MINISTRY OF HEALTH

REPUBLIC OF KENYA

Kaleidoscope
Championing Reproductive Justice Centered Health Systems

The Kaleidoscope Initiative

Reclaiming Sexual And Reproductive Health And Rights And Justice For All

Scoping Review of Management of Post Abortion Complications in Public Health Facilities in Four Counties in Kenya.

TICAH
Trust for Indigenous Culture and Health

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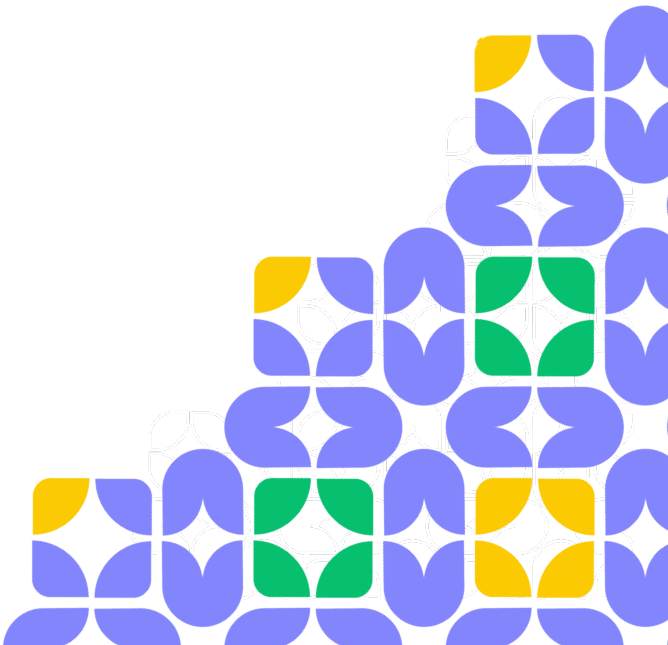

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ACKNOWLEDGEMENT

This report is the result of a collaborative scoping study on maternal aftercare services conducted across Kwale, Samburu, Kilifi, and West Pokot counties. The study was carried out by the Trust for Indigenous Culture and Health (TICAH) in partnership with the Ministry of Health, under the broader Kaleidoscope Project.

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This report belongs to all of you.
Thank you.

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Executive Director
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ABBREVIATIONS AND ACRONYMS

CAC	Comprehensive Abortion Care
CHMT	County Health Management Team
CHP	Community Health Promoter
CHV	Community Health Volunteer
CSO	Civil Society Organization
DQAs	Data Quality Audits
FGD	Focus Group Discussion
GBV	Gender Based Violence
KHIS	Kenya Health Information System
KEMSA	Kenya Medical Supplies Authority
LMIS	Logistics Management Information System
MOH	Ministry of Health
MVA	Manual Vacuum Aspiration
NGO	Non-Governmental Organization
OPD	Outpatient Department
PAC	Post-Abortion Care
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RH	Reproductive Health
SHA	Social Health Authority
SHIF	Social Health Insurance Fund
SRHR	Sexual and Reproductive Health and Rights
VCAT	Values Clarification and Attitude Transformation
WHO	World Health Organization

EXECUTIVE SUMMARY

Post-Abortion Care (PAC) is a lifesaving intervention and an essential pillar of Kenya's reproductive, maternal, newborn, child and adolescent health (RMNCAH) framework. It is legally permitted as emergency treatment for complications arising from miscarriage or unsafe abortion. While national policies and technical guidelines exist, significant gaps persist in service readiness, financing, and equitable access, particularly at the county levels.

The objective of this scoping study was to assess PAC service readiness, access, and quality across Samburu, West Pokot, Kilifi, and Kwale counties, and to generate evidence that can inform county-level programming and national policy. Conducted between September and December 2025, the study evaluated 42 health facilities, including county referral hospitals, sub-county hospitals, health centres, and selected private facilities. Engagement with health workers, partners, and Community Health Promoters (CHPs) at both national and county levels ensured that both supply- and demand-side perspectives were captured. Data collection employed a mixed-methods cross-sectional design. Quantitative facility assessments measured infrastructure, workforce capacity, availability of essential commodities, and financing mechanisms. Qualitative interviews and focus group discussions explored perceptions of service quality, barriers to access, and community dynamics. Triangulation of these data sources strengthened the analysis, allowing for a comprehensive understanding of PAC service delivery.

KEY FINDINGS

Legal and Policy Environment

Kenya's national framework supports PAC, but frontline awareness and application remain weak. Many providers lack familiarity with guidelines and remain cautious due to limited understanding of the legal context, leading to inconsistent implementation and reporting.

Service Availability and Readiness

PAC services are concentrated in Level 4 and 5 hospitals, while lower-level facilities face shortages of trained staff, equipment, and infrastructure. Essential commodities like gloves and speculums are widely available, but misoprostol access is uneven (67% overall, only 36% in West Pokot), with frequent stock-outs. Limited dedicated PAC rooms compromise privacy and efficiency. These gaps create referral backlogs and delays, disproportionately affecting adolescents, rural, and economically vulnerable women.

Workforce and Community Health Promoters (CHPs)

PAC capacity is often limited to a few trained individuals rather than institutionalized across teams. Training gaps in misoprostol use and Values Clarification and Attitude Transformation (VCAT) persist, while provider stigma, especially toward adolescents, undermines service quality. CHPs play a vital role in referrals and sensitisation but lack adequate training, logistical support, and funding. Strengthening workforce and CHP capacity is critical for timely care.

Referral Systems and Health Information

Most facilities (83%) have referral mechanisms, but effectiveness is hindered by shared ambulances, long distances, and difficult terrain, especially in Samburu and West Pokot. PAC data are integrated into KHIS/DHIS2 but remain inconsistently documented. Only 43% of facilities capture both statistics and outcomes, and weak disaggregation limits data utility for planning and equity monitoring.

Financing and Demand-Side Dynamics

PAC financing is embedded within broader RMNCAH budgets, making tracking difficult. Funding is inadequate and unpredictable, with reliance on reimbursements, partner support, and out-of-pocket payments. Adolescents and uninsured women face the greatest financial barriers. Demand-side challenges, including stigma, transport constraints, cost, and cultural norms continue to drive delayed care, showing that service availability alone is insufficient without addressing social and financial barriers.

RECOMMENDATIONS

This study highlights that while Kenya has a supportive national framework for Post-Abortion Care (PAC), significant gaps persist in service readiness, workforce capacity, financing, and community-level access. PAC services remain concentrated in higher-level facilities, leaving lower-level facilities underprepared and creating referral delays. Provider stigma, weak health information systems, and inadequate financing further constrain equitable access, particularly for adolescents, rural women, and economically vulnerable populations. These findings underscore the need for systemic reforms that bridge the gap between policy and practice, strengthen frontline capacity, and address demand-side barriers.

To advance Kenya's RMNCAH commitments, priority actions include harmonizing PAC guidelines with county plans, scaling up workforce training and mentorship, and integrating PAC commodities into reliable supply chains. Dedicated PAC budget lines, improved data systems, and adolescent-friendly service models are essential to ensure accountability and equity. Strengthening referral pathways, empowering Community Health Promoters, and engaging cultural leaders will enhance community acceptance and timely care-seeking. Together, these measures can transform PAC into a consistently accessible, high-quality service across all counties, reducing preventable complications and advancing reproductive health rights.

1. INTRODUCTION

Maternal mortality remains one of the most pressing global health challenges of our time. In 2023 alone, an estimated 260,000 women died from preventable causes related to pregnancy and childbirth, equivalent to one death every two minutes. Sub-Saharan Africa bears the heaviest burden, accounting for approximately 70% of these deaths, with unsafe abortions contributing significantly to the toll. Globally, nearly half of all pregnancies are unintended, and 6 out of 10 of these ends in induced abortion, amounting to an estimated 73 million abortions annually. Despite legal frameworks and international commitments to sexual and reproductive health and rights (SRHR), millions of women continue to face systemic barriers to safe abortion care and post-abortion services.

Kenya exemplifies this crisis. The country continues to grapple with a persistent and preventable public health crisis including maternal deaths linked to abortion-related complications. Despite constitutional guarantees for sexual and reproductive health and rights (SRHR), the country's maternal mortality rate remains alarmingly high at 355 deaths per 100,000 live births (Daily Nation, 2025). Unsafe abortions are a major contributor to this burden, driven by widespread stigma, limited provider capacity, and critical gaps in policy and service delivery. A recent study revealed an abortion incidence rate of 57.3 per 1,000 women of reproductive age, a stark indicator of the urgent need for targeted, systemic interventions (Guttmacher Institute, 2012; APHRC, 2023).

1.1 About the Kaleidoscope Project

In response to the growing reproductive health challenges, the Trust for Indigenous Culture and Health (TICAH) is leading the Kaleidoscope Project, a transformative initiative designed to eliminate preventable maternal deaths from abortion-related complications. The project aims to reduce maternal mortality and curb unsafe abortions by expanding access to accurate information on safe abortion practices, high-quality post-abortion care (PAC), and comprehensive SRHR services. While the project is intended to influence national health systems, its initial rollout focuses on four priority counties: Kwale, Samburu, Kilifi, and West Pokot, where reproductive health challenges are especially acute.

To support this effort, the Ministry of Health (MOH), in collaboration with TICAH and consortium partners, notably, Kisumu Medical and Education Trust (K-MET), Reproductive Health Network Kenya (RHNK), Zamara Foundation, ACK Development Services Nyanza (ADS-Nyanza), and Kenya Sexual Reproductive Health and Rights Alliance (SRHR Alliance), commissioned a scoping study to generate critical baseline data. This study will assess the readiness of health systems to deliver quality care for abortion complications, identify service and policy gaps, and inform evidence-based interventions.

Its findings will serve as a cornerstone for the Kaleidoscope Project's planning, monitoring, evaluation, and learning (PMEL) framework, guiding strategic implementation and long-term impact.

1.2 Purpose and Objectives of the Scoping Study

The scoping study aimed to establish a foundational understanding of the current landscape of maternal health, particularly as it relates to post-abortion care and comprehensive abortion care, in four priority counties: West Pokot, Kilifi, Kwale, and Samburu. The results will be used to support the development of strategic targets and inform the Kaleidoscope project's needs and evidence-based implementation, planning, monitoring, evaluation, and learning in the coming 4 years.

1.2.1 Scoping Study Objectives

The primary objective of this study was to conduct a comprehensive baseline and scoping study to assess the policy, systems, and service delivery landscape for CAC/PAC services in Kwale, Samburu, Kilifi, and West Pokot counties.

Specific objectives;

i Assess the policy and legal environment for PAC and other abortion complication-related issues, including harmonisation gaps between national guidelines and frameworks and county-level implementation.
ii Map service delivery capacity and availability of CAC/PAC services in public/private facilities and identify gaps that affect access to CAC and PAC (stigma, commodity stockouts, provider biases).
iii Analyse workforce readiness and training gaps in value clarification (VCAT) and attitudes of providers toward Adolescent girls and women of reproductive age in the provision of PAC services.
iv Evaluate health information systems to understand the gaps in data collection tools, systems and processes and identify PAC reporting gaps
v Map out key stakeholders for PAC implementation across the identified counties.

2. CONTEXT ANALYSIS

Abortion care, encompassing both Comprehensive Abortion Care (CAC) and Post-Abortion Care (PAC), is recognised by the WHO Abortion Care Guidelines (2022) as an essential component of reproductive health systems. From a systemic perspective, these services are non-negotiable. They must be delivered in line with the AAAQ framework - ensuring that care is Available (with trained providers, medicines, and facilities), Accessible (physically, financially, and legally), Acceptable (respecting dignity, rights, and cultural values), and of high Quality (safe, effective, evidence-based). Within this framework, abortion care extends beyond emergency interventions to include timely provision of safe abortion methods, management of complications, immediate access to post-abortion family planning, non-judgmental counselling, integration with broader reproductive health services, and health system strengthening through task-sharing and community partnerships (WHO, 2022).

Within this broader framework, PAC is a critical, life-saving intervention aimed at reducing the consequences of both spontaneous abortion (miscarriage) and unsafe induced abortion (WHO, 2022). Unsafe abortion often leads to medical emergencies such as haemorrhage, sepsis, and uterine perforation, necessitating immediate and high-quality care (Ganatra et al., 2017). The globally recognized holistic PAC model, endorsed by WHO and reproductive health consortia, extends beyond emergency treatment to focus on long-term well-being (WHO, 2022; Starrs et al., 2018). It comprises five interrelated elements: (i) treatment of complications, (ii) provision of contraception and family planning, (iii) non-judgmental counseling, (iv) integration of other reproductive and related health services, and (v) establishment of community and provider partnerships (WHO, 2022). A cornerstone of PAC is the integration of post-abortion family planning (PAFP). Evidence shows that up to 37% of women undergo subsequent abortions due to insufficient uptake of effective modern contraceptive methods following their initial procedure (Frontiers, 2025). PAFP has proven highly effective in reducing unintended pregnancies and repeat abortions, averting an estimated 121 million unintended pregnancies and 21 million unsafe abortions globally between 2019 and 2020 (Frontiers, 2025).

