REPUBLIC OF KENYA

MINISTRY OF HEALTH

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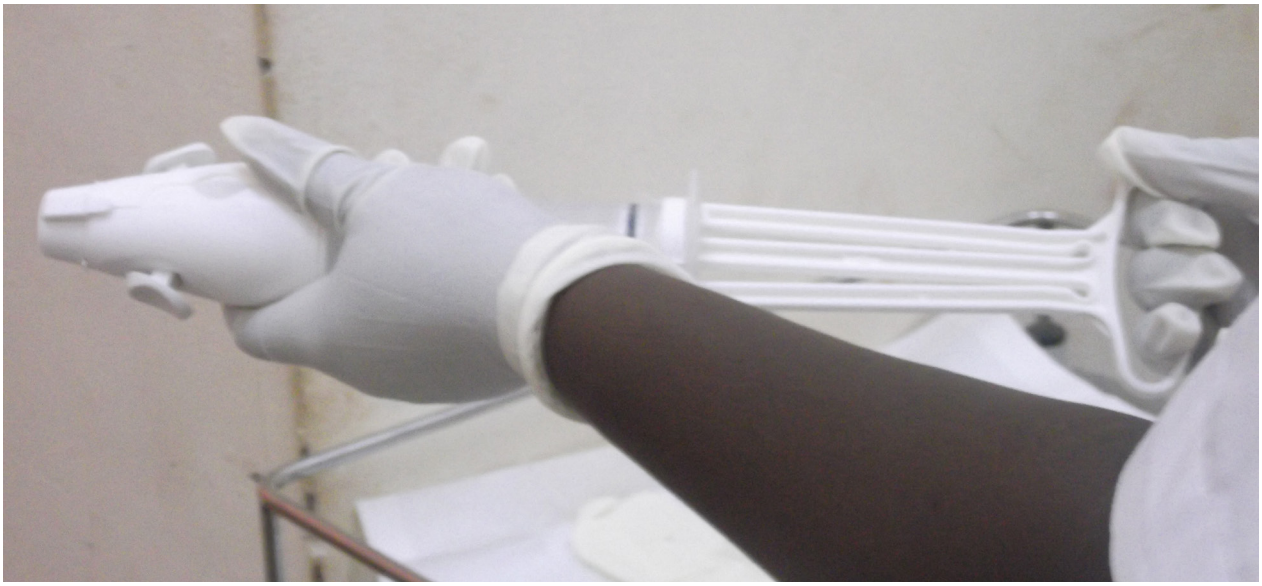
The Status of Post-Abortion Care in Kenya



Introduction

In Kenya, abortion is almost always unsafe, according to a nationwide study conducted by APHRC and the Ministry of Health. That study estimated that 464,000 induced abortions occurred in 2012. The majority of these unsafe abortions results in moderate to severe complications requiring varying degrees of restorative care in health facilities. Remarkably, close to 30% of women who experience abortion-related complications in Kenya do not receive the medical care they need. Yet, quality post-abortion care (PAC) is acknowledged to be critical for averting severe illness and deaths from unsafe abortion. This evidence brief summarizes data on the status of PAC services in Kenya from a nationwide cross-sectional survey of primary-level (n=211) and referral-level (n=42) health facilities across seven counties in Kenya, complemented by 819 patient-exit interviews.

Definitions

Basic post-abortion care: Expected of all primary-level facilities that provide delivery care services. This was assessed using seven signal function indicators: four on specific treatment services, two on staffing and referral, and one on the preventive service of post-abortion contraception.

Comprehensive post-abortion care: Expected of referral-level facilities and assessed using nine signal functions: four on specific treatment services, two on preventive service of post-abortion contraception, and the capacity for blood transfusions and conduct major abdominal surgery, one on staffing

Primary-level facilities: These include Level 2 and 3 facilities

Referral-level facilities: These include Level 4, 5 and 6 facilities

Key findings

Capacity of public health facilities to deliver post-abortion care

Basic post-abortion care

- Barely 3% of primary-level facilities could deliver all designated basic PAC services expected of this level – which included treatment of complications, family planning counselling and contraceptive services, ability to refer (availability of vehicle with fuel), and staff trained on PAC.
- After applying a less restrictive criterion (that excluded availability of staff trained on PAC, short/long acting and permanent family planning methods), there was no significant change in capacity of primary facilities to deliver basic PAC services.
- However, upon excluding availability of a vehicle with fuel for referral, 37% of primary facilities could deliver all other basic PAC services (Figure1).

