discrimination, communication, privacy and confidentiality, trust, predictability of costs and supportive care. These constructs are summarized in Table 13.

Table 13: Summary of patients experiences with post-abortion care by facility level

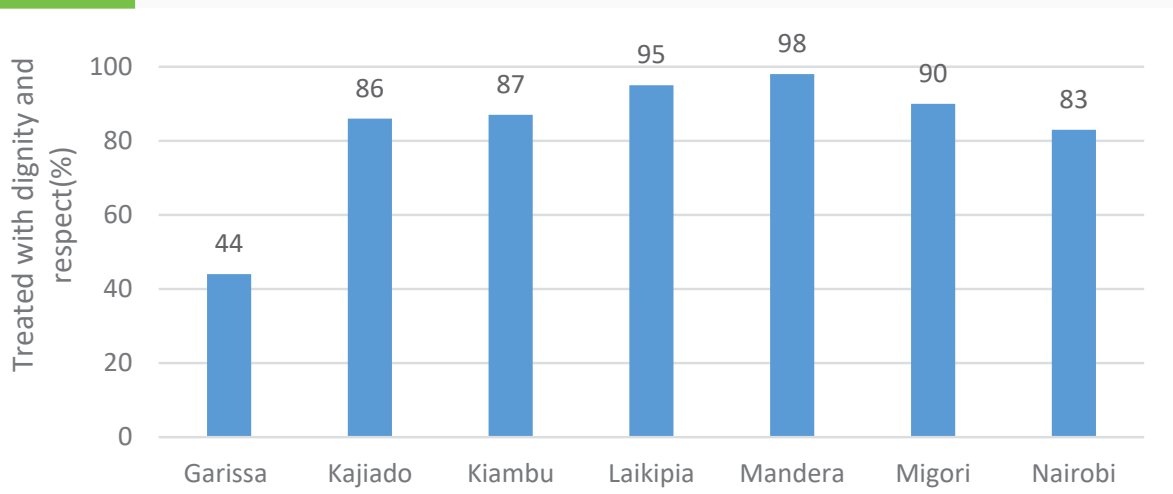
Construct	Proportion (%) of patients who rated their experience as good		
	Primary level: N=172, n (%)	Referral level: N=647, n (%)	Overall: N=819 n (%)
Dignity and respect	95.4	80.5	83.6
Privacy and confidentiality	64.0	28.1	35.7
Post-abortion counselling	68.0	33.5	40.8
Health facility environment	61.6	55.6	56.9
Autonomy	86.6	75.4	77.8
Communication	87.7	74.4	77.2
Supportive care	76.6	70.0	71.3
Trust	85.5	76.2	78.1
Predictability/transparency of payments	89.0	97.1	95.4
Stigma and discrimination	97.7	87.3	89.5

Dignity and respect

Patients rated dignity and respect highly with 83.6% of them indicating that they felt respected and their dignity preserved while seeking PAC services. Close to one in five PAC patients (16.4%) reported poor experiences. Of those who reported poor quality, 30% felt that the waiting time was long, and this was especially so among patients in referral level facilities. Similarly, half of the patients (49%) reported that health providers failed to introduce themselves during their first interaction (primary facility: 33%; referral facility: 53%). Notably, some patients (10%) reported being scolded, insulted, threatened, or spoken to rudely by health providers. Two percent of the women reported that they had been pushed, beaten, pinched, physically restrained or gagged. In general, the majority of patients felt more dignified and respected within primary level facilities (95.3%) compared to those in referral facilities (80.4%) (Table 13).

Across the counties, the majority of PAC patients in Garissa (55.8%) felt that dignity and respect was poor. However, patients in the rest of the counties reported good scores for dignity and respect, with Mandera County leading (98.2%) (See Figure 12).

Figure 12: Dignity and respect by county



In-depth interviews with patients illustrated how women experience dignity and respect when seeking PAC services especially in terms of waiting time and friendliness of providers.

a) Perception of waiting time

Nearly half of qualitative participants mentioned that they experienced a delay of at least one hour. Most patients treated immediately on arrival were often cases of emergency such as those with heavy bleeding or severe pain or those referred from other facilities. A patient from Laikipia described how fast she was attended to once she arrived:

Actually it was an emergency so they started it on the spot and they were so nice to me, that I must say because, even if they didn't know what happened because, maybe I might even have done something like abortion or something, but they didn't take it that way because it was an emergency and later on that is when they asked me if I did anything or something. But even after realizing that I did not do abortion or something, they did treat me well. (31 years old, married, teacher, urban, Laikipia).

Unlike this patient, others who reported delays felt that their condition was an emergency since they were bleeding heavily, and in severe pain. However, they were forced to wait for long hours, because of the caseload and few care providers. One patient who bled excessively and ended up having a spontaneous abortion while still queuing, reported feeling embarrassed. For this patient, the providers should have assessed her condition before allowing her to queue as narrated:

They should at least look at the state of the patient when they get here, observe them instead of making them queue and maybe they don't know what their situation is.[Had] they have checked my situation, I wouldn't have had the problem. I bled while I was just sitting and had the abortion there. So had they attended to me fast when I came, because I was in pain, you know I would at least have bled there and I wouldn't have bled in front of everyone else. (35 years old, single, employed, urban, Kiambu).

A 23-year-old patient from Kajiado, who “was told the child had died in the womb”, felt that this was an emergency situation that should have been handled immediately. Instead, she was kept waiting for long hours, a situation she felt could have worsened her condition and exposed her to more pain.

As illustrated in the following quotes, patients’ assessment of the appropriateness of the waiting time was also influenced by the number of patients on the queue, the number of service providers available, and the number of patients needing emergency care. As one patient (33 years old, married, employed, urban Kajiado) explained, “...there was a patient being attended to so I could not blame the doctor because she was alone and the patients were many.” This patient and many others felt that most health providers would prefer to offer immediate care to all patients in emergency situations but could not because of their heavy workload or the high number of patients.

Cases of provider burnout were also reported as a reason for delays in services, especially for patients who arrived at the facility in the evening. In one of the referral facilities, a service provider was found taking a nap while patients were still on the queue waiting to be attended to. As a result, patients piled up and new emergencies developed on account of long waiting hours. This is common in facilities with high volumes of patients and few providers.

In some cases, patients were initially taken in, but were then referred for other services such as ultrasound scan, further prolonging the wait time to receive treatment. As illustrated in the following narratives, patients who were instructed to take an ultrasound scan and other tests not only had to queue at the scanning room or lab and pay the approved fees before they received the services, they also had to cover some distance within the facility, a situation that further delayed their care process.

...So when I got there I started bleeding, then I was told to go for an ultrasound. I took the stairs and went for that. I was then sent to go for a rhesus test to know my blood group, I went and got tested. Then I was sent again to test for PDT [Pregnancy Diagnostic Test] again I was tested (...). So when I was there I kept using stairs and coming down, so I started feeling my abdomen being painful like I am in labor. So that’s when...because I had also drunk a lot of water, I went down to the toilet and I was bleeding profusely and could see clots coming out; then I would go and wait for results then go back to the toilet and bleed. So when I was given the results, I took them to the doctor down there and that’s where there was a problem; I waited for long ... to give him the results because people were so many and the doctors were very few. I waited for long and the abdomen pain continued like labor, like labor pain. (36 years old, married, casual laborer, urban, Nairobi).