In Kenya, the reproductive health landscape has shifted significantly since the last comprehensive national abortion study in 2012. The increased availability and use of medication abortion (MA), alongside important changes in legal and policy frameworks, have reshaped care-seeking behavior and complication profiles. While MA is safe and effective, gaps remain in updated data to assess its impact on complication severity, non-indicated PAC utilization, and facility readiness. This lack of evidence constrains the design of responsive, evidence-based health system interventions. Addressing these gaps through robust research is essential to ensure that PAC and CAC in Kenya meet AAAQ standards and align with WHO's global guidelines, thereby safeguarding women's health and strengthening reproductive health systems.

2.2 PAC Policy and Legal Framework

Kenya's legal framework for PAC is anchored in the Constitution of Kenya (2010), which marked a shift from the previously restrictive and criminalised environment. Article 43(1)(a) guarantees the right to the highest attainable standard of health, including reproductive health care, while Article 43(2) prohibits denial of emergency medical treatment. These provisions establish a constitutional obligation to provide life-saving services, including PAC. Article 26(4) permits abortion where, in the opinion of a trained health professional, there is need for emergency treatment, where the life or health of the mother is in danger, or where permitted by any other written law. The Health Act (2017) broadens the definition of "trained health professional" to include medical officers, nurses, midwives, and clinical officers who are trained and licensed to manage pregnancy-related complications, reflecting Kenya's task-sharing approach to addressing workforce shortages.

Kenya recently launched the Reproductive Health Policy (2022–2032) which constitutionally permitted abortion services within Kenya's RMNCAH framework. However, its adoption was legally challenged in 2022 on grounds of constitutionality, inclusivity, and impact on adolescents and women, led by the Kenya Legal and Ethical Network on HIV and AIDS (KELIN). In October 2025, the High Court upheld most provisions of the Policy but struck down a key clause requiring health professionals to consider the "health of the unborn child" when determining eligibility for termination of pregnancy. The Court found this requirement inconsistent with Article 26(4) of the Constitution, which clearly outlines the legal grounds for termination. The ruling reinforces constitutional protections for women and girls, clarifies the legal framework guiding abortion-related care, and reduces ambiguity that has contributed to provider hesitancy. However, the litigation underscores the continued sensitivity of abortion policy in Kenya and the need for consistent dissemination of legal and policy guidance to ensure alignment between national frameworks and frontline implementation.

2.3 Facility Readiness, Resource and Infrastructure Gaps

Recent health facility assessments in SSA consistently highlight a critical lack of facility readiness for both basic and comprehensive PAC services, with capacity being particularly low at the primary healthcare level (Juma et al., 2022; Singh et al., 2025). The issue of commodity and equipment stock-outs remains a major barrier. Studies in countries like Kenya, for example, show that even when facilities meet other criteria, they often fall short on the provision of at least three types of short-acting contraceptives post-abortion, a critical component of PAC that prevents repeat unintended pregnancies (APHRC, 2023).

Furthermore, a lack of functional surgical capacity, including equipment for Manual Vacuum Aspiration (MVA), operating rooms for major surgery, and the provision of blood transfusions, is a key driver of low readiness, especially at referral levels (Juma et al., 2022). Analysis based on PAC signal functions across multiple SSA countries reveals that a very low percentage of primary facilities have the capacity for basic PAC services e.g., only 18.3% of primary-level facilities in a 2023 Kenyan

survey, with similarly low capacity for comprehensive PAC at referral facilities (Singh et al., 2025; APHRC 2025). This overall capacity deficit is consistently driven by resource availability rather than clinical skill alone.

2.4 Human Resources Deficits

The scarcity of adequately trained health personnel is compounded by systemic failures that restrict their effective deployment, even where national policies are supportive (WHO, 2022). While international and regional guidelines recommend task-sharing PAC procedures, such as medical management and Manual Vacuum Aspiration (MVA), to mid-level providers like nurses, midwives, and clinical officers, their effectiveness is often stifled by structural deficiencies (High Impact Practices in Family Planning, 2022). Recent reviews emphasize that successful task-sharing hinges on "health system readiness," which includes reliable infrastructure, uninterrupted supply chains, and robust regulatory frameworks, elements that are frequently lacking in rural sub-Saharan African (SSA) settings (Ouedraogo et al., 2020).

Furthermore, the literature identifies a significant knowledge gap among existing healthcare providers regarding the comprehensive components of PAC. While many providers can manage physical complications, they often lack the skills to provide essential counseling on post-abortion family planning (PAFP) and psychological support (Ijadunola et al., 2023). This leads to fragmented and lower-quality care. For instance, recent regional assessments indicate that a minority of providers possess adequate knowledge of all PAC components, with a study in Ethiopia finding that only 25.9% of providers were fully competent across the entire care spectrum (Tarekegn et al., 2024).

Finally, although evidence confirms that the clinical effectiveness of trained mid-level cadres is comparable to that of physicians in managing PAC (WHO, 2022), several barriers prevent these providers from working to their full scope of practice. Ambiguous or poorly enforced policies, combined with a lack of consistent supervision and mentorship systems, create a climate of professional uncertainty (Munabi et al., 2025). Without clear legal protections and ongoing clinical support, non-physician clinicians may remain hesitant to provide the full range of PAC services.

2.5 Attitudinal and Social Barriers

Stigma and judgmental provider attitudes remain pervasive across many Post-Abortion Care (PAC) settings, particularly affecting adolescent girls and marginalized women. These attitudes discourage timely care-seeking, often resulting in delayed presentation when complications are already life-threatening. According to Izugbara et al. (2015), the fear of being shamed by healthcare workers acts as a primary deterrent for women experiencing obstetric emergencies following a pregnancy loss. Empirical studies from Kenya, Nigeria, and Zimbabwe confirm that abortion-related stigma is not only socially entrenched but also institutionally reinforced through provider behavior and facility culture. For instance, Yegon et al. (2017) found that in high-incidence regions of Kenya, perceived stigma was

significantly correlated with unsafe abortion practices and delayed care-seeking among young, unmarried women who prioritize secrecy over clinical safety.

Recent multi-country research highlights how stigma among both clinical and non-clinical staff directly obstructs care delivery. A study spanning Rwanda, Zimbabwe, Sierra Leone, and Nigeria revealed that providers often experience internal moral conflict, fear of legal repercussions, and social isolation, which in turn diminishes their willingness to offer PAC services (Bright et al., 2024). Furthermore, empirical evidence from South Africa demonstrates that staff attitudes can shift from facilitation to active obstruction. Bohren et al. (2023) found that this obstruction often manifests as prolonged waiting times, unnecessary medical procedures, verbal mistreatment, or the outright denial of services. These practices not only delay urgent, time-sensitive interventions but also erode trust in the health system. More critically, they contravene the principles of dignity, confidentiality, and emotional support that are central to comprehensive, rights-based abortion care.

2.5.1 Training Gaps and Institutional Accountability

Compounding these attitudinal barriers is a chronic lack of adequate provider training in PAC service provision including psychosocial support and Values Clarification and Attitude Transformation (VCAT). While clinical proficiency is often prioritized, the "soft skills" required for empathetic, non-judgmental care are frequently neglected in standard medical curricula. Evidence from a pilot of the Providers Share Workshop across three Sub-Saharan African countries demonstrated that targeted interventions can achieve measurable reductions in internal stigma and foster proactive advocacy for PAC patients up to six months post-intervention (Mosley et al., 2015). However, such programs are rarely integrated into national health systems and remain precariously dependent on short-term external funding.

In the absence of sustained institutional support, standardized clinical guidelines, and robust accountability mechanisms, stigma becomes structurally embedded within the health system culture. This normalization of bias reinforces socioeconomic inequities and acts as a silent deterrent that drives women away from formal PAC services toward less safe alternatives. As argued by Floris et al. (2023), dismantling these barriers requires a multi-level strategic approach: integrating VCAT into pre-service medical education, fostering community-based sensitization to reduce external shame, and enforcing policy mandates that guarantee respectful, woman-centered care as a fundamental patient right.

2.6 Poor Referral Systems

Referral system weaknesses remain a critical barrier to effective post-abortion care (PAC). The lack of reliable communication and emergency transport mechanisms between lower-level facilities and referral hospitals leads to dangerous delays in managing life-threatening complications (Bar-Zev et al., 2017). Multi-country analyses confirm that ineffective referral systems are among the most significant health system failures, often resulting in fatal delays. In Kenya, similar systemic gaps have been documented; a national assessment found that fewer than one in five primary-level facilities

and only about a quarter of referral-level facilities meet the standards required to provide comprehensive PAC services, underscoring persistent deficiencies in referral preparedness and facility readiness (APHRC, 2025). Local studies in Nairobi County further highlight how provider attitudes, weak coordination, and systemic barriers hinder timely PAC utilization, reinforcing the urgency of strengthening referral pathways (Omollo, Ngure, & Echoka, 2023).

These structural failures mean that essential, time-sensitive interventions such as blood transfusions and major abdominal surgery, services typically only available at referral hospitals, remain inaccessible to women presenting with severe complications at lower-level facilities (Juma et al., 2022). Weak coordination protocols, unclear triage criteria, and the absence of real-time decision support systems further undermine the responsiveness of referral pathways. In many settings, referral decisions are delayed not only by logistical constraints but also by hierarchical bottlenecks, where junior providers lack the authority or confidence to initiate emergency transfers, particularly in under-resourced or politically sensitive environments.

Referral inefficiencies disproportionately affect rural and marginalized populations, reinforcing geographic and socioeconomic inequities in access to PAC. Women from remote areas often face multiple layers of delay: first in recognizing complications, then in reaching a facility, and finally in being transferred to a higher-level center capable of managing severe morbidity (Starrs et al., 2018). These delays are compounded when referral hospitals themselves are overburdened or lack the capacity to stabilize patients promptly. Innovative interventions, such as mobile health (mHealth) platforms, community-based transport schemes, and decentralized blood banking, have been piloted in some regions, but scale-up remains limited. Moreover, the absence of standardized referral protocols and monitoring indicators within national PAC programs makes it difficult to assess system performance or hold facilities accountable for referral failures (WHO, 2022). Without robust referral systems, the promise of PAC as a life-saving intervention remains unrealized, particularly for women navigating intersecting vulnerabilities.

2.7 Trends in Access to PAC Services in Kenya

Analysis of historical Kenya Health Facility Information System (KHIS) data shows a clear upward trend in the overall number of clients accessing PAC services over the five years, though growth has slowed in recent years. Total number of cases handled rose from 28,925 in 2020–2021 to a peak of 43,646 in 2023–2024, before slightly declining to 39,298 in 2024–2025, averaging 39,510 annually. By age group, adolescents (10–19 years) show a consistent decline from 6,816 to 4,516, indicating reduced uptake or access among this group. In contrast, youth (20–24 years) experienced a sharp increase from 8,766 to over 14,000, remaining relatively stable thereafter, while adults (25+ years) account for the largest share, growing from 13,343 to over 24,000 before a slight drop in the last year.

Table 1: Summary of PAC Services Per Age Group (July 2020-June 2025)

Age Group	July 2020 - June 2021	July 2021 - June 2022	July 2022 - June 2023	July 2023 - June 2024	July 2024 - June 2025	Average
Adolescent (10-19yrs) accessing PAC services	6,816	5,658	5,369	5,090	4,516	5,490
Youth 20-24 yrs receiving PAC services	8,766	14,051	14,042	14,073	12,274	12,641
Receiving PAC 25yrs plus	13,343	22,715	23,846	24,483	22,508	21,379
Total	28,925	42,424	43,257	43,646	39,298	39,510

Source: KHIS Data

The chart below analyzes the trend of PAC services in Kenya over the 5-year period ending June 2025.