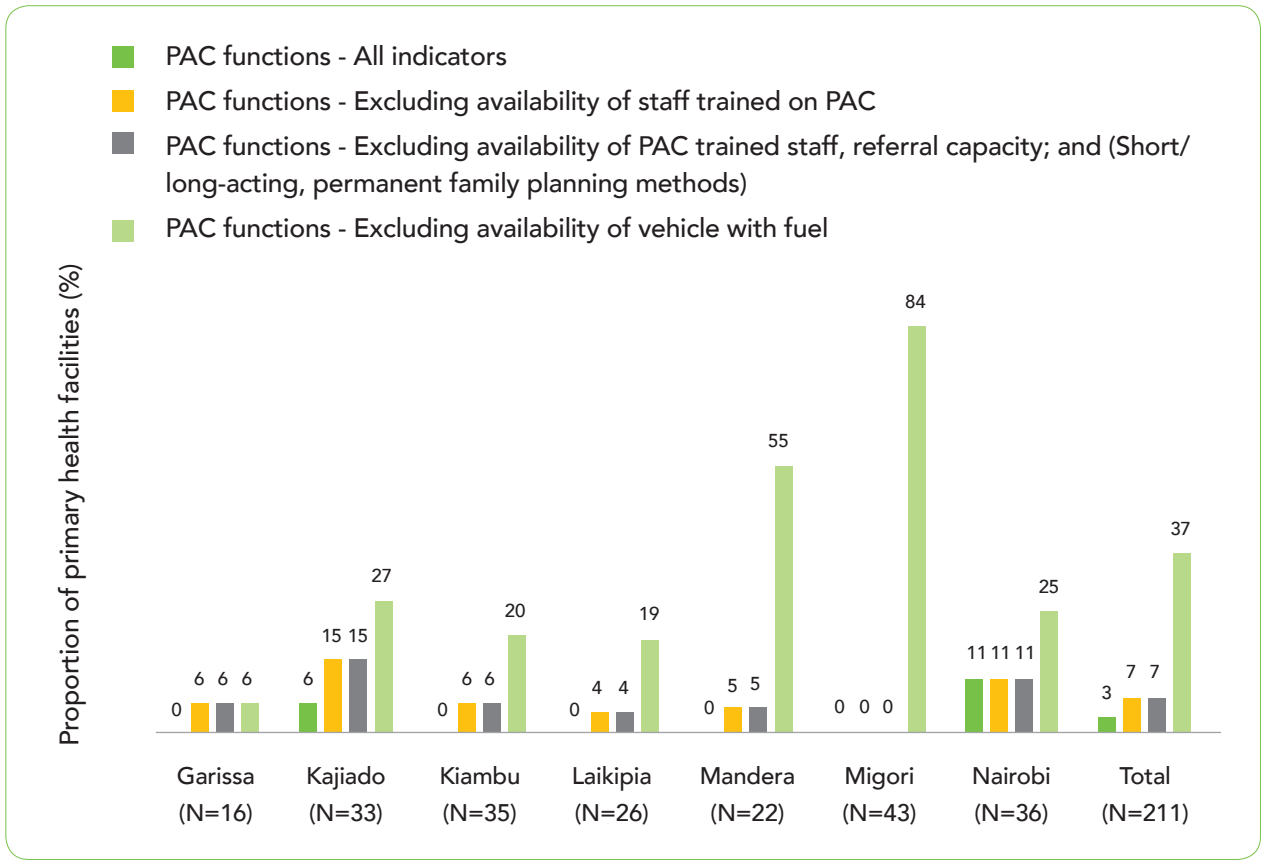


Figure 1: Proportion of primary level facilities capable of providing basic PAC

Comprehensive PAC services in referral level facilities

- 29% of referral-level facilities could provide the entire comprehensive package of PAC services –including treatment of complications, family planning counselling, provision of short and long acting contraceptive services, blood transfusion, major abdominal surgery, and a vehicle with fuel for referral.
- After applying a less restrictive criteria for PAC services in referral facilities (i.e. excluding staff trained on PAC, short and long-acting

or permanent family planning methods, having a fueled vehicle at facility), capacity for comprehensive PAC services did not change considerably (33%).