In other facilities, women simply could not get the scan because the ultrasound machine was broken, while others were sent elsewhere because the person in charge of performing the scans was unavailable. Some facilities provided ultrasound services at specific times and days of the week, hence patients who presented past working hours were referred for ultrasound services elsewhere. Even in cases where the ultrasound scan services were immediately available, some patients were unable to afford the service charge. They therefore had to postpone treatment.

Patients also noted that delays in receiving care resulted from inadequate equipment and medical supplies. A participant from Nairobi, for example, reported that she had to wait for more than four days before undergoing MVA treatment because of the lack of MVA equipment in the referral facility:

I came on Thursday evening and I was admitted, I was here on Friday, Saturday. On Sunday, the doctor who did the rounds told me that there was no MVA equipment and that I could go to a different hospital. I told him whoever will come here on Monday... so I relaxed and decided to wait for the equipment. They were brought on Monday ... I was "washed" in the evening. (30 years old, married, employed, urban, Nairobi).

b) PAC providers' friendliness

Patients judged providers as friendly if they were welcoming, checked on them, used encouraging words, shared life experiences or soothed patients to ease their pain. Other patients simply pegged provider friendliness in the way providers greeted them, gave them medication at the right time, and answered questions freely and openly. Most PAC patients across the counties felt that service providers were friendly to them, as explained by one of the participants in Kajiado.

A female tall and dark nurse, she really attended to me well. Even after she brought me here, she came back to check if I had been attended to. Yes, even the one we were with here attended to me well. You know some can attend to you, when you tell them to stop and that you are in pain, they tell you are disturbing and so on; but this one was saying sorry to me and attending to me well. I could tell her, wait a minute I feel sweaty and he could open the windows for me and attend to me well. (34 years old, married, business lady, urban, Kajiado).

However, some patients reported cases of physical, verbal and sexual abuse, especially when they were suspected to have had an induced abortion or were considered stubborn. These patients often felt vulnerable, they could not speak and chose to suffer in silence even when they were uncomfortable about how they were being treated:

You know... not that they weren't answering me alone, there were some who called them, and they just came and answered them rudely. Some doctors are grumpy. There was one you called him, he asked, 'what are you calling me for, stop disturbing me', he just comes at his own time. So how he answers me I just feel bad. We just kept quiet, we are sick we have been brought here... (25 years old, married, unemployed, urban, Kajiado)

Some PAC patients narrated how they were sexually abused while at a particular health facility. According to several patients, cases of sexual abuse in the health facility remained unaddressed even after the facility administration had been informed. During our facility observation, we encountered patients complaining among themselves and describing how a particular provider harassed and threatened some of them, requesting that they "hug him". According to the patients, this situation seemed to have persisted for some time with different women experiencing it. During the interviews, one of the patients recounted what she went through when one of the providers was evacuating her uterus:

When I was going to be washed, I came and removed my pants...so I assumed that position, he came and saw no remains coming out but he started throwing hands at me. He asked me, 'you don't feel well when you are touched to be ready for sex'...he touched my clit, and asked me, 'don't you feel good to receive a man'...asked me whether I didn't feel ready to have sex...You know if the doctor tells you something, you just relax, I felt very bad because still that morning the lady there came to my bed and told me she was also mistreated, the man touched her breasts or [hugged] her. (28 years old, married, unemployed, urban, Kiambu).

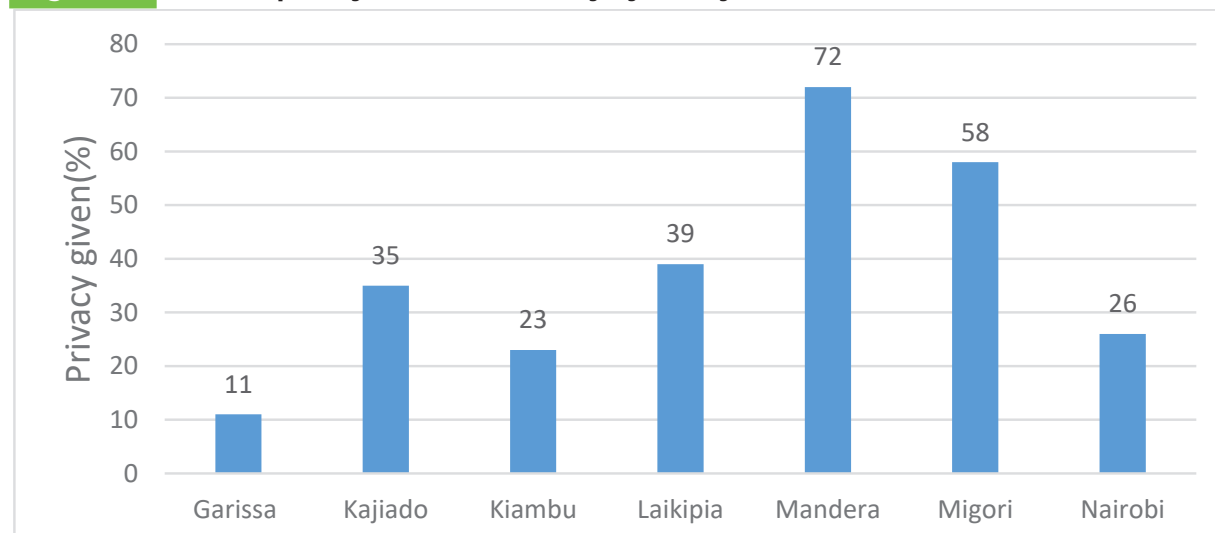
Such situations depressed patients as they trusted the providers with their care. Patients noted that whenever they refused the providers' sexual advances, they would be neglected during treatment in retaliation. As such, some PAC patients felt insecure and uncomfortable around male service providers, and wished male providers were transferred to male sections or other departments where there were no women.

After I was "washed", he came in and I didn't feel secure because we were just the two of us...I didn't fear a woman but when he came in, I didn't like it. I was not impressed by him being in a woman's job yet he is a man. He fondled my breast and I was not impressed...; I wouldn't prefer being (in) the ward, his character (is) not good, what he wanted to do to me yesterday night wasn't good to me. He tried to seduce me...he wanted to hold me but I moved away. I didn't see his reason for having such a habit. In fact, I preferred he be taken to the men's section or maybe to a different department with no women. (20 years old, separated, casual laborer, urban, Kiambu).

Privacy and confidentiality

In general, over 64% of the patients felt that their privacy was compromised. A higher proportion of women treated in referral level facilities (71.9%) than in primary level facilities (36.7%) felt that their privacy was compromised (Table 13). Across the counties, the majority of PAC patients in Garissa (89.4%), Kiambu (77.1%), Nairobi (74.4%), Kajiado (65%) and Laikipia (60.8%) felt that there was no privacy during PAC service provision. However, in Mandera County, the majority of PAC patients (72.3%) felt that they were accorded privacy (Figure 13).

Figure 13: Lack of privacy and confidentiality by county



The qualitative findings provide insights on the issues of privacy and confidentiality. For instance, in Kajiado and Garissa, patients reported occasions where the treatment rooms were not isolated, thereby leading to situations where other patients or people could eavesdrop on the conversations between providers and patients or even enter the room when the patient was naked on the surgical table. Other patients felt very uncomfortable or embarrassed when certain procedures like MVA were done with many healthcare providers in the treatment room.

...Because of course when you go to the theatre you remove all clothes so I was naked and there... the door was not closed, even those who were passing by could see you when you are being washed and there isn't a curtain. In fact, that guy who came to clean just got me there naked. (25 years old, married, unemployed, urban, Kajiado).