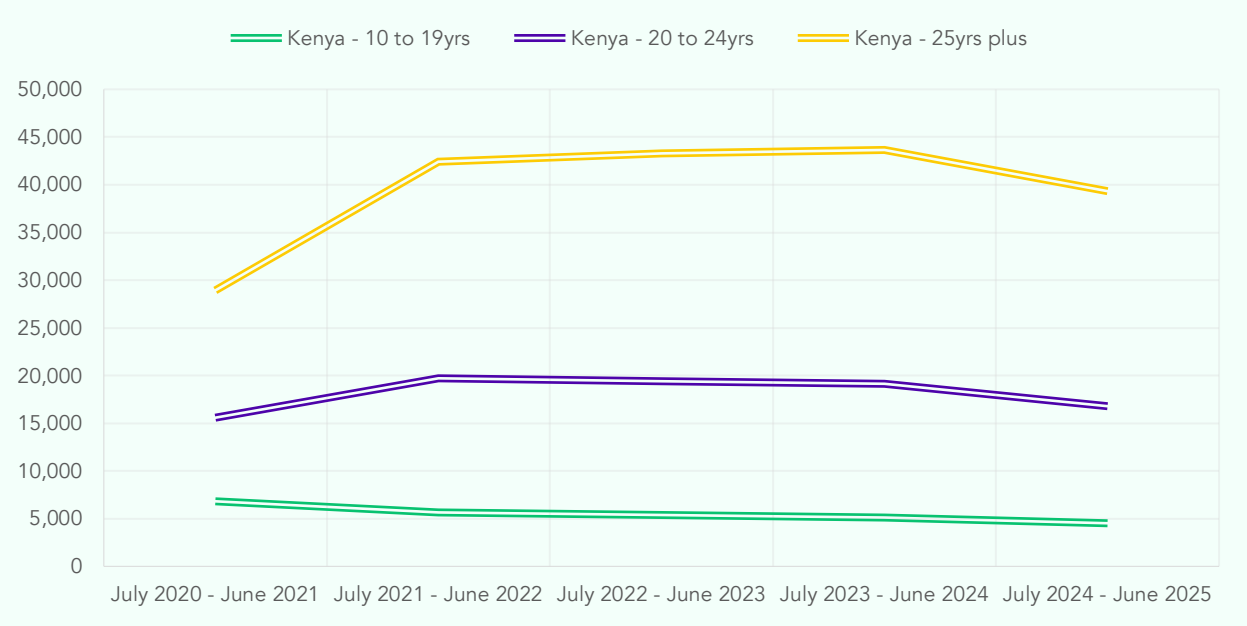


Figure 1: PAC Access Trend Analysis Per Age Group (July 2020 - June 2025)

Source KHIS

County analysis of utilization of PAC Services

We extracted KHIS data on utilization of post-abortion care (PAC) services between July 2020 and June 2025. The analysis focused on four target counties: Kilifi, Kwale, Samburu, and West Pokot, disaggregated by age groups (10–19 years, 20–24 years, and 25 years plus). Overall, the data revealed persistent demand for PAC services across all counties, with notable variation by age group over the five-year period. Adolescents (10–19 years) showed a fairly steady utilization of PAC services over the five-year period with Kilifi and West Pokot recording the highest number of PAC cases. Young adults (20–24 years) recorded the second consumption of PAC services with Kwale and Kilifi recording the highest consumption rates over the five-year period. Utilization among women aged 25 years and above was consistently the highest across all counties over the period of study. Overall, the increasing number of PAC cases recorded over the five years underscores the need for comprehensive service readiness at primary and referral levels.

Table 2: Summary of PAC Services Kilifi, Kwale, Samburu and West Pokot

Region/Age Group	July 2020 - June 2021	July 2021 - June 2022	July 2022 - June 2023	July 2023 - June 2024	July 2024 - June 2025	Average
Kilifi County - 10 to 19yrs	139	124	106	128	113	122
Kwale County - 10 to 19yrs	47	43	88	70	52	60
Samburu County - 10 to 19yrs	31	28	5	16	23	21
West Pokot County - 10 to 19yrs	29	64	46	107	32	56
Total - 10 to 19 Years	246	259	245	321	220	258
Kilifi County - 20 to 24yrs	291	275	264	322	319	294
Kwale County - 20 to 24yrs	108	224	255	189	207	197

Samburu County - 20 to 24yrs	33	26	17	56	33	33
West Pokot County - 20 to 24yrs	43	83	77	109	77	78
Total - 20 to 24 years	475	608	613	676	636	602
Kilifi County - 25yrs plus	492	632	612	626	560	584
Kwale County - 25yrs plus	164	328	380	437	391	340
Samburu County - 25yrs plus	46	68	51	67	36	54
West Pokot County - 25yrs plus	64	143	158	188	56	122
Total - 25 years Plus	766	1,171	1,201	1,318	1,043	1,100

Source: KHIS Data

Below is an analysis of PAC services utilisation per county.

Kwale County

Kwale County recorded a steady increase in PAC services utilization across all age groups between July 2020 to June 2023. There was significant decline in the recorded number of PAC services across all age groups in the period ending June 2024 apart from the 25 years plus group which continued to rise over the same period. The period ending June 2025 recorded an increase in PAC services utilization across all groups apart from the 25 years plus cohort that recorded a decline in the utilization.

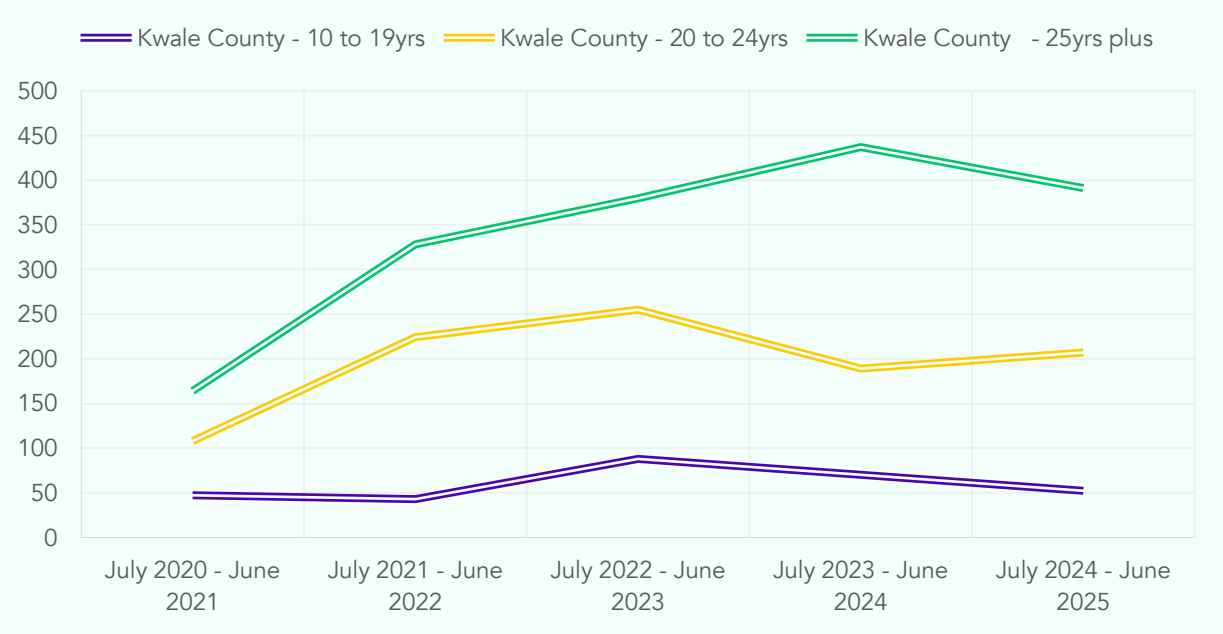


Figure 2: Kwale PAC Access Trend Analysis July 2020-June 2025

Source: KHIS Data

Kilifi County

In Kilifi, an upward spike was noted for the 25 years plus group in the period ending June 2022, a trend that was maintained over the two years before a drop in June 2025. Utilization of PAC services for the 20-24 years group remained stable in the first three years before slightly increasing in the year ending June 2024 and July 2025. Consumption of PAC services for the 10–19-year-olds was consistent over the five years. Figure 3 below summarizes the analysis.

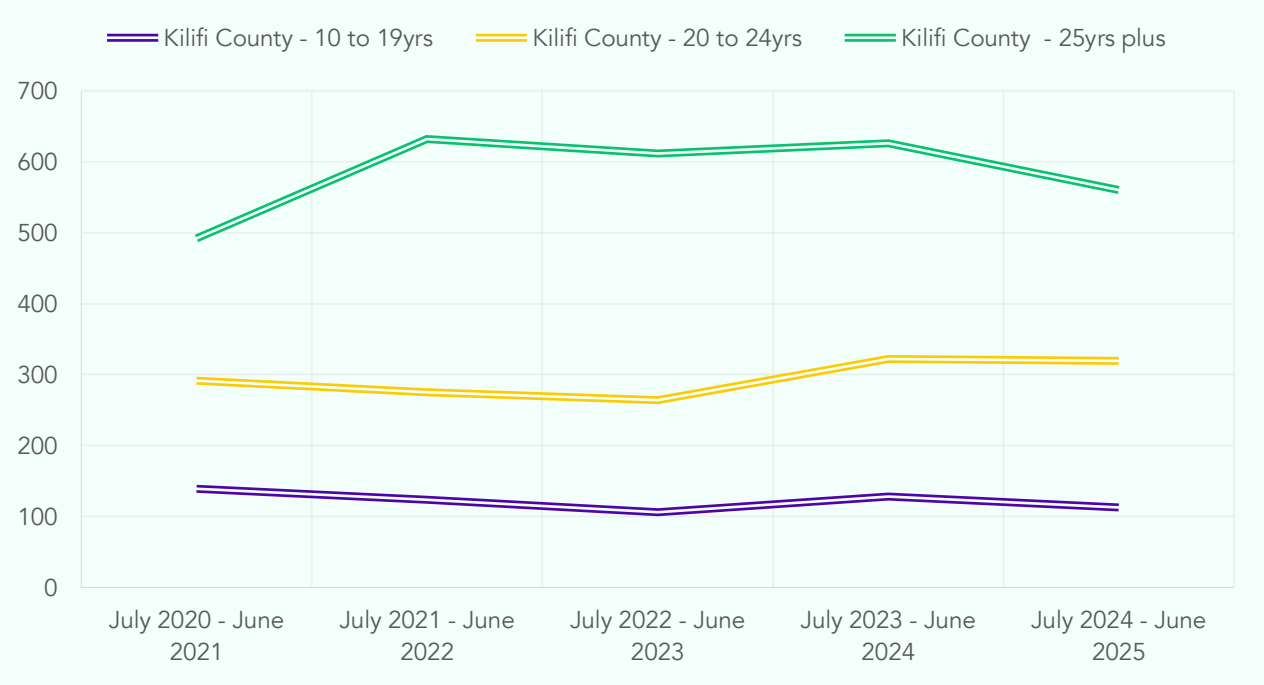


Figure 3: Kilifi County PAC service utilization Per Age Group July 2021 - June 2025

Source: KHIS Data

Samburu County

Samburu County recorded an unpredictable pattern over the five years characterized by a series of upward and downward trends. Notably, there was a drop in the recorded PAC services utilization across all the age groups in the period ending July 2023 followed by another drop in the period ending July 2025. The 10 to 19 age group was the only cohort that recorded an increase in PAC services utilization in the period ending July 2025.

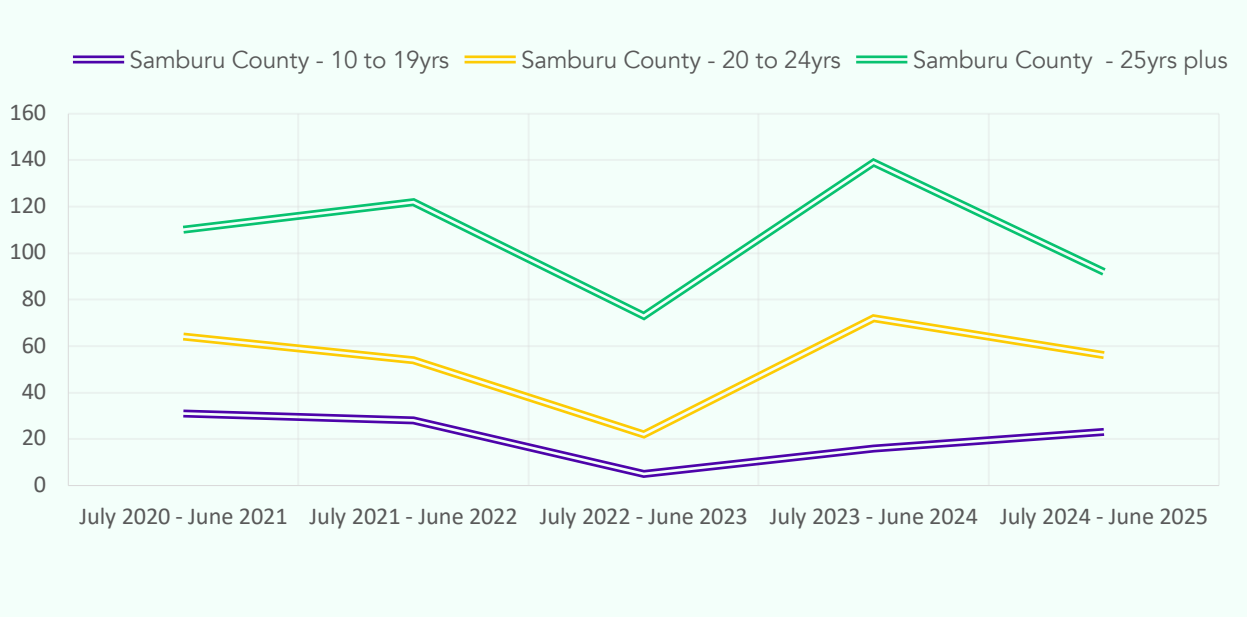


Figure 4: Samburu County PAC Access Per Age Group July 2020-June 2025

Source: KHIS Data

West Pokot County

The county recorded a steady upward trend in PAC services utilization from period ending July 2021 to the period ending June 2024 across the different age groups. This was however followed by a significant drop in the recorded number of PAC services utilization in the period ending June 2025.