- However, by excluding having a fueled vehicle at the facility - 33% of referral facilities could deliver comprehensive PAC services (Figure 2).

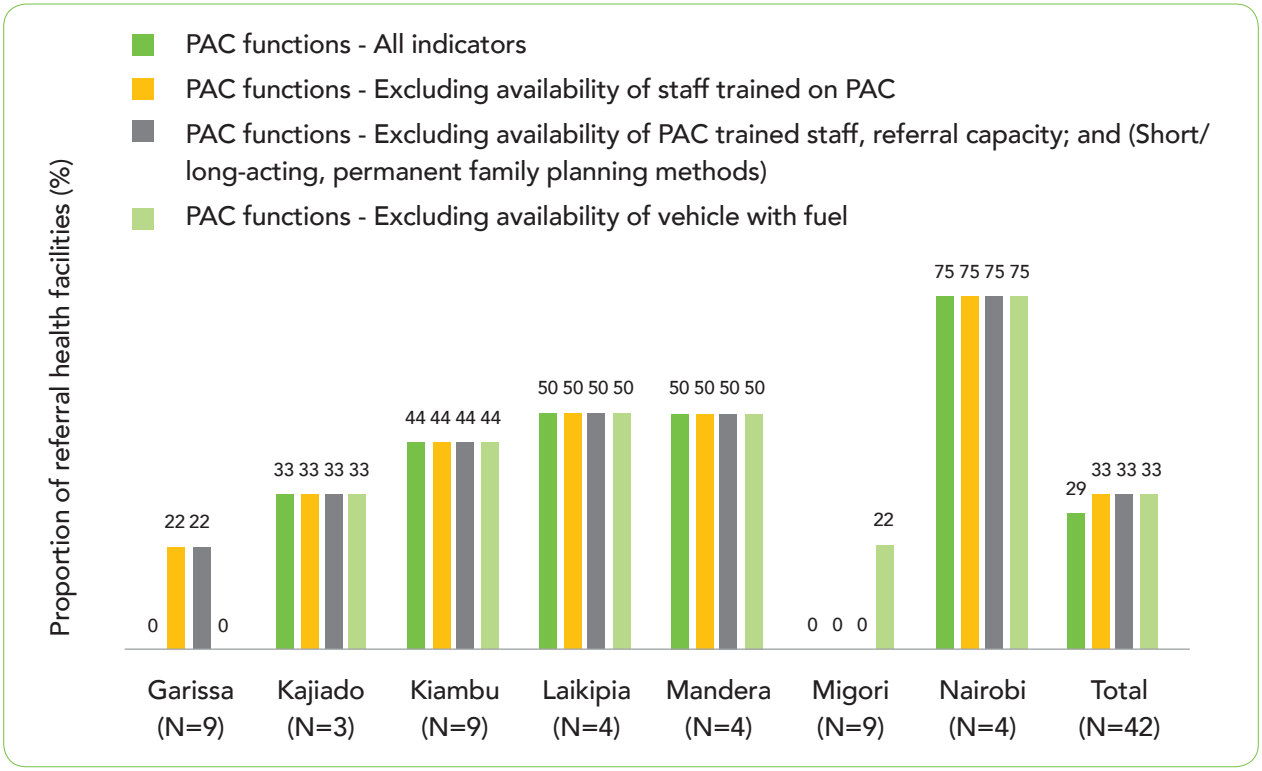


Figure 2: Proportion of referal level facilities capable of providing comprehensive PAC

Staff training on post-abortion care

- About 49.% of health facilities had staff trained on all the five components of PAC. Level 2 facilities (43%), Levels 3 (60%), Level 4 (64%) and Level 5 (75%).
- Most facilities in Migori (89%), Nairobi (63%) and Mandera (54%) 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.

