APHRC African Population and Health Research Center

Rutgers

Nisaidie, usinidhuru

A pilot intervention to improve the quality of post-rape and post-abortion care services in Kilifi County, Kenya

Learning brief

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Introduction

According to the Kenya Demographic and Health Survey (2022), over 14% of pregnancies are unintended, with nearly half resulting in induced abortions and serious complications. These pregnancies[1] are often driven by various socio-economic factors, including sexual and gender-based violence (SGBV). Evidence generated by African Population and Health Research Center (APHRC), Rutgers and Kilifi County Department of Health on adolescent girls and young women's (AGYW) lived experiences of abortion in Kilifi County, Kenya, shows that AGYW seeking post-rape care (PRC) and/or post-abortion care (PAC) run the risk of being emotionally, verbally, physically and sometimes sexually abused by healthcare providers[2] when seeking care in the health care setting. They are also denied important services such as pain medication, emergency contraceptives or safe pregnancy termination following sexual violence. Healthcare providers' attitudes were found to be driven by their values that often prohibit sex out of marriage and stigmatize abortion, as well as limited knowledge of PAC and PRC guidelines.

In response, APHRC and its partners, through the ICFP Quality Innovation Challenge, implemented the Nisaidie, Usinidhuru (Help Me, Don't Hurt Me) project in Kilifi County, Kenya, in a year-long pilot study from 2023 to 2024. The pilot intervention sought to improve the quality of PAC and PRC in Kilifi North sub-county by addressing barriers like poor patient-provider interactions and lack of access to services through:

- Co-creation of two curricula and messages for providers and AGYW using human-centered design approach.

- Training of healthcare providers and youth advocates using the cocreated curricula
- Health talks with adolescent girls and young women using the life skills curriculum.

An ethnographic approach was used to monitor the intervention process and document early changes. The approach involved participant observations of PAC and PRC provision by trained healthcare providers, as well as the health talks sessions. We also conducted in-depth interviews with providers, exit interviews with PAC and PRC patients, key informant interviews and focus group discussion (FGD) with the trained youth advocates.

Early findings

A. Health facility- level intervention

Shift in beliefs and attitudes towards PAC and PRC patients

Results from the process monitoring at the health facilities and interviews with providers demonstrated a positive shift in their stigmatizing belief attitudes towards PAC and PRC patients. Providers reported a shift from seeing PAC as illegal services or support to "deviant patients" to healthcare and life saving service. Regarding PRC, providers reported a shift from blaming rape patients to viewing them as victims/ survivors who need support.

"After the training I realized that it is not their fault. It is not their fault for real maybe somebody has done it deliberately... So, from the training I had to ask myself 'Oh God forgive me because I have been mistreating these cases.' But after the training I have totally changed I am helping these kids." (Provider)

The attitude shifts translated into improvements in how they provided care, this included being empathetic and respectful, ensuring privacy, and enhanced communication skills leading to better patient engagement, trust, and openness. The improvements in care provision were also noted, with an increased awareness of and adherence to PAC and PRC guidelines by providers (i.e. seeking informed consent before beginning treatment, safeguarding patient privacy and improving pain management practices, provision of the option of safe pregnancy termination to PRC patients with unintended pregnancy).

Greater attention to mental health

Providers also reported an increased awareness on the need to pay attention to their mental health and how to address burnout and distress. Hence, providers highlighted prioritizing self-care and managing burnout, enabling them to offer better care. They encouraged their colleagues to adopt similar self-care practices, recognizing the value of a healthy, well-supported workforce.