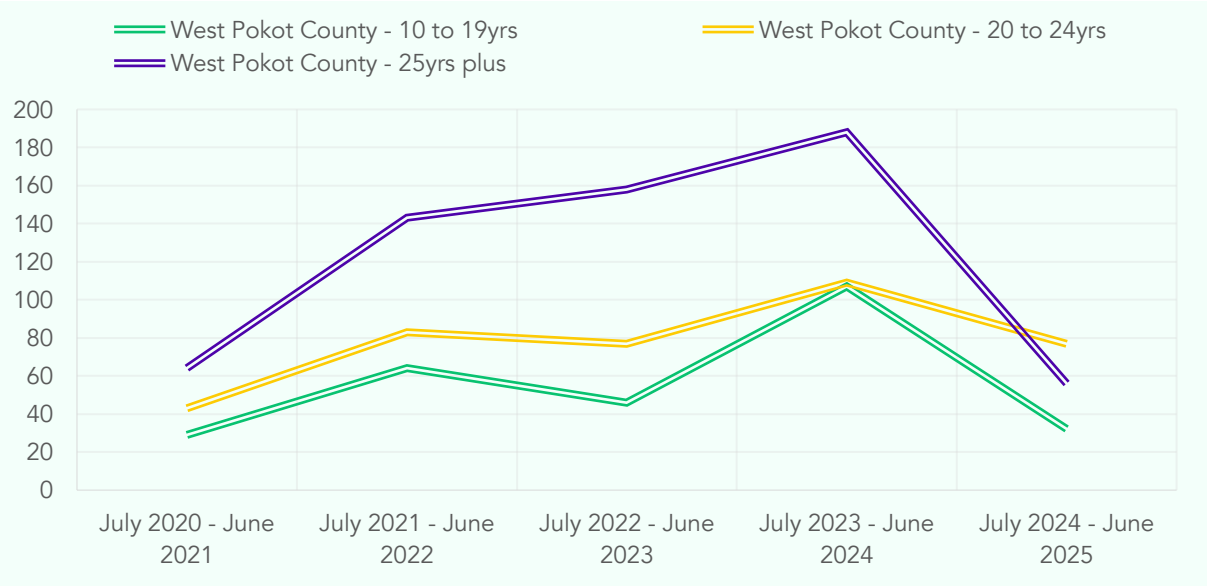


Figure 5: West Pokot County PAC service utilization Per Age Group July 2020-June 2025

Source: KHIS Data

Despite the unique patterns observed in access to PAC services per county per age group, analysis of the data in the four counties indicates a sustained trend of consumption of PAC services. In some counties, like West Pokot above, there is a sharp increase in the number of patients seeking PAC services across all the age groups. This trend reinforces the need for the government to invest in the much-needed infrastructure and staff resources to provide quality PAC services. The section below describes the approach and methodology used to assess access to PAC services and the analysis approach used to arrive at the findings documented later in this report.

3. METHODOLOGY

3.1 Overall Approach

The Kaleidoscope study adopted a participatory scoping review approach, engaging the Ministry of Health (MOH) at both the national and county levels, TICAH and other consortium members, as well as other relevant stakeholders involved in the implementation of post-abortion care (PAC) and comprehensive abortion care (CAC) services in Kenya. This inclusive process was designed to foster stakeholder ownership and ensure that all key decisions throughout the assessment were collaboratively informed. The study employed a mixed-methods design, integrating qualitative and quantitative approaches to generate a comprehensive understanding of PAC/CAC service delivery. Qualitative data collection was primary.

3.2 Study Design

The study was primarily qualitative in nature, designed to capture the nuanced policy, systems, and service delivery realities shaping PAC and CAC implementation. Qualitative methods were prioritized to explore stakeholder perspectives, provider attitudes, and contextual barriers such as stigma, legal ambiguity, and cultural norms. Quantitative data were used in a supportive role, specifically to generate indicators on PAC service delivery. These included facility-level statistics on PAC cases and reporting practices within KHIS/DHIS2. The integration of quantitative indicators provided a baseline for triangulation with qualitative findings.

3.3 Study Population

The study population consisted of key stakeholders and service providers directly engaged in PAC services and abortion complication management across Kilifi, Kwale, Samburu, and West Pokot counties. It included county-level actors such as Directors of Health, Reproductive Health Coordinators, Health Records Officers, Facility Managers, and County Health Management Team members, alongside frontline providers like nurses, clinical officers, and medical officers. Stakeholders, including NGOs, CSOs, were also involved to capture perspectives on stigma, access, and advocacy, while national-level actors such as the Ministry decision makers, provided policy context. At the community level, community health promoters (CHPs) were targeted as they play a critical role in PAC by educating communities,, identifying and referring women with complications, and providing counselling and follow-up support. In essence, they act as trusted connectors between households and the health system, ensuring PAC services are accessible, acceptable, and life-saving.

3.4 Sampling

The study focused primarily on public health facilities across the four priority counties of Kilifi, Kwale, Samburu, and West Pokot, ranging from Level 5 (county referral hospitals), Level 4 (sub-county hospitals) to Level 3 (health centres) and Level 2 (dispensaries). Facilities were selected using a stratified sampling approach to reflect variation in service levels, geographic distribution, and population coverage. County referral hospitals and Level 4 sub-county hospitals were prioritised for their expected role in offering specialised PAC/CAC services, while Level 3 health centres and Level 2 dispensaries were included to assess access and capacity at the community level. Level 1, which is the community health units were represented by community health promoters who participated in group discussions. The table below provides a breakdown of the sampling of health facilities in the study.

Table 3: Health Facility Sample Sizes

Type of Facility	Number Sampled Per County	Total
Level 5	1	4
Level 4	3	12
Level 3	3	12
Level 2	3	12
Private facilities	2	2
Total	10	42

In addition, two private facilities, including faith-based or mission hospitals, were purposively sampled in some counties to capture the role of non-state actors in service delivery and to provide a more comprehensive picture of PAC/CAC availability. The selection also considered urban, peri-urban, and rural contexts to highlight disparities in service availability and infrastructure. In total, 42 health facilities of different service levels were sampled across the four counties. A profile of the sampled health facilities is provided in the next section.

For qualitative data, respondents within each facility were purposively selected based on their roles in SRHR service delivery and data management. These included medical officers, nurses, clinical

officers, facility in-charges, and health records officers who were directly involved in PAC services. Their insights were critical in understanding both operational realities and attitudinal dynamics affecting service delivery. In addition, perspectives were gathered from county-level managers, national-level stakeholders, and community actors to capture policy, financing, and strategic dimensions. Those interviewed were purposively selected dependent on their direct involvement in providing leadership in regard to SRHR/ PAC services provision at both the county and national level.

The final sample size was determined by facility density, population served, and logistical feasibility in each county. While the study aimed for methodological robustness, it remained flexible to accommodate field realities and ensure meaningful representation. This was done in consultation and guidance of the respective County Health Management Teams, through the office of the Director of Health and County Reproductive Health Coordinators.

3.5 Data collection

The study began with an initial document review phase, providing the foundation for tool design and contextual framing. A desk review of national and county-level documents, including health policies, SRHR guidelines, legal frameworks, strategic plans, and facility protocols offered critical insights into the alignment between national commitments and county-level implementation, while highlighting existing knowledge gaps.

Before commencement of data collection, a team of four research assistants were recruited from the respective counties to support the data collection process. The research assistants were picked based on their extensive experience in undertaking similar studies, with strong competence in undertaking mixed methods studies, sexual reproductive health studies, medical related courses and resident or experience working in the respective county. The team underwent a two-day training which covered introduction to the project, study objectives, evaluation ethics, orientation to data collection tools, role plays, and pilot testing of study tools, which informed revision of the tools. A member of the TICAH project team attended the training and provided background information to the project.

Fieldwork data collection was conducted from the last week of November to early December 2025. These included KIIs with county health officials, facility managers, frontline providers, civil society actors, and community leaders; stakeholder consultations to foster ownership and validate emerging findings; and FGDs with CHPs conducted at a central location in each county.

KII guides and FGD guides were developed and applied to gather relevant information. A copy of the study tools is provided in Annex 2. Table 4 provides a breakdown of the key informant interviews conducted.

Table 4: Key Informant Interviews

Organization/ Stakeholder	Designation	Type of Interview	Number Targeted	Number Reached
Ministry of Health - County Government	CEC Health/ County Director of Health	KII	4	-
	RH Coordinators	KII	4	3
	Nurses/ Facility In Charge/ Health Record Officers	KII	40	48
Ministry of Health – National Level	RH Decision makers	KII	2	2
Partners	Consortium and other development partners	KII	8	5
Community	Community Health Promoters	FGD	4	4

Complementing the qualitative inquiry, quantitative data were collected through structured facility assessments and analysis of health information systems (KHIS). These generated baseline indicators on PAC service delivery, commodity availability, and reporting practices, helping to identify systemic gaps in service delivery and data capture. Quantitative data were captured using **Kobo Collect**, a mobile-based platform enabling real-time entry and geo-tagging. The table below presents the profile of the health facilities that participated in the facility assessment:

Table 5: Profile of Health Facilities Assessed

Facility Type	Number Reached	Percentage of Total Facilities Assessed(%)
Referral Hospitals (Level 5)	4	10%
Sub-county Hospitals – Level 4	14	33%

Health centres – Level 3	17	40%
Dispensaries/ clinics – Level 2	7	17%
Total	42	100%
Facility Ownership		
Public	39	93%
Private	2	5%
Mission/ Faith based	1	2%
Facility Location		
Rural	19	45%
Peri-urban	13	31%
Urban	10	24%

3.6 Data Quality

To ensure data quality throughout fieldwork, supervisors conducted daily debriefings, reviewed completed tools, and performed spot checks across study sites, while real-time monitoring and feedback mechanisms promptly addressed emerging challenges such as delays in securing responses from county officers. This rigorous oversight minimized errors, enhanced consistency across diverse settings, and fostered accountability, while supervisors also monitored adherence to ethical standards, including confidentiality and informed consent. Collectively, these measures safeguarded the integrity of the data and ensured that the study produced reliable evidence to inform policy and practice

3.7 Data Analysis

Data analysis was conducted using a mixed-methods approach to ensure a comprehensive understanding of the findings. Quantitative data collected through Kobo Collect were exported into

statistical software, SPSS and for cleaning, coding, and analysis. Descriptive statistics were used to summarise key indicators related to PAC/CAC service availability, infrastructure, human resource, and health information systems. Where applicable, cross-tabulations and disaggregated analyses by county, facility level, and population served were performed to highlight disparities and emerging trends.

Qualitative data from key informant interviews and focus group discussions were transcribed, translated where necessary, and analysed thematically using NVivo software or manual coding frameworks. Thematic analysis focused on identifying recurring patterns, stakeholder perceptions, and contextual barriers to access and service delivery. Triangulation of qualitative and quantitative findings was employed to validate insights and enrich interpretation.

3.8 Ethics Consideration

The study adhered to rigorous ethical standards to protect the safety, dignity, and rights of all participants. Informed consent was obtained from all respondents, with additional assent and guardian consent secured for minors, in line with national research guidelines. Participation was entirely voluntary, and respondents were free to withdraw at any point without consequence.

Confidentiality and anonymity were maintained through secure data handling and de-identification protocols. Interviews and focus group discussions were conducted by trained facilitators in safe and private settings. Ethical approval for the study was obtained from the Daystar University Ethics Review Board. Permission to conduct the study was also sought from the Kenya National Commission for Science, Technology and Innovation (NACOSTI). All study activities were guided by principles of cultural sensitivity, respect for vulnerable populations, and compliance with national and international research ethics frameworks.

4. FINDINGS

4.1 Policy and legal environment for PAC

4.1.1 National Legal and Policy Framework

As introduced in the Context section, PAC is anchored within the Reproductive Health Policy (2022–2032), which positions PAC as a core component of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) (MOH, 2022). Supporting this policy are National PAC Guidelines and Standard Operating Procedures (SOPs) that provide technical direction on service delivery, counselling, infection prevention, referral, documentation, and reporting (MOH, 2018). However, comprehensive abortion care (CAC) remains highly restricted and contentious, creating a challenging environment in which PAC is often misunderstood or conflated with induced abortion (Mutua, Manderson, Musenge, & Achia, 2018).

In MOH, we don't talk about comprehensive abortion care. We only focus on PAC. We go by the constitution of the country (National Level Decision maker)

Although the national legal and policy framework for PAC is relatively clear, the restrictive legal context surrounding abortion continues to shape provider attitudes, leading to cautious policy interpretation and heightened risk perception in service delivery. RH Coordinators and facility providers acknowledged that PAC is firmly anchored in the *Reproductive Health Policy (2022–2032)* and supported by guidelines and SOPs. Yet, they emphasized that restrictive abortion laws generate uncertainty, stigma, and hesitation in practice. As providers explained, *"PAC is permitted and guided, but the overlap with comprehensive abortion care (CAC) makes implementation sensitive and difficult"*

4.1.2 County-Level Policy Adaptation

Across study counties, PAC was generally described as integrated within RMNCAH structures, rather than established as a standalone programme. PAC appeared in county work plans, service delivery platforms, and reporting systems under maternal health, emergency care, or reproductive health. While this integration recognizes PAC as part of essential health services, it has also resulted in limited visibility, and prioritisation of PAC within county systems.