Availability of equipment and supplies

- Sixteen percent of health facilities had a functional operating theatre or an Manual vacuum aspiration room, with just 4% of level 2 facilities, 23% of level 3, and 55% of level 4 facilities reporting having functional theatres or Manual vacuum aspiration rooms.
- Within the PAC treatment room, less than half of all facilities had specific suction tubes (20%), vacuum aspirator kit or syringes (36%), or a Manual vacuum aspiration pack on hand (54%).
- Slightly below one-third (29%) of facilities had backup generators in case of power black outs (10% of level 2 and 36% of level 3), nonetheless

most (91%) of the referral facilities had backup generators.

- Slightly more than half of the facilities (57%) had a functional landline or mobile phone for calls in case of emergency.
- Almost all the facilities (≥98%) indicated having a private room for examining/counselling women and performing reproductive health procedures, an examination or procedure bed and a clean running water source.
- All referral-level facilities had all medicines available, whereas 76% of level 2 had uterotonics, 60% had anticonvulsants. Only 45% of level 2 and 68% of level 3 facilities had antiretroviral medicines on hand.

Evacuation of retained products of conception

- Only 32% of health facilities could deliver medical uterine evacuation, while 37% could perform surgical uterine evacuation during PAC for first trimester pregnancies.
- Least capability was recorded in primary level facilities where only 18% and 21% level 2 facilities could provide medical and surgical PAC respectively, compared to 74% and 87% of level 4 facilities that could provide medical and surgical PAC procedures (Figure 3).