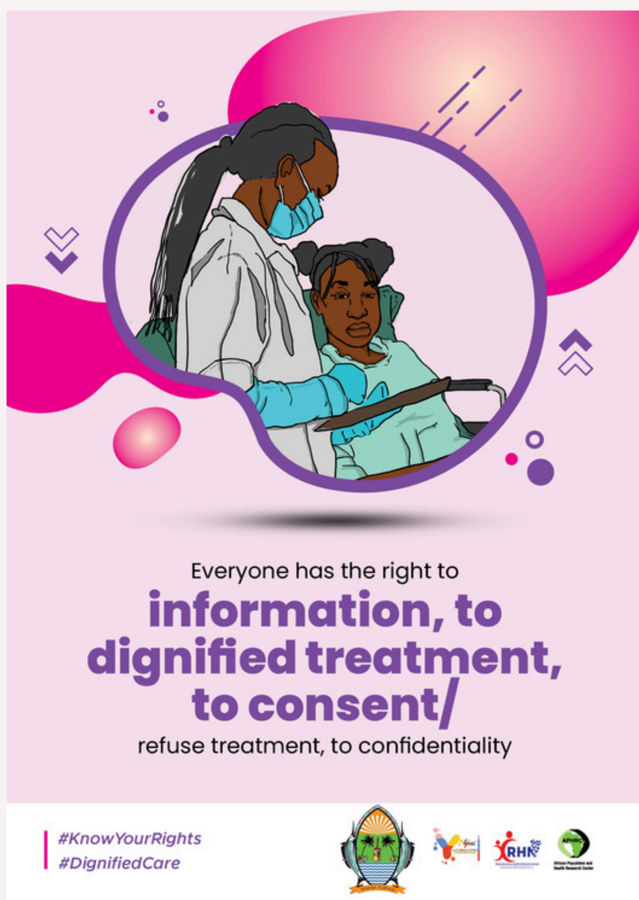
"We were taught about burnout, how to manage burnout...So I learned that when I have burnout I cannot work well. I learned how to take breaks- the physical break, psychological break...So sometimes when I feel I'm not okay sometimes I will look for an off and then I rest...There is a girl who is going for break now, she has just passed now she is a nurse. They used not to go for break, they used to work, nowadays they go when they feel tired [They say] 'Matron I'm going to this place for a bit.' I just tell them to go. That one has gone so they know how to take the breaks. They go take something then come back." (Provider)

Greater attention to mental health

Exit interviews with PAC and PRC patients and our observations echoed these findings where patients highlighted experiences of kindness, feeling secure in the rooms they received care, receiving pain relief medication prior to PAC, pregnancy termination or contraceptive counseling:

"It had privacy. I liked it because no one could hear what we were talking about. .... Even when examining me my parent wasn't there, she was outside."
(PRC patient)

PAC patients noted a greater appreciation of their agency by service providers and subsequent involvement in care decisions. For instance, one patient highlighted how detailed explanation of the treatment options available enabled her to make informed decisions. This empathetic approach creates a supportive environment, making patients feel respected and understood.



B. Community- level intervention

Ten youth advocates, who had been trained to deliver health talks in community youth groups, facilitated sessions intended to address beliefs and attitudes around sexual violence, abortion, PAC and PRC, and patient rights. Twenty health talks were conducted with adolescent girls and young women (AGYW) aged 15 to 24 in Kilifi North.

Unique and effective curriculum and facilitation approach

Findings from the participant observations of community health talks, key informant interviews (KIIs), and focus group discussions with the youth advocates and AGYW who attended the health talks show positive feedback on the content and the facilitation of the health talks. AGYW and facilitators appreciated the uniqueness of contents such as the VCAT activities, consent, post-rape care, post-abortion care and their right to these services. Participants also appreciated the use of visual aids, such as charts and illustrated materials, which helped clarify complex topics such as pathways for seeking PAC and PRC.

The facilitators also managed to create a safe space where participants felt encouraged to freely express their thoughts and feelings about sensitive topics like rape, abortion, PRC, and PAC. This fostered an environment for open and honest discussions. Interactive and creative approaches (i.e. group discussion, role play and icebreakers) also helped participants to engage actively with the curriculum, and gain practical insights into real-life scenarios and livened up the

training. These approaches helped maintain participants' interest and made learning more dynamic and interactive.