We only rely on national policies and standards. We do not have county-specific policies or guidelines for abortion. We have done dissemination of the national PACs standards during training of the health providers and in a few health facilities that we during supervision - RH Coordinator

While the counties (notably Kilifi and Kwale) reported that county-specific guidelines were under development, these had not yet been disseminated to facilities. As a result, national protocols remained the default reference, but without structured county-level adaptation or enforcement.

4.1.3 Health Workers Awareness and Policy Dissemination Gaps

The study established that the majority of frontline health workers had limited awareness of PAC-specific policies, SOPs, and quality standards, despite their routine involvement in managing abortion-related complications. While senior county officials and RH coordinators were generally familiar with national guidelines, this awareness did not consistently translate to lower levels of the health system.

Dissemination of PAC-related policies and guidelines was widely reported as inadequate and irregular, particularly to lower-level facility health workers. In several facilities, providers indicated that they relied on informal access to guidelines via websites or peers, rather than structured dissemination and training. In others, providers reported never having received PAC-specific SOPs or orientation.

Among counties that reported some level of effort towards policy dissemination, this was often not extensive or externally supported by partners, rather than institutionalised within county structures. Samburu and Kwale reported that they had recently undertaken their first-ever structured dissemination of PAC quality standards, supported by Kaleidoscope and the Ministry of Health. However, frontline awareness remained uneven, and PAC guidelines were not consistently embedded in routine supervision across the county.

The disconnect between policy availability and frontline use undermines quality, standardisation, and provider confidence in PAC service delivery. Without systematic dissemination, refresher training, and integration of PAC guidelines into routine orientation and supervision, frontline providers will continue to rely on informal practices, perpetuating variability in care and reinforcing stigma-related hesitancy.

4.2 Service Availability

4.2.1 General Service Availability Across Facility Levels

The assessment revealed that while PAC services were broadly available across the four counties, there was a distinct disparity in service readiness when disaggregated by facility level. Level 4 and 5 facilities, such as the County Referral Hospitals in Kilifi and West Pokot, consistently demonstrate the highest capacity for comprehensive PAC, providing a full range of emergency and preventive services. Conversely, Level 2 dispensaries and many Level 3 health centers across all four counties exhibit significant service gaps that undermine the primary healthcare network's ability to manage obstetric emergencies locally. These gaps are primarily driven by a combination of human resource

constraints and logistical barriers, including the chronic lack of essential commodities like MVA kits and Misoprostol. Consequently, this tiered inequity creates a "referral bottleneck," forcing women in rural or hard-to-reach areas of Samburu and Kwale to navigate long and often dangerous referral chains, which significantly increases the risk of severe clinical complications such as sepsis and hemorrhage.

4.2.2 Emergency and Referral Services

In terms of clinical scope, the majority (69%, n=29) of the facilities assessed provide PAC through integrated inpatient and outpatient departments, a trend that was most robust in West Pokot where nine out of eleven facilities offered this integrated model. However, nearly a quarter of the facilities across the study areas offer services strictly on an outpatient basis, a limitation that effectively excludes women presenting with more severe, life-threatening complications requiring overnight observation. Most critically, the total absence of PAC services in three specific facilities, one each in Kilifi, Kwale, and West Pokot was attributed not to a lack of physical infrastructure, but to a profound skills gap among frontline providers. Healthcare workers in these sites reported a fundamental inability to conduct MVA procedures or administer medical management protocols with confidence, suggesting that in these specific sub-counties, service availability is currently tethered to individual provider competencies rather than institutionalized readiness.

A critical finding of this study is the disparity in "Emergency Readiness" regarding ambulance availability. While the overall availability of emergency transport stands at 74% across the counties, the operational models vary. In Kilifi (82%) and Kwale (80%), facilities largely rely on a centralized "hub-and-spoke" model, where ambulances are stationed at sub-county or referral hospitals. Conversely, in Samburu (90%) and West Pokot (64%), several lower-level facilities have dedicated on-site ambulances. However, participants noted that having a vehicle on-site does not guarantee immediate transfer. Challenges such as availability of fuel are common.

The assessment also established that a formal referral system for PAC is universally recognized across the four counties, with 100% (n=42) of the sampled facilities reporting established protocols for managing complications. This system is particularly vital for Level 2 and Level 3 facilities that do not offer direct uterine evacuation. For these sites, the referral mechanism is the primary life-saving intervention. While the administrative linkage to higher-level hospitals is clear and consistent across Kilifi, Kwale, Samburu, and West Pokot, the transition from protocol to clinical action is often hampered by significant logistical and geographical barriers.

"One major problem is training in PAC. It is when we are undergoing training. There is a partner who has been taking us for training at the referral. So, for emergencies, we refer to the referral hospital" - Health Provider, Kilifi Health Center.

"The ambulance covers many facilities. When it is away, we cannot move the patient immediately, even when it is an emergency." – Health worker, West Pokot

"Even if we don't have the service here, we already know which hospital to call and send the client to." – Health worker, Samburu

4.2.3 Integration of the PAC Package of Care

The study further identifies a lack of cohesion in the delivery of the holistic PAC "package of care," which by Kenyan national standards must include emergency treatment, counseling, and contraceptive provision. While emergency stabilization is prioritized, the integration of preventive services remains fragmented, particularly in Samburu and Kilifi, where a higher proportion of facilities reported offering counseling and family planning only on an outpatient basis. Less than half (40%, n=17) of the facilities across the four counties, family planning services restricted to outpatient departments, creating a systemic "missed opportunity" for patients admitted to inpatient wards for emergency stabilization. This gap may reflect limited resources, staff workload, or patients' desire for rapid discharge, which reduces opportunities for comprehensive counselling. It may also signal prioritisation of emergency treatment over holistic care.

Participants indicated that the transition from clinical stabilization to contraceptive counseling often fails during the discharge process, as there is no formal mechanism to ensure inpatient clients are linked to family planning providers before leaving the facility. This fragmentation suggests that while the health systems in counties like Kwale and West Pokot are capable of managing the immediate crisis of an unsafe abortion, they are currently struggling to address the underlying need to prevent repeat unintended pregnancies.

Table 6: PAC Services Availability Across Health Facilities

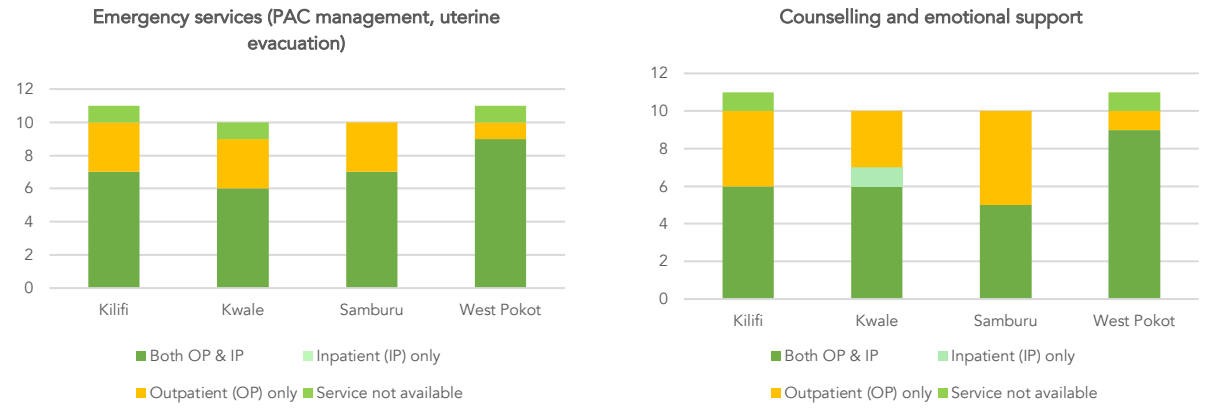
Name of County	Both Outpatient & Inpatient	IP only	OP only	Service not available	Grand Total
Emergency services (PAC management, uterine evacuation)					
Kilifi	17% (n=7)	-	7% (n=3)	2% (n=1)	11
Kwale	14% (n=6)	-	7% (n=3)	2% (n=1)	10
Samburu	17% (n=7)	-	7% (n=3)	-	10

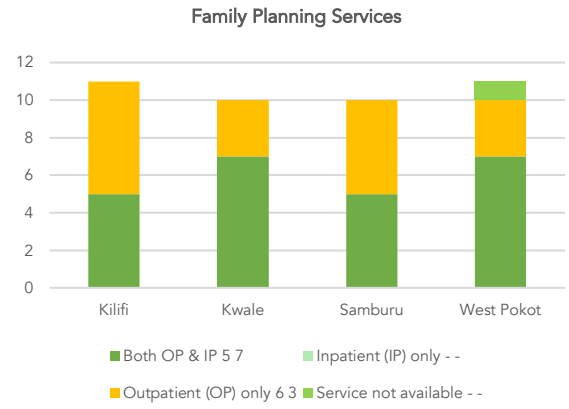
Name of County	Both Outpatient & Inpatient	IP only	OP only	Service not available	Grand Total
Emergency services (PAC management, uterine evacuation)					
West Pokot	21% (n=9)	-	2% (n=1)	2% (n=1)	11
Total	69% (n=29)	-	24% (n=10)	7% (n=3)	
Counselling and emotional support					
Kilifi	14% (n=6)	-	10% (n=4)	2% (n=1)	11
Kwale	14% (n=6)	2% (n=1)	7% (n=3)	-	10
Samburu	12% (n=5)	-	12% (n=5)	-	10
West Pokot	21% (n=9)	-	1	2% (n=1)	11
Total	62% (n=26)	2% (n=1)	30% (n=13)	5% (n=2)	42
Family Planning Services					
Kilifi	12% (n=5)	-	14% (n=6)	-	11
Kwale	17% (n=7)	-	7% (n=3)	-	10
Samburu	12% (n=5)	-	12% (n=5)	-	10
West Pokot	17% (n=7)	-	7% (n=3)	2% (n=1)	11
Total	24	-	40% (n=17)	2% (n=1)	42
Reproductive Health and general services (Screening for STIs)					

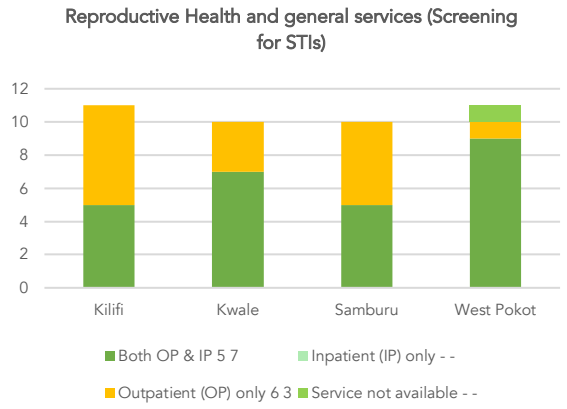
Name of County	Both Outpatient & Inpatient	IP only	OP only	Service not available	Grand Total
Emergency services (PAC management, uterine evacuation)					
Kilifi	12% (n=5)	-	14% (n=6)	-	11
Kwale	17% (n=7)	-	7% (n=3)	-	10
Samburu	12% (n=5)	-	12% (n=5)	-	10
West Pokot	21% (n=9)	-	2% (n=1)	2% (n=1)	11
Total	62% (n=26)	-	36% (n=15)	2% (n=1)	42

Source: Kaleidoscope Scoping Study 2025

Figure 6: Summary of PAC Services Access







4.3 Workforce Readiness and Training

4.3.1 Health workers training on PAC Services

The assessment of workforce readiness across Kilifi, Kwale, Samburu, and West Pokot reveals a significant gap between reported theoretical availability and actual clinical competency. While Table 11 indicates that a majority of facilities have at least one staff member trained in key PAC components, MVA (86%), infection prevention (90%), and counseling (86%), further interrogation of the data suggests that PAC capacity is insufficiently institutionalized. Instead of being embedded within facility-wide standard operating procedures, knowledge is largely retained at the individual level. This makes service delivery highly vulnerable to interruptions caused by staff rotations, turnover, or absenteeism, particularly in rural Level 2 and Level 3 facilities where the absence of a single trained provider can lead to a complete cessation of PAC services.

> ***"Capacity of staff I think we are only two who can do that. Me and the Clinical officer. The others, no." – Health worker, Samburu County***

A cross-county comparison highlights specific vulnerabilities in technical clinical management. While Kwale reported 100% staff training across all PAC indicators, West Pokot showed a notable deficit in medical management readiness, with only 55% of facilities having staff trained in Misoprostol use. Furthermore, despite national efforts to embed PAC competencies into pre-service curricula through KMTC, many frontline workers across all four counties reported having had no formal training in the last two years. In Samburu, the training of only 15 healthcare workers through partner support was described as a "drop in the ocean," highlighting the massive scale of unmet need for systematic, county-wide capacity building.