Sometimes like MVA, because it's more of you showing part of your body a lot, at some point, you feel they are too much in the room, I never loved that. You find that they are like eight people and like six of them are just storytelling, the students are not necessary there. (23 years old, single, beautician, urban, Kiambu).

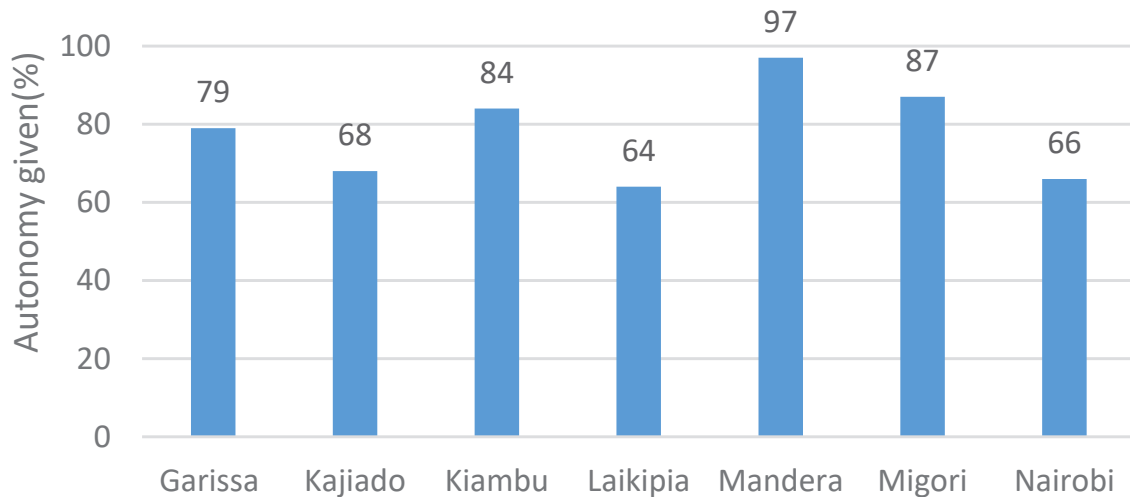
There were a few reported instances where providers spoke so loudly that others were able to hear their conversation with patients. Breach of privacy was aggravated when such interactions happened while the consultation or procedure rooms were close to intake or waiting areas, or close to the washing rooms. In some cases, the interactions with the provider happened in overcrowded places such as treatment or hospitalization rooms with many patients. Patients who felt that their privacy was breached described feeling embarrassed.

He asked me, 'Do you want to heal or what?' and they [other patients] all heard. It's not good because you expect to tell the doctor your problems but not for others to hear. It embarrassed me. (23 years' old, single, urban, Kajiado).

Although such privacy concerns were reported by various patients, they were more common among young and single women, some of whom had induced abortion. According to these patients, the breach of confidentiality would put them at risk of stigmatization in their communities.

Autonomy

Autonomy was meant to capture patients' involvement in the decisions around their care. The overall score on autonomy was fairly high, with patients from primary facilities reporting higher scores (87.1%) compared to referral level facilities (75.5%) (Table 13). About one in every five PAC patients (22%) felt that their autonomy was not respected. Autonomy during PAC service provision was also highly rated across the counties, with the highest figures seen in Mandera (97.3%), Migori (87%) and Kiambu (84.1%). However, in Laikipia, Nairobi and Kajiado, about one in three patients (36.1%, 34.1% and 32.5% respectively), reported that autonomy was not provided (Figure 14).

Figure 14: Autonomy by county

While data from the quantitative findings indicated that most PAC patients were consulted during treatment, IDIs depicted a completely different picture regarding their autonomy and involvement in decisions regarding their care. Most PAC patients indicated they were not involved in making decisions regarding their treatment. According to patients, providers made decisions about the kind of treatment (i.e. choice between MVA and MA for the uterine evacuation) without consulting them or their caregivers. Even in situations where some patients felt they could refuse certain procedures, they did not make any objections as they feared providers' reactions.

As I have told you, we are never in a position to tell the doctors that we want to be treated, you just come and you see them come to give you drugs. (23 years, single, urban, Kajiado).

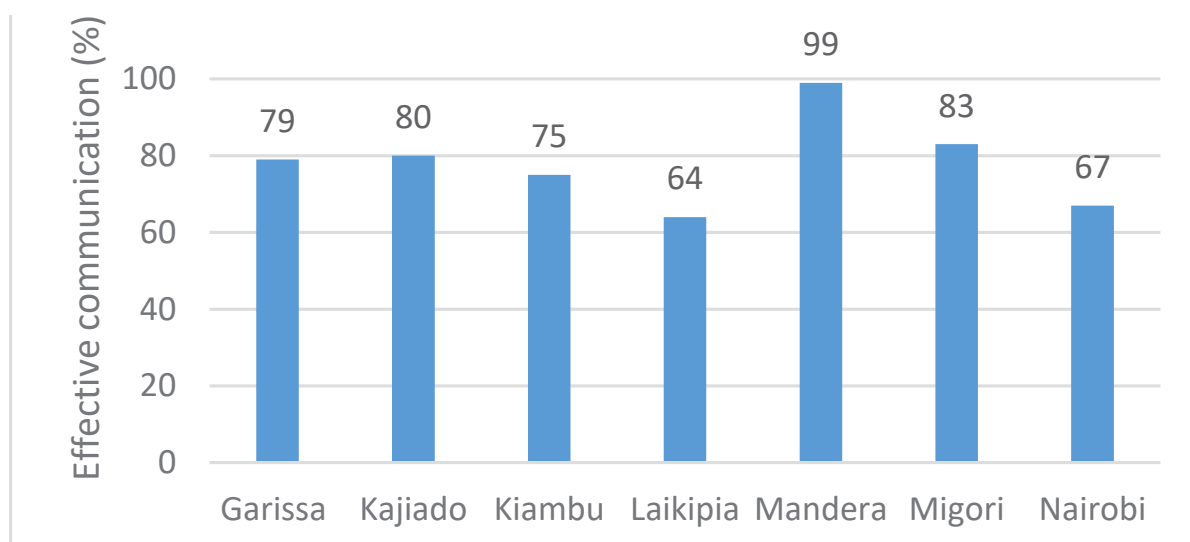
Some patients were even surprised when the question about their involvement was asked, because to them, patients' non-involvement has always been the practice. Moreover, some patients felt that the healthcare providers were more knowledgeable, therefore, they would accept whichever treatment is provided to them as long as they got well. A participant noted:

Mostly they do say that you cannot argue with the doctor, because he is the one who knows the medication to give you so that's why you cannot always ask a question even when you have. (33 years old, married, employed, urban, Kajiado).

Communication

Most PAC patients (77.2%) reported that communication between them and healthcare providers was good or effective, with 87.7% in primary level facilities and 74.4% in referral level facilities stating that this was the case (Table 13). Overall, fewer patients reported understanding the language used by healthcare providers (65.1%), reasons why they could not be accompanied by other family members or friends during treatment (56.2%), and reasons for giving medicines (66.3%). At county level, the majority of PAC patients in Mandera (99.1%) reported good communication. Even so, it is worth noting that over 32% and about 35% of PAC patients in Nairobi and Laikipia respectively felt that there was poor communication between them and the healthcare providers (Figure 15).