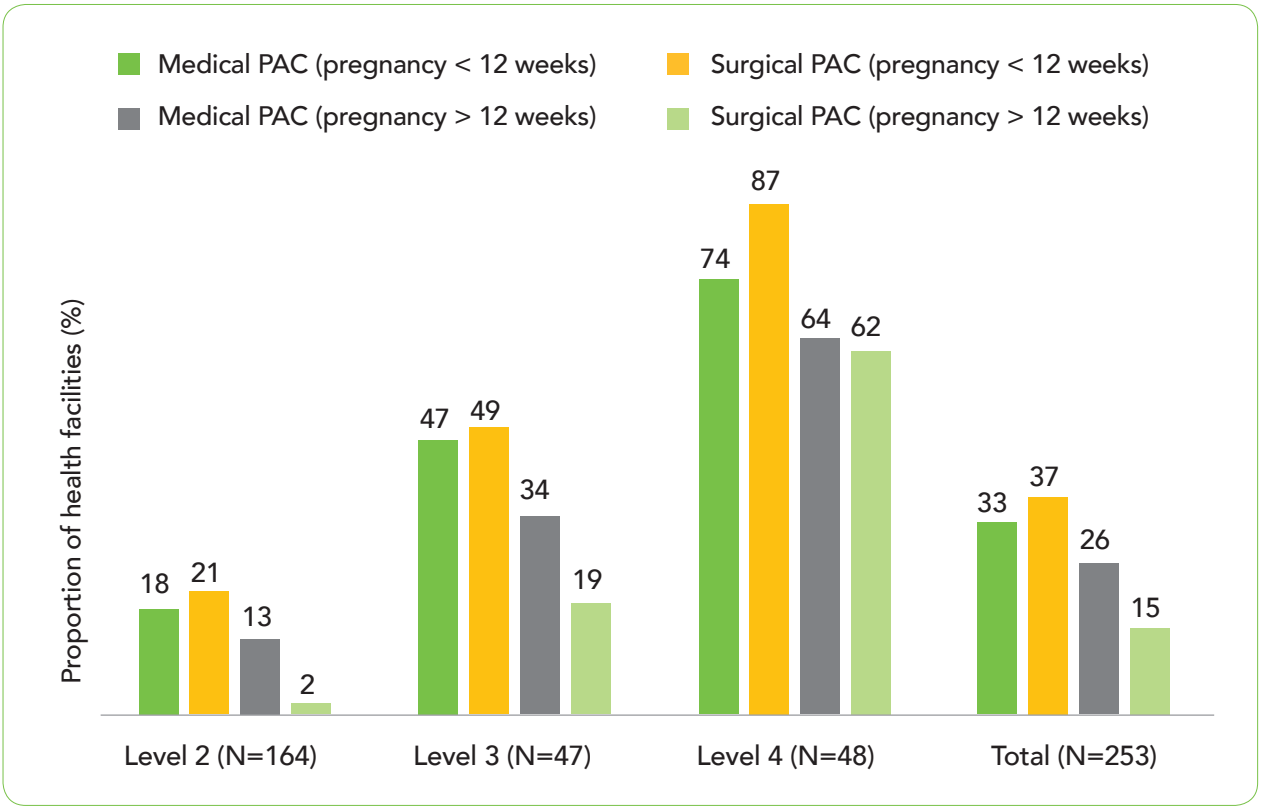


Figure 3: Health facilities providing surgical and medical PAC for 1st and 2nd trimester pregnancies by facility level

Availability of contraceptive services after PAC

- All primary-level facilities (level 2 and 3) could provide at least one short acting contraceptive method, and most of level 2 (90%) and 3 (83%) could provide at least one long acting reversible contraceptive method.
- Nearly all referral-level facilities (97%) could provide short and long acting contraceptives following PAC, whereas just 50% of level 5 and 6, and 31% of level 4 facilities could provide permanent contraceptives methods.

Reasons why facilities could not deliver full package of PAC services

- The main reasons facilities were unable to conduct surgical procedures to manage abortion complications where lack of trained providers (85%), lack of equipment (90%) and absence of commodities and supplies (83%).
- Inability to perform blood transfusions was mainly blamed on the lack of blood supplies (94%) and lack of equipment such as blood banks (80%)
- In a minority of cases, hospital policies and health providers' moral and ethical standing prevented provision of services such as administration of IV fluids and medical PAC respectively.

Patients' experiences during post-abortion care services

- A majority of PAC patients in Kenyan public health facilities reported lack of privacy and confidentiality (64%), and 43% indicated they felt the health facility environment was not conducive for care. Referral facilities often lacked dedicated manual vacuum aspiration procedure rooms. Therefore, patients shared crowded rooms for examination and treatment.
- Fifty-nine percent of PAC patients did not receive post-abortion contraceptive counselling before exiting the facility.
- Most PAC patients indicated positive scores for transparency of payment (95%), absence of stigma and discrimination (90%), dignity and respect (84%), trust (78%), autonomy in decision-making (79%), and patient-provider communication (77%) (Figure 4).
- In-depth interviews with PAC patients accentuated cases where patients experienced long waiting time, complex referral processes and hostile and abusive PAC providers who did not involve patients in care decisions.