"We have only trained 15 health care workers... if you look at 15 in this county, how many facilities are those? Very minimal, like a drop in the ocean." – RH Coordinator

Beyond technical skills, the study identified provider attitudes as a primary determinant of PAC quality. Value Clarification and Attitude Transformation (VCAT) training was reported as limited and uneven, with Samburu being the only county to note recent interventions that reduced stigma. In contrast, providers in West Pokot, Kilifi, and Kwale explained that without VCAT exposure, personal religious and cultural beliefs often override professional ethics. This is particularly harmful for adolescents, who frequently face judgmental questioning and moralizing that discourage early care-seeking and increase the risk of complications.

"There was a health worker who said, 'my religion does not allow me to do that, where you did it finish from there.' So just imagine if a health worker can say that." – RH Coordinator.

Ultimately, the data suggests that equipment and commodities alone are insufficient to guarantee access. In Kilifi and other counties, healthcare workers emphasized that without a fundamental shift in provider attitudes to address fear of legal implications and moral stigma, many facilities will continue to provide substandard care or avoid service provision altogether. As one provider noted: ***"Without attitude change, even equipment will not help."***

A possible reason VCAT is not systematically embedded in training may be the prioritization of technical competencies over attitudinal change, limited resources for continuous professional development, and the politically sensitive nature of abortion discourse. These factors make institutions hesitant to formally integrate VCAT, even though provider attitudes are central to the quality and accessibility of PAC services.

Table 11: Percentage of Staff Trained on PAC Services

Name of County	Yes	No	Grand Total	% Staff Trained
(a). MVA?				
Kilifi	8	3	11	78%
Kwale	10	-	10	100%

Samburu	9	1	10	90%
West Pokot	9	2	11	82%
Grand Total	36	6	42	86%
(b). Misoprostol use				
Kilifi	8	3	11	78%
Kwale	10		10	100%
Samburu	8	2	10	80%
West Pokot	6	5	11	55%
Grand Total	32	10	42	76%
(c). Infection prevention				
Kilifi	8	3	11	73%
Kwale	10	-	10	100%
Samburu	10	-	10	100%
West Pokot	10	1	11	91%
Grand Total	38	4	42	90%
(d). Counselling and psychosocial support				
Kilifi	8	3	11	73%
Kwale	9	1	10	90%

Samburu	10	-	10	100%
West Pokot	9	2	11	82%
Grand Total	36	6	42	86%

4.3.2 Role of Community Health Promoters

Frontline Identification and Referral Pathways

CHPs are actively involved in the early stages of the PAC service chain. Their work includes identifying women with complications, providing initial comfort, and physically escorting patients to the hospital. Because they are trusted members of the community, they are often the only ones who know when a woman is in trouble. However, they lack formal referral protocols, meaning the journey to the hospital is often uncoordinated and depends on the CHP's personal initiative.

Knowledge gaps and training needs

While CHPs have a basic understanding of PAC, there is significant confusion between medical treatment (PAC) and the act of abortion. Many CHPs have not received dedicated training and rely on general health knowledge. They expressed a strong need for specific training on how to spot "danger signs," how to talk to adolescents without judging them, and how to handle the emotional trauma of pregnancy loss.

> ***"Post-abortion care is the services a girl or mother receive after pregnancy gets terminated... spontaneous or induced." – CHP, Kilifi***

Financial Burden and Personal Sacrifice

A major finding of this study is that CHPs perform their life-saving work with almost no institutional support. In all four counties, CHPs reported using their own meager income to pay for a client's emergency transport. This "personal tax" on volunteers is a major threat to the sustainability of community health. Without a formal system to cover emergency costs, the poorest women are left at risk if their local CHP cannot afford to help them that day.

4.4 Infrastructure

The physical environment for Post-Abortion Care (PAC) across the four counties is characterized by a high degree of service integration within existing maternal and child health units, rather than standalone infrastructure. While 36% of facilities (n=15) report having a dedicated PAC room, with the highest availability found in Kwale and Samburu (50% each), observational data suggests that these spaces are rarely exclusive. In most assessed sites in Kilifi and West Pokot, PAC procedures are performed within general maternity or outpatient units. Healthcare workers noted that this spatial overlap frequently compromises patient confidentiality and visual privacy, particularly during peak hours for labor and delivery. The practice of admitting PAC clients to general maternity wards was highlighted as a significant source of psychological distress, especially for adolescents or women experiencing pregnancy loss, as they are forced to share recovery spaces with patients who have delivered live births.

> ***"Privacy is an issue because PAC is done in maternity. Others can see and hear what is going on." – Health worker, West Pokot***

Sometimes you find young mothers put together with older women who have had a stillbirth in one room. Health Worker, Kwale

Some facilities reported partner support in establishing dedicated PAC spaces, though exclusivity remained limited:

> ***"We have dedicated PAC spaces like the MVA room, we were supported by partners." – Facility In-Charge, Kilifi***

Critical infrastructure for infection prevention, such as water access and waste management, showed significant regional disparities. While Kilifi reported 100% access to running water, West Pokot exhibited the greatest deficit, with only 27% of facilities indicating consistent access. Even in facilities with stable county-level water supply, such as those in Samburu and Kwale, internal plumbing often failed to reach the PAC procedure room directly. Consequently, staff reported a heavy reliance on manually fetching water in buckets, a practice that not only disrupts the clinical workflow but also undermines the maintenance of a sterile environment for invasive procedures like Manual Vacuum Aspiration (MVA). Despite these water challenges, waste disposal systems were largely functional, with 95% of facilities maintaining sharps and biohazard protocols, although final disposal often relied on external incineration services.

"We have running water, but not in the PAC room. Water has to be carried using buckets."
– Health worker, Samburu

Table 7: Assessment of PAC Infrastructure Across Sampled Facilities

Name of County	Yes	No	Grand Total	% Available
(a). Does the facility have a dedicated PAC/CAC room?				
Kilifi	3	8	11	27%
Kwale	5	5	10	50%
Samburu	5	5	10	50%
West Pokot	2	9	11	18%
Grand Total	**15**	**27**	**42**	**36%**
(b). Privacy ensured during PAC (visual and auditory)				
Kilifi	6	5	11	55%
Kwale	7	3	10	70%
Samburu	8	2	10	80%
West Pokot	9	2	11	82%
Grand Total	**30**	**12**	**42**	**72%**
(c). Running water available?				
Kilifi	11	-	11	100%
Kwale	9	1	10	90%
Samburu	7	3	10	70%

West Pokot	3	8	11	27%
Grand Total	**30**	**12**	**42**	**71%**
(d) Handwashing station available?				
Kilifi	11	-	11	100%
Kwale	10	-	10	100%
Samburu	2	1	3	67%
West Pokot	8	3	11	73%
Grand Total	**31**	**4**	**35**	**89%**
(e). Waste disposal system (sharps, biohazard)				
Kilifi	11	-	11	100%
Kwale	10	-	10	100%
Samburu	10	-	10	100%
West Pokot	9	2	11	82%
Grand Total	**40**	**2**	**42**	**95%**

Source: Kaleidoscope Scoping Study 2025

4.5 PAC Equipment and Supplies

A review of PAC supplies and equipment presented a contrasting picture. On the one hand, quantitative data showed that most facilities had the essential items required for basic infection prevention and immediate clinical care. Sterile gloves and speculums were nearly universally available (95% and 98%, respectively), while IV fluids, antibiotics, and pain management drugs were

also widely stocked. MVA kits were present in 88% of facilities, with Kwale reporting full coverage, followed by Samburu, and slightly lower availability in West Pokot and Kilifi.

> ***"We generally have gloves and consumables, but shortages happen on and off." — Health worker, Kwale***

However, these strengths were undermined by notable gaps in key PAC commodities and equipment. Misoprostol had the lowest availability at only 67% overall, with West Pokot particularly affected at just 36%. Stock-outs were common, with 51% of facilities reporting shortages in the previous three months. Qualitative interviews confirmed these findings, with providers describing intermittent access to misoprostol, antibiotics, and analgesics, and in some cases relying on patients to purchase drugs externally.

> ***"Due to wear and tear, most of our MVA kits have been worn out. So, we need to replace." – Health worker, Kilifi County***

Even where MVA kits exist, low kit count, wear-and-tear, and sterilisation constraints disrupted service delivery.

> ***"Sometimes you find overnight people have done two to three MVAs then you find the MVA kits are dirty... you have to wait for another 15–20 minutes for the equipment to be sterilized." – HCW, Samburu***

Beyond kits, broader infrastructure challenges were also raised.

> ***"Bigger challenge is equipment... including lighting in the room. When it wears out, there is no replacement." – RH Coordinator***

Notably, a number of facilities reported challenges in ordering replacement parts for MVA kits, as some components are not available on the Kenya Medical Supplies Authority (KEMSA) system. Overall, stock-outs were described as occurring "on and off," indicative of systemic supply chain issues, compounded by outstanding bills associated with non-payment of supplies by respective county governments.

Table 8: PAC Equipment and Supplies Across Sampled Facilities

Name of County	Yes	No	Grand Total	% Available
(a). MVA kits (functional)				
Kilifi	9	2	11	82%
Kwale	10	-	10	100%
Samburu	9	1	10	90%
West Pokot	9	2	11	82%
Grand Total	37	5	42	88%
(b). Sterile gloves				
Kilifi	11	-	11	100%
Kwale	10	-	10	100%
Samburu	10	-	10	100%
West Pokot	9	2	11	82%
Grand Total	40	2	42	95%
(c). Speculum				
Kilifi	11	-	11	100%
Kwale	10	-	10	100%
Samburu	10	-	10	100%
West Pokot	10	1	11	91%
Grand Total	41	1	42	98%
(d). Misoprostol tablets				
Kilifi	7	4	11	64%
Kwale	10	-	10	100%
Samburu	7	3	10	70%
West Pokot	4	7	11	36%
Grand Total	28	14	42	67%
(e). IV fluids				
Kilifi	11	-	11	100%

Kwale	10	-	10	100%
Samburu	10	-	10	100%
West Pokot	10	1	11	91%
Grand Total	41	1	42	98%
(f). Antibiotics				
Kilifi	11	-	11	100%
Kwale	10	-	10	100%
Samburu	10	-	10	100%
West Pokot	10	1	11	91%
Grand Total	41	1	42	98%
(g). Pain management drugs				
Kilifi	11	-	11	100%
Kwale	10	-	10	100%
Samburu	10	-	10	100%
West Pokot	10	1	11	91%
Grand Total	41	1	42	98%
(h). Stock-outs in the last 3 months?				
Kilifi	7	4	11	64%
Kwale	5	5	10	50%
Samburu	2	1	3	67%
West Pokot	4	7	11	36%
Grand Total	18	17	35	51%

Source: Kaleidoscope Scoping Study 2025

4.6 Health Information Systems

This section analyses the performance of PAC-related health information systems across counties, focusing on the generation, compilation, analysis, dissemination, and use of data at facility and county levels. The assessment examined the availability and functionality of PAC data collection tools, integration of PAC indicators within national platforms (KHIS/DHIS2), data quality dimensions

(completeness, accuracy, timeliness, and disaggregation), and the utilization of PAC data for planning, resource allocation, and service delivery improvement.

4.6.1 Availability and Use of PAC Registers

A review of PAC data capture and utilization revealed substantial variation across counties, reflecting the absence of a consistently applied approach to PAC reporting. Facilities within the same county reported markedly different practices: some maintained dedicated PAC registers, others relied on outpatient, maternity, or family planning registers, while a significant proportion had no register at all. This inconsistency reflects both structural and capacity-related gaps in the health information system.

Findings from the facility assessment show that only 43% of facilities had PAC registers capturing both service statistics and outcomes, 20% recorded only basic PAC data (largely limited to case counts), and 37% reported having no PAC register despite national recommendations. County-level comparison revealed wide variation: Kwale demonstrated higher compliance, with all assessed facilities maintaining some form of PAC record; Kilifi showed mixed compliance; Samburu had partial coverage; and West Pokot was the least compliant. Interviews with providers and managers corroborated these findings, noting fragmented documentation where PAC was integrated into other registers.

> ***"There is no standalone PAC register; it is integrated within our routine reporting tools."***
> ***– Facility in-charge, Kwale***

In some counties, such as Kilifi and Kwale, partner support (e.g., Marie Stopes) facilitated distribution of registers, underscoring the role of external actors in filling systemic gaps. However, the uneven availability of registers, even though they are recommended, suggests weaknesses in dissemination, supply, and prioritization. Moreover, where registers exist, many lack fields for age, method, complications, and referrals, limiting the ability to generate disaggregated data for equity monitoring. The fact that PAC data are rarely reviewed in routine county data meetings further reinforces the perception that PAC services are less prioritized within RMNCAH programming.