Figure 15: Communication by county



Although most of the qualitative survey participants were not involved in decision making regarding their treatment, many of them were reportedly informed about the providers' choices, the reasons underlying those choices, and what the PAC procedures (e.g. MVA) entailed. Some respondents also applauded service providers for giving them a chance to ask questions. Women reported that the information helped them to prepare psychologically. For instance, a participating patient explained how her discussion with the provider helped her psychologically before her womb "washing":

He told me how he would "wash" me, and prepared me psychologically, and told me it's a bit uncomfortable, that I would feel some pain, so I felt okay. So before I got in, I was prepared. (29 years old, married, sales and marketing, urban, Laikipia).

Those who reported that they lacked information explained that they could not ask questions because they were afraid that the providers would respond rudely or even stop the procedure. In most cases, the fear and the reluctance around asking questions was driven by previous experiences with providers who did not encourage positive provider-patient interactions. The few who were courageous enough to ask questions or requested to know the reasons for certain medications, were threatened with dire consequences. Many were left with the impression that providers are not people who entertain questions from patients. Some of these concerns are illustrated below:

You know I feared them, I didn't ask them. There was just one sister whom I asked and told me that you will just get pregnant and then I just kept quiet because I was satisfied with what she told me. (22 years old, married, business woman, urban, Nairobi).

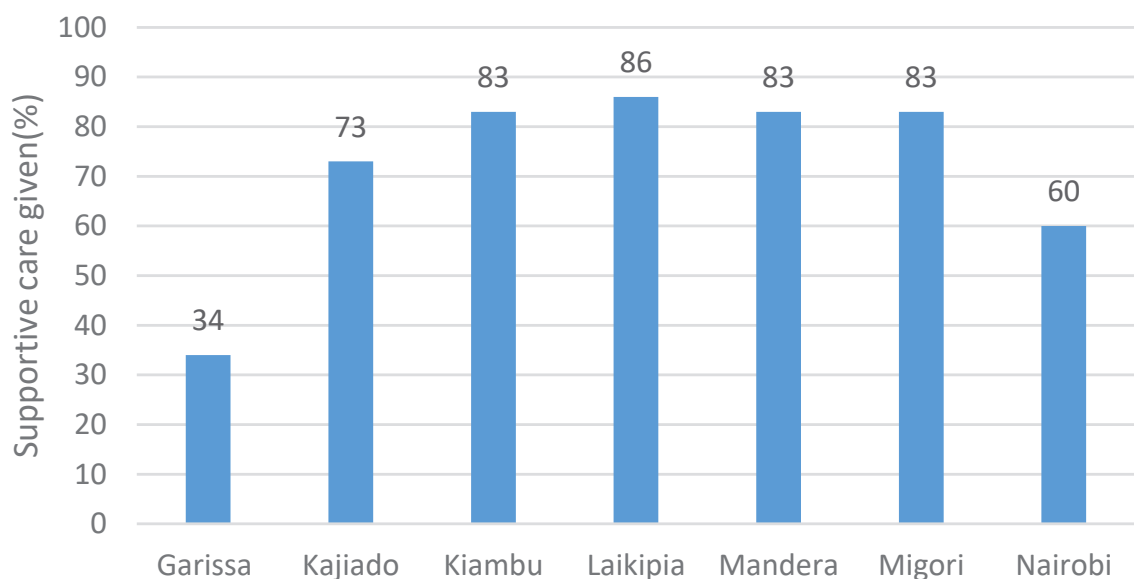
I told her that the injection was [causing] more pain. She told me 'either you accept these drugs or go there'. I asked her where? 'Won't you die', she said. I felt bad, yes, because she didn't want to tell me the reason for that medication. (28 years old, separated, business woman, urban, Laikipia).

Supportive care

Seventy-seven percent of PAC patients in primary facilities and 69.9% of patients in referral level facilities indicated that they received supportive care (Table 13). Specifically, almost all patients, irrespective of facility level reported that health providers took measures to control their pain. A fairly high proportion of patients in primary (86.1%) and referral level (76.9%) facilities also confirmed that health providers paid attention to their requests for help.

At county level, the majority of PAC patients (at least 70%) reported receiving supportive care, with the exception of Garissa and Nairobi counties where only 33.7% and 59.8%, respectively, reported that they had received supportive care (Figure 16).

Figure 16: Supportive care by county





In the qualitative interviews, patients confirmed that they received supportive care. They described supportive care as empathetic care from providers and being given pain management drugs. Some patients, particularly those who had miscarriages and experienced psychological distress, described how providers took time to listen to their stories and advised them. Such counselling helped the patients to overcome the pain of pregnancy loss. In some cases, the psychological support reportedly received was detailed information on pain associated with procedures such as MVA, which helped calm their fears. One patient explained how the information she received helped her prepare psychologically for the MVA, and overcome her fears and misconceptions.

They gave me enough information and they would prepare me. Like the MVA, I really feared, because I had heard stories plus I was Googling when I was in the ward because you are scared, you have been told it's an incomplete abortion, you don't even know what it is. So, when they realized I was scared, they first told me what it entails and everything. So, I think they helped me overcome it by giving me information, like trying to teach me what treatment they were giving me. (23 years old, single, beautician, urban, Kiambu).

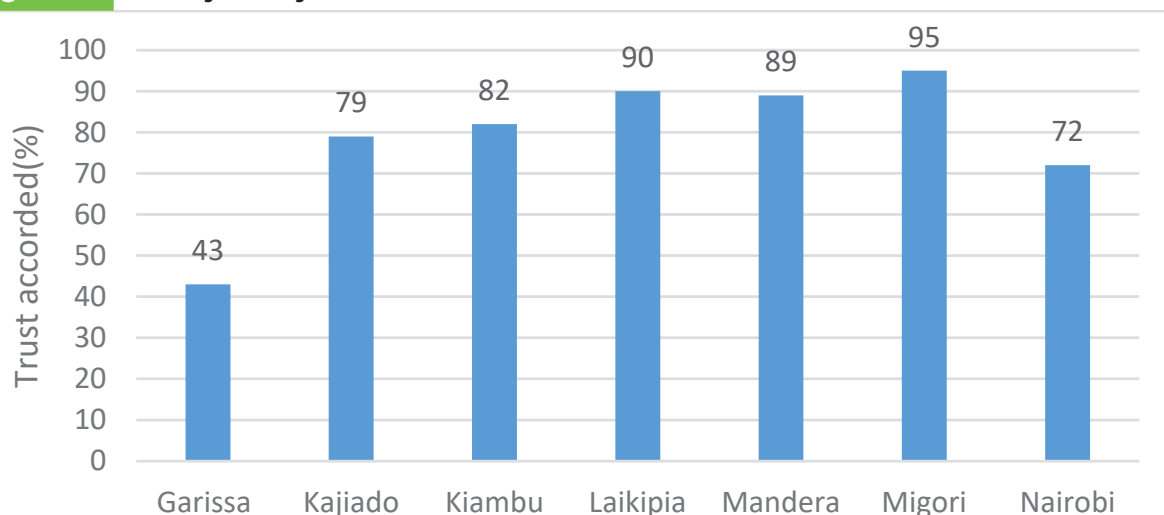
It is worth noting that patients who received such counselling were mostly those who reported that they received respectful and friendly care. For patients who were suspected to have induced their abortions, their interactions with providers were largely characterized by tension and rudeness, devoid of supportive counselling.

Trust

Majority of PAC patients (78.1%) felt that they could trust the healthcare providers and expressed confidence in the care they received. This was more common among patients at primary level facilities (90.7%) compared to those in referral facilities (83.2%). By implication, the majority of patients who expressed lack of trust were from referral level facilities (Table 13).