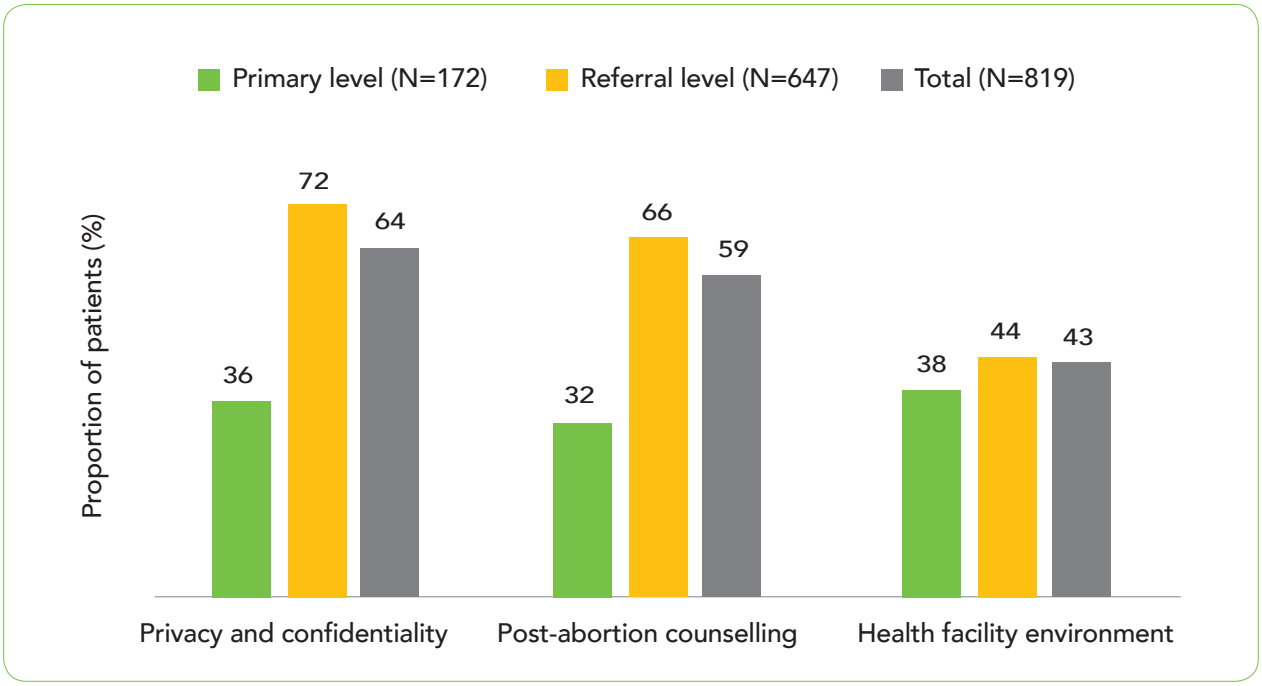


Figure 4: Proportion of patients who rated privacy and confidentiality, post-abortion counselling, health facility environment as poor

Key barriers to the provision of quality PAC services in Kenya

- The low capacity for basic and comprehensive PAC impedes delivery of quality services in public health facilities.
- Poor patients' experience while seeking PAC services – especially the lack of privacy and confidentiality, hostility of providers, stigma and discrimination and long waiting times – deters PAC patients' from seeking timely care.
- The fragmentation of PAC services within health facilities – for instance, treatment services and post-abortion counseling and contraceptives as well as ultrasound services creates gaps in care, which results in many patients leaving without receiving post-PAC counseling and contraceptives.
- Most PAC patients attending primary-level facilities with moderate or severe complications will be in need of referral, owing to the weak PAC capacity in primary facilities, yet these facilities cannot refer patients as they lack ambulance services.
- The confusion perpetuated by the legal status of abortion in Kenya, as well as the withdrawal and subsequent reinstatement of the "Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya" has left many providers and patients unsure of what can and cannot be provided under the law. This has also disrupted provider training on PAC, as well as the availability of PAC supplies and commodities

Conclusion and recommendations

Quality PAC services are critical for averting severe illness and deaths from unsafe abortions. However the findings from this study demonstrate that patients with abortion-related complications in public health facilities are not fully guaranteed of quality PAC services, including effective clinical and non-clinical interventions, a strengthened health infrastructure, optimum skills and a positive attitude of health providers. To address the gaps at health system and facility levels, and promote universal access to PAC services, there is need for strong political will, strategic investment and research aimed at:

1. Expanding access to, and utilization of high quality of PAC services by upgrading the capacity of primary-level facilities to provide all essential basic PAC components through training, availing infrastructure, equipment and supplies needed for PAC. These facilities are the first point of care for a majority of women and girls.
2. Strengthen the supply chain of medical supplies for PAC, especially medical uterine evacuation drugs and contraceptives.
3. Establish and strengthen resilient referral systems for post-abortion patients.
4. Establish distinct units for PAC services and improve the integration of various PAC services, including post-abortion contraceptive counseling and services.
5. Promote task shifting and task sharing policy in the context of PAC to address staff capacity and burn-out.
6. Ensure full implementation of various policies and guidelines, including the reinstated of Standards and Guidelines for Reducing Morbidity & Mortality from Unsafe Abortion in Kenya, among others.
7. Strengthen community education about contraception and prevention of unsafe abortion as well improving access to PAC
8. Investing in values clarification and attitude transformation (VCAT) of healthcare providers
9. Update PAC clinical guidelines, the PAC training curriculum, manual, and logbook for training and mentoring of healthcare providers to increase awareness of PAC guidelines among sexual and reproductive health actors nationwide.

Acknowledgement

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