Increased knowledge on PAC and PRC

The early findings also show an improved knowledge on PAC, PRC, and patients' rights. AGYW increased knowledge: The AGYW who participated in the training reported little knowledge about PAC before the health talks. Afterward, they were able to articulate the safe methods of care and understand that PAC includes respect, pain management, and privacy. They also came to understand Kenya's legal framework on abortion, that PAC services are their right (therefore removing the fear they often had about being reported to the police), and how to seek care after sexual violence. Therefore, they reported intention to use their knowledge to inform their care-seeking decision and that of their peers.

The training incorporated values clarification and attitude transformation sessions to help AGYW unpack biases and judgmental attitudes they held against those who had abortions or experienced sexual violence. Following the sessions, the girls reported feeling more understanding, supportive, and open-minded to their peers who experienced the same. Moreover, they acknowledged that these negative perceptions were influenced by social norms, and now felt empowered to challenge these norms.

Learnings and recommendations for scale up

Our pilot intervention shows great potential in improving the quality of PRC and PAC and replication in other areas. However, our overall reflection shows that, although providers reported changes in beliefs and attitudes, there are still persistent gaps in the quality of care received by AGYW. Potential reasons could be the fact that the intervention implemented only a one-off training approach, yet continuous training and mentorship was needed.

Moreover, the intervention did not consider solutions to systemic barriers (that is, understaffing, and frequent stockouts) that may affect provision of quality PAC and PRC. At the community level, AGYW and facilitators reported improved knowledge on PAC, PRC and patients' rights; and empowered to seek care.

However, they face challenges in reconciling their gained knowledge with their existing beliefs and broader gender norms on adolescent SRHR, including on sexual violence, consent, contraceptives use or abortion. For example, the belief that consent cannot be withdrawn, contraceptives perceived as only for those who have given birth and the use of Kangaroo courts to 'resolve' sexual violence cases (these are informal or unofficial courts that does not follow the rules of law and fairness - resulting in biased and predetermined decisions).
In both settings, the need for addressing systemic level barriers along with individual level barriers to quality PAC and PRC was emphasized.

The key learnings and recommendations are:

Learnings	Recommendations
Health system level	
One-off training improved knowledge but may not be sufficient to sustain provider confidence in technical procedures like pain management, and respectful and empathetic care. Hence, the likelihood of some providers reverting to initial practices over time.	• Technical training of providers: emphasize in training practical MVA and pain management skills and post abortion contraception in future trainings. • Need for Continuous Training and Mentorship: Conduct continuous training and mentorship sessions to reinforce knowledge and skills.
Although the training improved providers awareness on their mental health and tips for selfcare, the intervention did not offer enough response to providers that needed more than selfcare tips (i.e. counseling services.	Mental health support for providers, including counseling support, supervision, and debriefing sessions for staff to enhance their well-being and ability to provide quality care.
Focus on individual level barriers and leaving out systemic barriers to quality care (i.e. understaffing, shortages of pain medication, emergency contraception, abortion pills, and family planning options that undermined quality care.	Advocacy efforts with health sector managers and policy actors through dialogues at county and national levels to improve health financing, stockouts and policies, creating an enabling environment for quality care.
Integrating preceptors from KMTC into training extended impact to future healthcare providers and reinforced skills among students and interns. This was essential in addressing the regular staff rotations in facilities, ensuring continuity of quality care.	Collaborate with medical training institutions to engage instructors. This will ensure training content is incorporated into institution curricula, ensuring sustained reinforcement of PAC and PRC among healthcare providers in training.

Learnings	Recommendations
Community level	
Facilitation methods for participatory engagement were appreciated but can be enhanced by adding elements like social media engagement.	Enhance the curriculum by adding interactive elements like videos, social media engagement and creative messaging methods (e.g., comic strips).
Knowledge of justice-seeking for survivors of rape is missing, yet this would help AGYW and community members to resort to formal justice system and reduce the likelihood of choosing Kangaroo court as option.	Engage legal experts in training to educate AGYW and community members on formal justice mechanisms.
Limited engagement with adolescent boys and young men (ABYM) and community members such as parents and leaders perpetuates harmful gender norms.	Design specific training for adolescent boys and young men to address toxic masculinity and challenge harmful gender norms.