At county level, with the exception of Garissa, where only 43% of patients indicated that they trusted their providers, over 70% of PAC patients in the other counties felt that they could trust their providers (Figure 17).

Figure 17: Trust by county

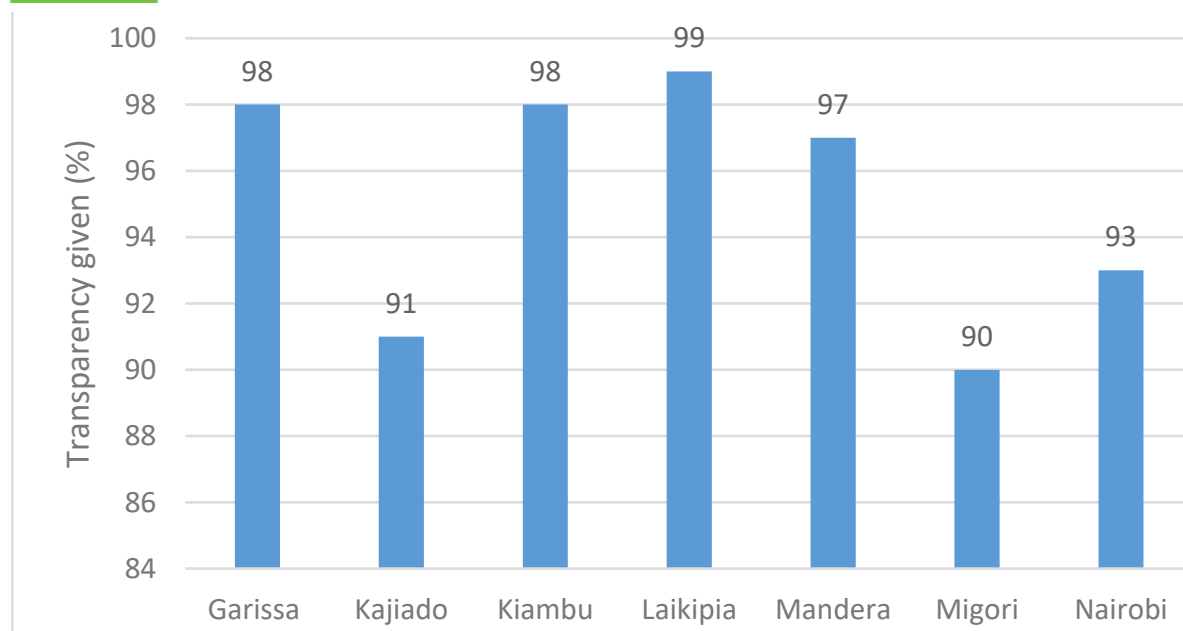




Predictability and transparency of payments

The vast majority of the patients in primary (89.5%) and referral (97.2%) level facilities stated that payments for PAC were transparent (Table 13). Most PAC patients (91.9%) in primary level and nearly all (97.8%) in referral level facilities reported that they had never been asked for a bribe to facilitate the care process. Considering the counties, most PAC patients felt the payments were transparent and predictable with less than one in every ten patients reporting lack of transparency and accountability (Figure 18).

Figure 18: Predictability and transparency of payments by county

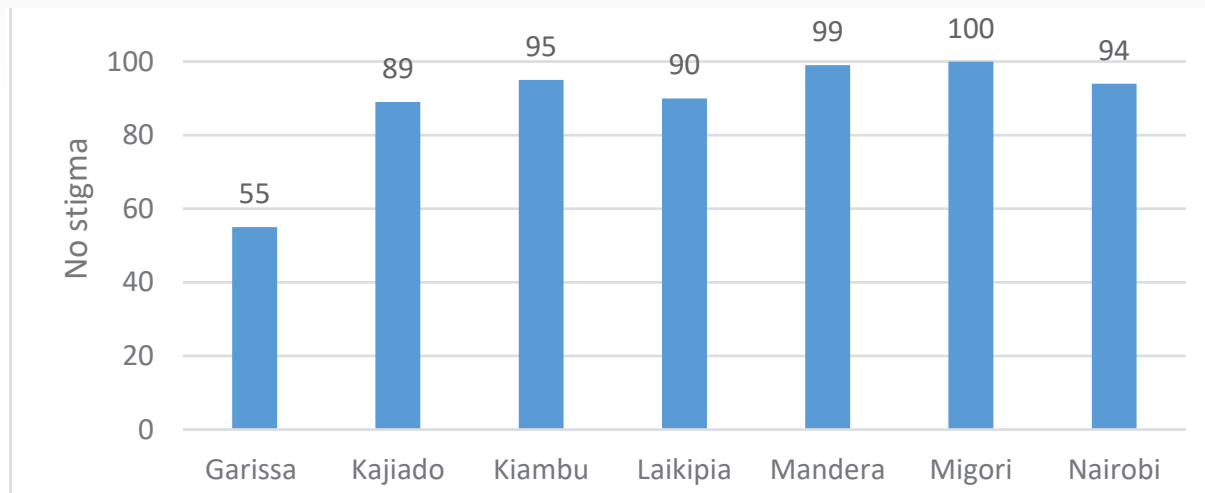


Stigma and discrimination

While the majority of PAC patients (89.5%) did not experience stigma and discrimination by health providers or other personnel during their stay in the facility, about 12.8% of patients in referral facilities experienced some form of stigma (i.e. being treated differently because of the type of abortion, or their personal attributes such as age and marital status), compared to only 1.8% in primary health facilities (Table 8).

The highest proportion of patients reporting that they had experienced stigma and discrimination cases was in Garissa, where 45.2% of reported that they experienced stigma (Figure 19).

Figure 19: Stigma and discrimination by county



Women reported experiences of being treated in a demeaning manner such as being shouted at or spoken to rudely, abused and threatened based on their personal attributes. This was aptly reflected when some PAC patients reported being sexually harassed. Patients felt that providers were intentionally acting or behaving in certain disparaging ways because of their conditions. A 19-year-old single PAC patient from one of the referral facilities in Nairobi County explained how she was mistreated right from the consultation to the treatment area:

When I got in there and was talking to the doctor, one of them was on Facebook just pressing the phone, another one was saying 'I cannot do that is difficult'; and then a young doctor came and gave me this injection. Though when he said he would help me, I waited for long. I was in so much pain and had to go to the bed all by myself. I cried but there was no doctor in sight. So I just had to cry there and hang on and fortunately the baby came and I pushed, so when the baby came, that lady shouted 'nurse come and help this girl'. That's when she came and told me to push, and she went back and she came and checked if I had pushed... You know, I waited for long. I do see that when a patient comes here, they are attended to fast but here when you come you are just made to wait out there and feel the pain. People were just... yes, people were many but not very many, and the person who was to help me was only with me and when I asked he told me that I am with you. So I don't know why he took so long. (19 years old, single house help, urban, Nairobi).

Nevertheless, there were reported instances where providers protected PAC patients from community driven stigma. During our health facility observations in Kajiado County, for example, a service provider tried to hide a PAC patient to protect both of them from community attack and humiliation arising from the perception about their having participated in an abortion procedure. In the follow-up discussion with that provider, he lamented about the extreme levels of stigma around abortion in the county, including against PAC providers.