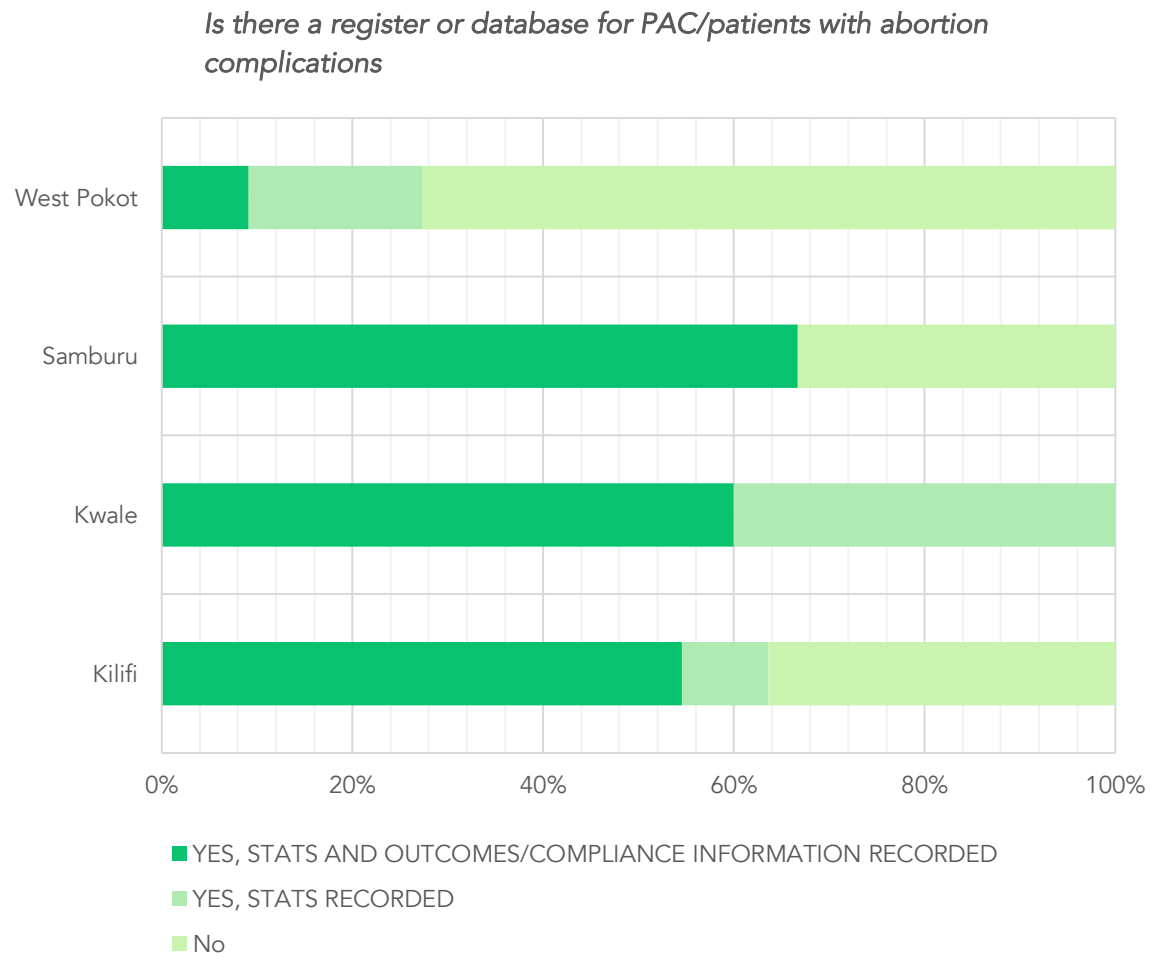


Figure 7: Utilization of PAC Registers Across Counties

Source: Kaleidoscope Scoping Study 2025

4.6.2 Reporting PAC Data to National Health Information Systems

Reporting of PAC data to national health information systems was relatively strong overall, with 71% of facilities indicating that PAC data was submitted through platforms such as KHIS/DHIS2, Tibabu, or Taifa Care.[1] However, this reporting was typically embedded within broader RMNCAH or OPD reporting tools rather than through PAC-specific indicators.

[1] Taifa Care is Kenya's government- funded Universal Health Coverage (UHC) program, launched in October 2024 managed through the Social Health Authority (SHA). Tibabu consists the digital infrastructure under Taifa Care used by health facilities to manage patient data, track and audit services.

Both Kwale and Samburu recorded full compliance (100%), followed by Kilifi (91%), while West Pokot showed significant gaps, with only 18% of facilities reporting PAC data digitally. Interviews with RH Coordinators and health workers confirmed that most facilities submitted PAC data monthly through KHIS/DHIS2, often using integrated reporting tools such as MOH 710/711, in line with RMNCAH reporting structures.

> ***"Data is collected from registers and uploaded into KHIS monthly, but challenges exist in completeness and timeliness." – Health Facility In-charge***

4.6.3 PAC Data Disaggregation

While basic reporting of PAC cases exists in many facilities, the depth and quality of data remain limited. Only 64% of facilities reported disaggregating PAC data by key variables such as age, method used, complications, or referrals. This limits counties' ability to analyse PAC trends, client profiles, referral effectiveness, and quality-of-care issues.

Disaggregation was relatively higher in Samburu (90%), Kilifi (82%), and Kwale (80%), but critically low in West Pokot (27%). The lack of age-disaggregated data is particularly concerning, as it prevents counties from identifying adolescent-specific needs, despite their higher risk for complications. In addition, it limits counties' ability to analyse PAC trends, client details, referral effectiveness, and quality-of-care issues.

Table 10: PAC Data Reporting and Disaggregation Across Sampled Facilities

Name of County	Yes	No	Grand Total	% of Use
(b). Reporting PAC data to KHIS/DHIS2/ Tibabu/ Taifa Care				
Kilifi	10	1	11	91%
Kwale	10	-	10	100%
Samburu	10	-	10	100%
West Pokot	2	9	11	18%
Grand Total	**32**	**10**	**42**	**71%**

(c). Data disaggregated by age, method, complications, referrals?				
Kilifi	9	2	11	82%
Kwale	8	2	10	80%
Samburu	9	1	10	90%
West Pokot	3	8	11	27%
Grand Total	**29**	**13**	**42**	**64%**

Source: Kaleidoscope Scoping Study 2025

4.6.4 Key Challenges in PAC Data Management

Across counties, respondents acknowledged the existence of data gaps and inconsistencies, driven by incomplete documentation, staff workload pressures, limited training on PAC registers, limited availability of reporting tools, and constraints within digital platforms that do not fully accommodate PAC services. In West Pokot, PAC data was described as scarce, incomplete, and unreliable, largely due to lack of registers, inconsistent reporting tools, limited mentorship, and, in some instances, deliberate non-reporting linked to informal payments.

> ***"Even in our KHIS the data is very scarce. The data from PAC is very scarce because of the capture tools and also the reporting." – RH Coordinator***

Qualitative findings also indicated that PAC data review meetings, routine data quality audits (DQAs), and feedback loops were infrequent or ad hoc across the counties. In many facilities, PAC data was not explicitly reviewed unless incorporated into sub-county or county level performance meetings. Where PAC data was consistently captured, some facilities reported conducting routine internal reviews, often at monthly or quarterly intervals, which informed commodity forecasting and identifying service gaps.

Overall, the findings point to a fragmented PAC health information system, where despite reporting to national platforms, facility-level data systems and processes require strengthening. Without standardized registers, routine disaggregation, investment in staff capacity and strengthened data review processes, PAC data will remain underutilized for planning, budgeting, and quality improvement. Weak data systems undermine evidence-based planning, resource mobilisation, and accountability for PAC service delivery.

4.7 Key Stakeholders for PAC Services Implementation

This section analysed the stakeholders supporting PAC implementation at national, county, facility, and community levels, with emphasis on roles, influence, collaboration patterns, and emerging partnership opportunities.

4.7.1 National-Level Stakeholders

At the national level, the Ministry of Health (MoH) provides stewardship for PAC policy direction, guideline development, and integration within the broader RMNCAH framework. National leadership ensures PAC is formally recognized as a reproductive health priority, though implementation relies heavily on counties.

> ***The MOH has been very supportive trainings and providing standards and guidelines. They come down to support trainings together with the partners. – RH Coordinator***

A range of international and national partners, including WHO, UNFPA, IPAS, Engender Health, CRCK, RHNK, and KMET, and Marie Stopes, have played a significant supportive role. Their contributions focus on: Policy development and interpretation; Health providers training, supervision support and mentorship; Supply of PAC commodities and equipment (e.g. MVA kits, misoprostol) as well as advocacy and stigma-reduction initiatives.

Training institutions play a critical role in strengthening the long-term sustainability and quality of PAC service delivery by embedding PAC competencies within pre-service curricula. Institutionalising PAC training ensures that health care workers enter the workforce with the appropriate clinical skills, ethical grounding, and confidence to provide safe, respectful, and standardised PAC services from the outset of their practice. Both public and private training institutions are therefore essential partners in ensuring adequately prepared providers across all levels of the health system.

4.7.2 County-Level Stakeholders

At county level, County Health Management Teams (CHMTs) are responsible for planning and oversight of PAC implementation, including budgeting, supervision, coordination, reporting, and integration into RMNCAH plans. Members of County Assembly are critical to PAC legislation and financing. Through relevant Health and Budget committees, they can support domestication of national PAC policies, advocate for dedicated PAC budget lines, and push for increased and predictable county funding to strengthen service delivery and accountability.

CHPs are central frontline stakeholders across all counties. They play a critical role in community education and sensitisation, identification of PAC complications, referral and follow-up of clients. However, CHPs are often overstretched and under-supported, operating with limited training, transport, and institutional backing.

International, national, and local NGOs and CSOs continue to provide historical or ongoing support for PAC implementation across counties. Their engagement has mainly focused on provider training and mentorship, provision of essential supplies and commodities, and facilitation of community dialogues aimed at addressing stigma and improving awareness. This support is usually project-based and time-bound, resulting in varying levels of coverage and sustainability across counties.

Faith-based organisations (FBOs) are highly influential community actors in shaping perceptions of PAC. In some settings, FBO positions reinforce stigma and moral opposition to abortion and related services. At the same time, stakeholders acknowledged that when meaningfully engaged, particularly through influential religious leaders, FBOs can serve as key partners for social norm change, community acceptance, and dissemination of accurate information on PAC.

Similarly, community elders and local leaders are important gatekeepers whose support can either hinder or enable access to PAC services. Engaging these leaders offers an opportunity to address stigma, challenge harmful cultural norms, and promote timely referral and utilisation of life-saving PAC services at the community level.

4.7.3 Emerging Consortiums and Networks

Two collaborative platforms were identified as particularly promising for advancing PAC and broader SRHR coordination. The Kaleidoscope Consortium, working in close partnership with the Ministry of Health (MOH) at both national and county levels, represents a multi-stakeholder initiative that convenes NGOs, CSOs, and academic institutions to harmonize advocacy, learning, and service delivery. Its strength lies in bridging technical expertise with grassroots advocacy, while ensuring alignment with government priorities and health system frameworks. By pooling resources and knowledge, Kaleidoscope reduces fragmentation, enhances the credibility of PAC and SRHR advocacy, and provides a structured channel for policy dialogue and implementation. However, its long-term effectiveness will depend on sustained funding and the ability to balance diverse institutional priorities.

The Pamoja Alliance is distinguished by its deeply rooted community orientation, with a particular emphasis on stigma reduction and youth-centered PAC/CAC advocacy. Its comparative advantage lies in amplifying community voices and challenging entrenched social norms, especially those that restrict adolescent access to PAC services. By embedding advocacy within local structures, Pamoja normalizes PAC as an essential component of reproductive health and cultivates bottom-up accountability, ensuring that communities themselves drive demand for responsive and ethical care. The Alliance is composed of diverse member organizations, each anchoring PAC advocacy in specific counties and thematic areas: Pamoja Yawezekana CBO operates in Kilifi County (Kilifi North, Kilifi South, Magarini, Ganze), focusing on health awareness, HIV/AIDS support, and community

microfinance; Pamoja for Transformation (P4T) works in Kisumu, Bungoma, Siaya, and Nairobi, advancing peacebuilding, governance, climate resilience, and gender-responsive land governance while integrating PAC into broader SRHR dialogues; Pamoja Kenya Mentorship Alliance (PAKEMA) engages youth in slums, urban, and rural areas nationwide, equipping them with leadership and life skills that include advocacy for adolescent access to PAC/CAC; and Pamoja Projects Kenya supports early childhood development and education, embedding SRHR awareness into family and community structures. Together, these organizations form a multi-sectoral fabric that blends PAC advocacy with governance, education, and livelihood support. Yet, Pamoja's reliance on community mobilization also presents a vulnerability: without deliberate and sustained linkage to formal health systems, PAC efforts risk becoming siloed and unsustainable. To maximize impact, Pamoja must strategically integrate its community-driven advocacy with institutional frameworks, thereby securing both cultural legitimacy and systemic durability.