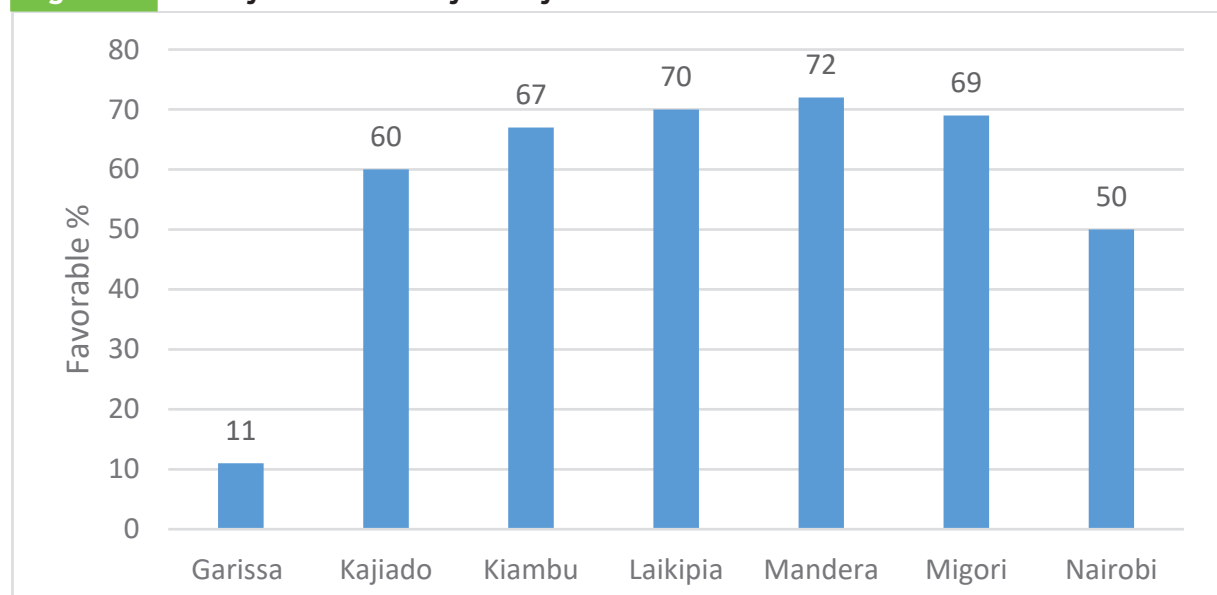
As a result, patients were reported to seek secret abortions and hiding any complications, resulting in delays in seeking care. Providers were also noted to be afraid of handling PAC patients because community members (in most cases women) could raid the facility and attack or shame the patients and providers. According to one provider, high levels of stigma forced many women who could afford it to cross into Tanzania (across the border) to procure an abortion or seek treatment for post-abortion complications.

Health facility environment

Over 60% of the patients in the primary level facilities and 55.6% in referral facilities felt that the health facility environment was favorable (Table 13). Across all primary level facilities, 72.7% of women felt that there was enough space in the ward in which they were treated, whereas in referral level facilities only 58.3% stated the same. However, only 8.7% of patients in primary facilities considered the general environment to be clean compared to 25.8% in referral level facilities. About the same proportion of patients at both levels (primary: 80.2% and referral: 81.6%) reported that the facilities had electricity. Also, 71.5% and 68.8% of patients in primary and referral levels respectively indicated that the facility had a tap and running water.

Across the counties, the majority of PAC patients felt that the health facility environment was favorable. However, four in five (80.4%) PAC patients in Garissa indicated that the facility environment was unfavorable. In Nairobi County, half (50%) of the patients considered the environment unclean (Figure 20).

Figure 20: Facility environment by county



Overall, qualitative interviews and observations suggested that the physical environment of most health facilities was favorable. Nevertheless, patients recalled certain cases where wards were crowded, especially in referral facilities, and where patients had to share hospital beds. They also spoke about facilities without specific MVA rooms and where patients were treated together with others.

Observations also highlighted instances where patients' histories were collected in open spaces where other patients could listen in. In such situations, PAC patients requiring emergency care (especially those having induced abortion) could omit abortion complications from their histories or go into hiding in the facility until some confidentiality could be assured. This increased waiting times with potentially detrimental effects on outcomes.

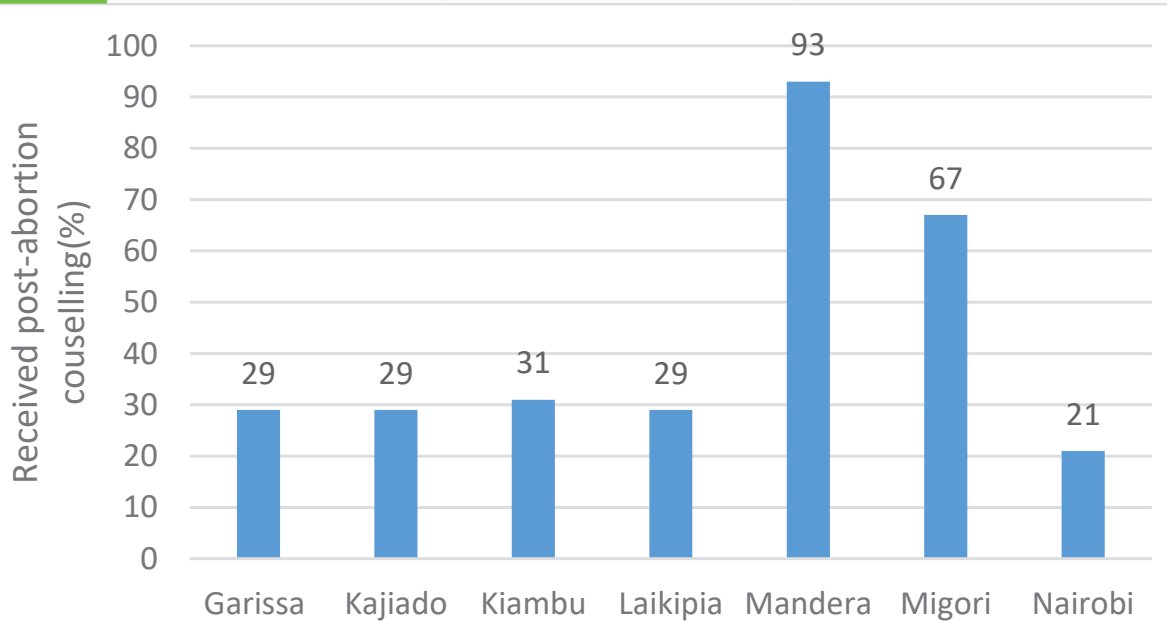
Some patients also complained about the poor state of hospital sanitation especially toilets and bathrooms. In most cases, the toilets were very dirty especially in crowded facilities, while others were blocked. In certain facilities with dirty toilets some patients opted to use bathrooms to urinate, pushing others to avoid bathing there for fear of potential infections. A respondent from Kiambu County narrated:

Wards are clean but the toilets are not clean and even the bathrooms. Since I came here I haven't gone to the toilets, they are dirty, they don't scrub the floor and you know there are patients who urinate there (bathrooms). It's because the toilets are dirty, they urinate in the bathroom to avoid infections from the toilet and you avoid taking bath in the bathroom to avoid infections. (28 years old, married, unemployed, Kiambu).

Post-abortion contraceptive counselling

About three in every five patients (60%) were not offered post-abortion contraceptive counselling as part of PAC services. A greater proportion of patients in referral hospitals (66.5%) than in primary level facilities (31.6%) did not receive post-abortion counseling (Table 13).

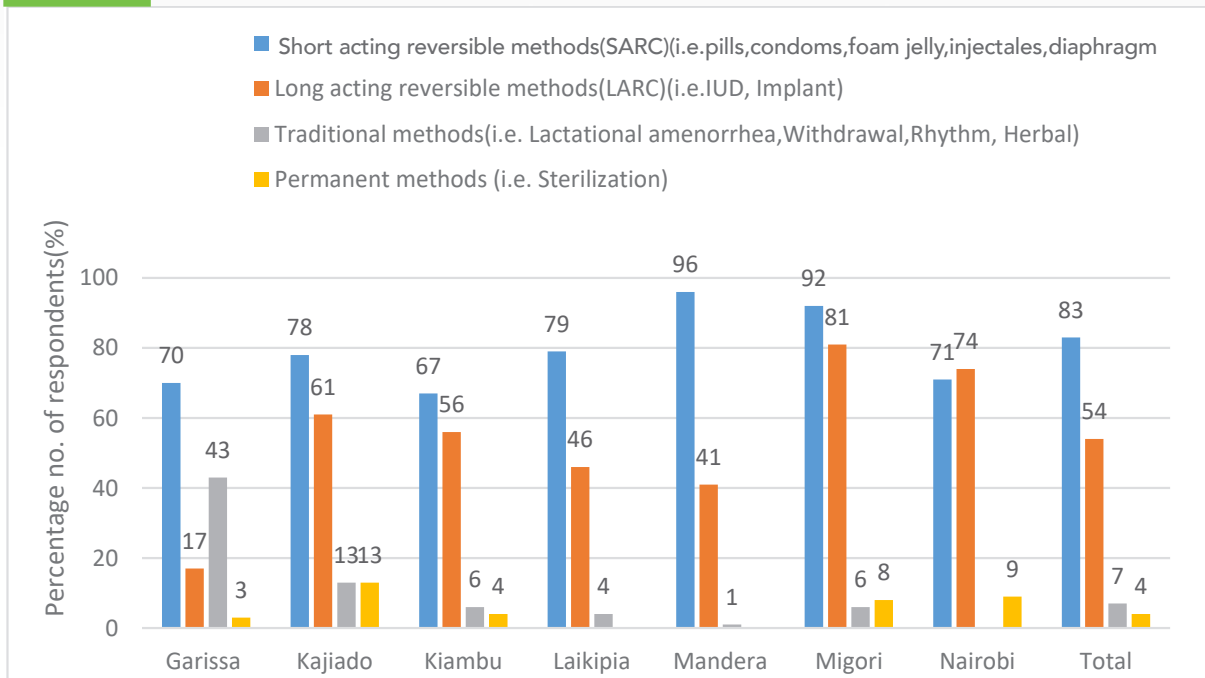
At county level, contraceptive counselling was very low in five of the seven counties: Nairobi (21.3%), Garissa (28.8%), Kajiado (28.8%) and Laikipia (28.9%) and Kiambu (31%). Mandera county had the highest contraceptive counselling provision with nine in ten (92.9%) patients receiving counselling before exiting the facility, followed by Migori where two in every three (67.4%) patients were counselled (Figure 21).

Figure 21: Provision of post-abortion counselling by county

Among patients who received post-abortion contraceptive counselling, majority (83.2%) were informed about and/or offered short acting family planning methods (such as pills, condom, foam jelly, injectable, and diaphragm), while about half (53.9%) were informed about and/or offered long acting reversible methods (such as IUDs and implants). Less than 10% of women were informed about traditional (lactational amenorrhea, withdrawal, rhythm and herbal) family planning methods (7.5%); and far less about long acting permanent methods (i.e., sterilization or tubal ligation) (4.2%).

Majority of PAC patients across all counties were offered short-term contraceptive methods, as opposed to long-acting methods, even though these were offered at high levels in Migori (81%), Nairobi (74.3%) and Kajiado (60.9%) (Figure 22).

Figure 22: Contraceptive methods offered (by counties)



Few patients who participated in the in-depth interviews reported that they had received post-abortion counselling before discharge. This is consistent with reports from the healthcare providers who indicated counselling was limited due to the unavailability of counsellors or lack of time. Moreover, patients who received counselling explained that healthcare providers mentioned family planning and the need to prevent future pregnancies without offering enough information on the type of methods available, their advantages and possible side effects depending on patients' future aspirations for parenthood. As a result, patients were unable to choose a method, because they had reservations about the side effects (e.g. infertility) and they left the facilities without a contraceptive method. Some patients also left the facilities without a contraceptive method because they were not accessible (either because the unit was closed or far from the ward where they were treated, patients did not have money to pay for it, or wanted to avoid stigma etc.).

In the case of participants treated using medical uterine evacuation, the counselling was done when they received the medical uterine evacuation (MUE) drugs, and they were supposed to receive contraceptives during the ensuing checkup visit (usually after one week). Two participants from Kiambu and Migori were given appointments to allow them to finish their medication:

They have told me that since they have given me drugs, I should come and join family planning on Monday. (24 years old, married, casual worker, urban, Kiambu).

I didn't receive it but I was planning that when I heal I will come back. (22 years old, married, business-maize, rural, Migori).

However, we followed up and it seems that none of them went back to the facility for subsequent check-ups and the contraceptives. Indeed, in the cases where abortion was induced and the patient went through difficult interactions with providers (i.e., police being called to threaten them), patients were reluctant to return for check-ups (including counselling).

Discussion

Capacity of public health facilities to offer quality PAC services

The study findings reveal that majority of primary and referral health facilities had relatively low capacity to deliver essential elements of PAC consistent with their respective level [20]. The greatest weaknesses were reported in Level 2, 3 and 4 facilities [9]. The main reasons for the limited capacity to deliver PAC services included unavailability of staff trained on PAC and the absence of functional PAC equipment, supplies and commodities. While referral facilities receive emergency cases from primary facilities, a considerable proportion of them lacked the essential equipment, commodities and supplies for the provision of PAC services. Moreover, primary facilities did not have adequate referral capabilities - in the form of ready transportation (vehicle with fuel or ambulance) for critical patients - which often compelled patients to arrange their own transport or self-refer themselves to higher level facilities. Such weaknesses in the referral system translate to delays in reaching and obtaining PAC, and creates gaps in key services such as post-PAC contraceptive counselling with implications for health outcomes. The few primary or referral facilities that reported having capabilities to deliver all PAC services are often overwhelmed and overcrowded with emergency cases, translating into long hours of work for providers, staff burnout and diminished quality of care to patients, and ultimately poor health outcomes [24].

Regarding staff availability and training, our findings showed that few facilities at the primary level had medical staff present for 24 hours daily. Further, the shift system also affected the continuous presence of trained staff. Consequently, various services such as MVA procedures, ultrasound scans, and contraceptives were not offered 24/7 across all levels of facilities. Limited operating hours means that patients may only be able to access such services on certain days or times per week, exposing them to delayed care, unnecessary referrals, severe complications, as well as a significant risk for unplanned pregnancies and repeat abortions due to lack of access to contraceptives.

Patients' experiences on quality of post-abortion care

PAC patients' experiences revealed significant variations in the quality of care across the counties, and across health facility levels. Whereas most patients reported being treated with dignity and respect, a number of them felt the opposite. Cases of long waiting hours, complex referral chains, provider hostilities, and sexual harassment were highlighted by several participants. Patients who reported disrespectful care and abuse felt that they were stigmatized because of their age or assumptions that they had induced the abortion. These concerns were particularly prevalent in Garissa and Kiambu counties and may create mistrust and perpetuate feelings of stigma and discrimination among PAC patients. Patients confirmed that supportive care offered psychological healing to them, especially for those who experienced miscarriages.

Concerns about privacy during examination and treatment as well as worries about the confidentiality of patients' health information were also highlighted. These concerns seemed more pronounced in referral facilities. The lack of privacy and confidentiality was compounded by the environment where services were delivered (crowded wards or open spaces, shared hospital beds, lack of specific MVA rooms leading to PAC patients being treated alongside others). Such situations increased the risk of abortion disclosure, pushing patients to hide their conditions and delay access to care. Consistent with prior evidence, the lack of privacy and confidentiality degrades the dignity of women and exposes them to the risk of stigma. The result is that some women shy away from health facilities, even when faced with severe abortion-related complications.

Based on in-depth interviews, some patients reported that decisions about treatment were made solely by providers, and patients were only informed about the treatment procedure to be undertaken with no consideration for their concerns. This approach to care assumes providers have all the knowledge, and always have the best interests of patients. Drawing from studies on abortion stigma, the choice of treatment including technologies for uterine evacuations (i.e. medical abortion versus MVA) may perpetuate or mitigate the risks of stigma for patients. On the other hand, strengthening patients' roles in care decision making could potentially improve in-facility experiences for patients, influencing PAC health seeking behavior and reducing risks of obstetric violence [25].

The findings also revealed critical gaps in communication between PAC patients and providers. These gaps were more pronounced in referral facilities, perhaps because of the high patient volumes and limited number of providers. In such facilities, providers sometimes expressed negative and hostile attitudes and behavior towards PAC patients, especially those thought to have induced abortions. This in effect hindered communication. Some patients never understood the reasons why certain treatments or procedures were undertaken, and did not dare to ask questions because they feared the provider's reaction. Poor patient-provider communication is problematic, and limits patient's education regarding risks of unsafe abortion, PAC and contraceptive use. Poor patient-provider communication may translate into suboptimal adherence to treatment (especially where there are side effects) and other self-care measures.

The majority of PAC patients across the counties and facility levels did not receive post-abortion counseling and contraceptive methods before discharge. A core component of PAC services is counseling women on abortion, risks of abortion and contraception methods as well as guiding them to a preferred choice with the aim of preventing further unplanned pregnancies and repeat unsafe abortions. This gap may be blamed on stigma, involvement of police in the care process, lack of awareness, provider behavior, disintegration of services and patient flow arrangements in each facility that earmarks PAC counselling as the last stage of care before discharge, even as it is not compulsory and is somewhat detached from the treatment wards. There were significant missed opportunities among patients treated with MA drugs, who were discharged to complete their drugs at home, but failed to return for subsequent appointments during which counselling and contraceptives were supposed to have been provided. Considering that 45% of PAC patients had unplanned pregnancies, the lack of post-abortion counselling curtails opportunities to foster patients' awareness, promote uptake and use of contraceptives and prevent unsafe abortions.

Barriers to the provision of quality PAC services

Despite commitments made to ensure availability of PAC services, there are numerous impediments to provision of quality care. Using data drawn from multiple sources, three main categories of barriers to quality PAC services were apparent: structural challenges, facility-related factors and patients' experiences with care.

Structural-related challenges

The overall legal, political and cultural context of abortion in Kenya, makes availability and access to PAC controversial. While the Kenyan Constitution permits abortion to protect the health or life of a pregnant woman, abortion remains criminalized in the penal code. This inconsistency instils fear and confusion among providers and patients. The lack of clear policy guidelines from the Ministry of Health and the sudden withdrawal of PAC guidelines in 2013 (even though these have now been reinstated) further exacerbates the confusion, influencing provider behavior and practices (i.e. police involvement or prioritization of personal values). As such, without clear policies and guidelines, training of providers on PAC is inhibited, distribution of PAC supplies, commodities and equipment are not streamlined and facilities experience frequent stock outs as they are largely dependent on NGOs to fill these gaps.

Facility-related challenges

Facilities had very low capacity to deliver all or comprehensive PAC services or even some basic ones. The overall weak health system preparedness to address PAC complications was largely attributable to an inadequate number of providers due to the low numbers who are trained on PAC as well as high staff turnover, lack of equipment, inadequate supply of commodities, and inadequate spaces for treatment that guarantee privacy. Also noted was the lack of PAC clinical protocols and patient flow charts to guide patients especially in obtaining services that have not been mainstreamed in delivery of PAC, such as post-abortion counselling. Improved clarity through PAC protocols may also spell out if and when an ultrasound scan is necessary during PAC, and establish the necessary infrastructure. Finally, a PAC service protocol would outline a clear referral process for PAC patients thus eliminating delays in care. Other challenges include high patient volumes and the disintegration of services in various facility departments and units.

Individual related barriers

At the individual level, stigma and personal values appear to be key barriers to both the delivery of and access to quality PAC services. Study findings revealed instances where providers' personal values made them deny care to patients and/or treat them differently especially those with induced abortions, which in turn prevented patients from seeking care or to delay doing so because of fear of stigma and confidentiality breaches. Negative provider attitudes have direct effects on the quality of care and can result in negative health outcomes. Efforts to improve provider attitudes through values clarifications training and other approaches could have long term benefits on patients' health and satisfaction.

Study Limitations

The study combines perspectives from both the health system and patients to examine the quality of post-abortion care available in Kenya, and effectively including the structure and process components of healthcare provision. However, this study does not include the examination of patient health outcomes in assessing the quality of post-abortion care.

This study addresses three of the five essential components of post-abortion care, including treatment of incomplete and unsafe abortion complications, contraceptive and family planning services, and availability of reproductive and other health services. Also, the signal function component on the preparedness of health facilities did not assess counselling to identify and respond to women's emotional and physical health needs and concerns as well as community and service provider partnerships for prevention, mobilization of resources and ensuring that health services reflect and meet community expectations and needs. Nevertheless, the qualitative findings provide some insights on the type and content of counselling provided and forms of partnership for prevention of unsafe abortion and unintended pregnancies.

Policy Recommendations

The current analysis demonstrates that access to quality PAC is not fully guaranteed across all levels of public health facilities in Kenya. Further, a good number patients face varied experiences while seeking PAC, such as stigma and provider-hostility. To address the multiple gaps in PAC services – at the health system and facility levels – there is need for strong political will, strategic investment and research aimed at:

1. Upgrading the capacity of primary facilities to provide all essential PAC service components through training, availing infrastructure, equipment and supplies needed for PAC. This ensures access to PAC services for majority of women and girls who mostly visit primary healthcare facilities due to their proximity. This will limit PAC referrals to only the most severe cases and reduce delays in care, additional costs, risks of disclosure among others.
2. Updating PAC Clinical Guidelines, the PAC training curriculum, manual, and logbook for training and mentoring of healthcare providers. Increasing awareness of PAC guidelines among sexual and reproductive health actors nationwide is also critical.

3. Strengthening the supply chain of medical supplies for PAC, especially medical uterine evacuation (MUE) drugs and contraceptives
4. Establishing and strengthening resilient referral systems for post-abortion patients
5. Establishing distinct units for PAC services and improving PAC service organization within health facilities, with a focus on integration of various PAC services such as other reproductive health services and contraceptives into PAC services
6. Promoting task shifting and task sharing policies in the context of post-abortion care to address staff capacity and burn-outs
7. Ensuring full implementation of various policies and guidelines including the reinstated '*Standards and guidelines for reducing morbidity & mortality from unsafe abortion in Kenya*' among others
8. Strengthening community education about contraception and prevention of unsafe abortion as well improving access to PAC
9. Investing in values clarification and attitude transformation (VCAT) of healthcare providers

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