Together, these networks offer important opportunities to strengthen coordination, reduce duplication, and align advocacy, service delivery, and community engagement across counties. Kaleidoscope provides the policy and technical backbone through its MOH partnerships, while Pamoja anchors community legitimacy and social norm change. If effectively integrated, they could create a multi-level ecosystem that connects national policy reform with grassroots demand generation, positioning PAC and SRHR as both a health service and a rights-based imperative.

4.8 Financing and Budget Allocation

4.8.1 PAC Services Financing

Findings from interviews with health workers, facility managers, and county reproductive health coordinators revealed that post-abortion care (PAC) financing is embedded within broader RMNCAH budgets, with no standalone or ring-fenced budget lines at county or facility level. Counties also lacked program-based budgets specific to PAC. While this integration formally positions PAC within essential health services, it simultaneously renders PAC expenditures financially invisible. As one RH Coordinator explained, *"PAC is under RMNCAH, but when the budget is approved, we don't know how much is for PAC. It is invisible."*

Across all counties, respondents consistently reported that available funding for PAC services was insufficient and unpredictable, reflecting the low prioritization of PAC within county health financing structures.

PAC services were broadly financed through a hybrid model:

Government insurance (SHA/SHIF) was highlighted as the primary source of funding. When functional, reimbursements reduced direct costs for clients. However, facilities noted that PAC-related procedures, diagnostics (such as ultrasound), and emergency interventions were not consistently reimbursed. A health worker in Kilifi observed, *"We depend on SHA, but the reimbursements delay and that affects planning."* In some cases, PAC services were not recognized

as billable within digital platforms, forcing facilities to use alternative diagnoses or request cash payments.

Out-of-pocket payments remained the default for populations not registered under government insurance, particularly adolescents and young women. This often delayed care or discouraged service uptake. Facility managers reported applying waivers on humanitarian grounds, especially for school-going girls, but acknowledged these practices were unsustainable. As one facility in charge in Kwale explained, *"For those without SHA, the social worker assesses and we waive, but there is no specific PAC budget."*

4.8.2 Supplies and Equipment Financing

County governments were also identified as the primary suppliers of PAC commodities, including drugs and consumables procured through KEMSA. However, because PAC commodities were procured as part of broader reproductive health or essential medicines lists, they competed with other priorities during procurement and budget approvals. This contributed to recurrent stock-outs of PAC-related supplies and commodities.

In some counties, facilities were empowered to directly purchase maternal and newborn health (MNH) commodities, which included PAC supplies. This flexibility was reported in Kwale, where county health teams allowed facilities to allocate resources based on service delivery needs and performance indicators. As one RH Coordinator explained,

> ***"We empower facilities to purchase based on their strengths and build their capacity to spend funding based on their needs, guided by data on health indicators. Like high-volume facilities will be prioritized if they have high abortion records."***

In several counties, development partners complemented government support by providing MVA kits, supply donations, training, and mentorship. While this support strengthened service availability in the short term, it was widely regarded as unpredictable and time-bound. A health worker in Kilifi remarked, *"Partners like Marie Stopes have helped with supplies, but it is not consistent."* Respondents emphasized that reliance on partners exposed PAC services to disruption when donor priorities shifted or programs ended.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

Post-Abortion Care (PAC) is firmly embedded within Kenya's national legal, policy, and health-system frameworks, yet its implementation across counties remains fragmented and inconsistent. The disconnect between policy and practice, driven by limited dissemination of guidelines, inadequate refresher training, and weak integration into supervision has undermined standardization and reinforced stigma. As a result, frontline providers often lack confidence, and women seeking care encounter uneven service quality across different regions.

Access to PAC services is further constrained by their concentration in higher-level facilities, which creates delays, increases transport costs, and forces reliance on emergency referrals. These barriers disproportionately affect rural and economically vulnerable women, entrenching geographic and socio-economic inequities. Adolescents and young women, in particular, face additional challenges due to stigma and provider attitudes, leaving them at heightened risk of unsafe practices and delayed care.

Service readiness is shaped less by infrastructure than by human resource capacity and attitudes. Limited PAC-specific training, weak coverage of values clarification and attitude transformation (VCAT), and persistent stigma among providers restrict timely and respectful care. Community Health Promoters (CHPs), though critical in identifying complications and facilitating referrals, remain under-supported and often bear personal financial costs to assist clients. Without deliberate investment in their training, referral support, and institutional recognition, their potential to expand equitable access will remain unrealized.

Finally, systemic weaknesses in data and financing undermine sustainability and accountability. While PAC data is included in national and county health information systems, inconsistent documentation, limited disaggregation, and weak analytical use reduce its value for planning and monitoring equity. At the same time, the absence of dedicated financing leaves PAC invisible within consolidated RMNCAH budgets, exposing vulnerable populations to gaps in care. Addressing these challenges requires coordinated policy action, strengthened workforce capacity, improved data systems, and sustained community engagement to ensure PAC is delivered as a rights-based, life-saving service across all counties.

5.2 Recommendation

Laws and Policy Context

- Harmonize national PAC/CAC guidelines with County Integrated Development Plans (CIDPs) to ensure consistent prioritization. Clarify the legal distinction between PAC (permitted) and CAC (restricted) to reduce provider fear and stigma.
- Institutionalise PAC/CAC indicators in national and county performance contracts.
- Engage faith-based and cultural leaders in policy dialogues to build community acceptance.
- Establish dedicated PAC budget lines in county health budgets to reduce reliance on donor funding.

Health System Element

- Integrate PAC commodities (misoprostol, MVA kits) into KEMSA procurement and LMIS for reliable supply chains.
- Ensure dedicated PAC rooms in Level 3–5 facilities to safeguard privacy and confidentiality.
- Strengthen referral pathways between CHVs and facilities using harmonized tools (MoH 100, Taifa Care).
- Expand adolescent-friendly PAC/CAC service packages with integrated GBV support.
- Scale up insurance schemes to reduce out-of-pocket costs for marginalized women.

Human Resource

- Scale up health worker training on new PAC guidelines
- Roll out Value Clarification and Attitude Transformation (VCAT) training for all cadres to reduce stigma. Embed PAC/CAC competencies in nursing curricula for pre-service training.
- Establish county mentorship networks for PAC providers to build confidence and skills.
- Incentivize retention of trained staff in underserved counties through allowances or career progression schemes.
- Train CHVs as PAC/CAC champions with clear referral roles and modest incentives.

Health Information and Data

- Distribute standardized PAC registers to all facilities and train staff on proper documentation. Harmonize community and facility-level reporting tools to reduce mismatched data.
- Digitize PAC/CAC records and integrate into KHIS/DHIS2 dashboards for real-time monitoring.
- Ensure data disaggregation by age, method, complications, and referrals in all counties.
- Include private sector PAC data in national reporting systems to capture the full picture.
- Conduct quarterly data reviews at the county level to inform resource allocation and service improvements.

Service Delivery

- Expand PAC services to all tiers of the health system, ensuring equitable access in rural and underserved counties. Introduce mobile outreach clinics and youth-friendly corners in facilities to reach adolescents and young women.
- Standardize counselling and post-PAC family planning services across counties.
- Strengthen commodity security by monitoring stock-outs and ensuring timely replenishment.

Financing Equity and Access

- Advocate for the creation of dedicated PAC budget lines at the county level to reduce reliance on donor funding.
- Launch community dialogues, including youth forums and community leaders, to reduce stigma and normalise PAC/CAC access.
- Strengthen partnerships and networks, through consortia (Kaleidoscope, Pamoja) to amplify community voices and coordinate advocacy.
- Use IEC campaigns tailored for adolescents and rural women to raise awareness of rights and available services

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6. ANNEXES

Data Collection Tools

Health Facility Assessment Tool

Module	No.	Question	Results	Skip
		Cover		
		1.1. COVER PAGE AND FACILITY IDENTIFIER		
		1.1.1. FACILITY IDENTIFIERS		
		ADAPT NUMBERING FOR COUNTIES AND HEALTH FACILITIES		
All	100	Facility code	----------	
All	101	Name of facility	----------	
All	102	Is this facility known by any other names? IF YES, PLEASE SPECIFY	YES ..... 1 NO ..... 2 IF YES, SPECIFY: _____	
All	103	Name of County and code	----------/.....	
All	104	Interview date	Visit No. ---- Date: DD MM YYYY; Interviewer code; Result Code	
			*RESULT CODE 1 = INTERVIEW STARTED 2 = POSTPONED 3 = FACILITY CLOSED 4 = FACILITY DESTROYED 5 = FACILITY NOT FOUND 6 = OTHER	

			COMPLETE GPS COORDINATES FOR RESULTS CODES 1 THROUGH 4	
		1.1.2. GEOGRAPHIC COORDINATES – of study sites		
		1.1.4. FACILITY CHARACTERISTICS		
ALL	105	FACILITY LEVEL	sub-County hospital .....1 HEALTH CENTRE ..... 2 CLINIC/DISPENSARY 3	
ALL	106	OWNERSHIP OF THE FACILITY	PUBLIC: MINISTRY OF HEALTH ..... 1 MISSION/FAITH-BASED ..... 2 PRIVATE .....3 (others specify: 4	
ALL	107	FACILITY LOCATION: URBAN OR RURAL OR PERIURBAN (FROM SURVEY LIST)	URBAN ..... 1 RURAL ..... 2 PERIURBAN 3	
ALL	108	SERVICE LEVELS AVAILABLE	OUTPATIENT ONLY..... 1 *INPATIENT ONLY ..... 2 BOTH OUT AND INPATIENT..... 3	

Module	No.	Question	Results				Skip
		2. SERVICE AVAILABILITY					
		2.1. SERVICES PROVIDED FOR POST ABORTION CARE BY THE FACILITY					
			Out-patient	In-patien	Both OP&IP	Service not	

			(OP) only	t (IP) only		availa ble	
A_C	109	**1.** Emergency services a. Management of complications from spontaneous or unsafe abortions (such as heavy bleeding, infection, or injury.) **b**. Uterine evacuation procedures - including manual vacuum aspiration (MVA) or medical management to ensure the uterus is empty	1	2	3	4	
A_C	110	Counselling and emotional support	1	2	3	4	
A_C	111	Family Planning Services	1	2	3	4	
	112	Reproductive Health and general services (Screening for STIs)					
		2.2 REFERRAL AND EMERGENCY SERVICES					
	113	Referral system in place for PAC complications	YES .....1 (if yes, specify: .....) NO 2				
	114	Availability of ambulance or emergency transport	YES .....1 (if yes, specify: .....) NO 2				

	115	Linkage with higher-level facilities	YES .....1 (if yes, specify: .....) NO 2	
		3 HUMAN RESOURCE		
	116	Do providers in this facility diagnose, prescribe treatment for, or manage patients with post abortion complications	YES .....1 (if yes, specify: .....) NO 2	
		3.1. Number of staff trained in PAC in the last 2 years		
R_C	117 (a)	Nurses/midwives	YES .....1 (if yes, specify numbers.....) NO 2	
	117 (b)	Clinical officers	YES .....1 (if yes, specify numbers.....) NO 2	
	117 (c)	Doctors	YES .....1 (if yes, specify numbers.....) NO 2	
		3.2 Availability of staff trained in:		
	118 (a)	MVA	YES..... .1	

			NO 2	
	118 (b)	Misoprostol use	YES.....1 NO 2	
	118 (c)	Infection prevention	YES.....1 NO 2	
	118 (d)	Counselling and psychosocial support	YES.....1 NO 2	
		4. INFRASTRUCTURE AND INFECTION PREVENTION		
R_C	119 (a)	Does the Facility Have a Dedicated PAC room or space	YES.....1 (if yes, specify if integrated.....) NO 2	
R_C	119 (b)	Privacy ensured during PAC (visual and auditory)	YES.....1 NO 2	
	119 (c)	Running water	YES.....1 NO 2	
	119 (d)	Handwashing station	YES.....1 NO 2	
	119 (e)	Waste disposal system (sharps, biohazard)	YES.....1	

			NO 2	
		5. EQUIPMENT AND SUPPLIES		
		Are the following supplies available?		
	120 (a)	MVA kits (complete and functional)	YES.....1 NO 2	
	120 (b)	Sterile gloves	YES.....1 NO 2	
	120 (c)	Speculum	YES.....1 NO 2	
	120 (d)	Misoprostol tablets	YES.....1 NO 2	
	120 (e)	IV fluids	YES.....1 NO 2	
	120 (f)	Antibiotics	YES.....1 NO 2	
	120 (g)	Pain management drugs	YES.....1	

			NO 2	
	120 (h)	Stock-outs in the last 3 months (Yes/No, specify)	YES.....1 NO .....2 Specify	
		DOCUMENTATION AND DATA SYSTEMS		
		Use of PAC registers or integrated RH registers		
	121 (a)	Is there a register or database for PAC/patients with abortion complications/ IF YES, ASK TO SEE THE REGISTER.	YES, START AND OUTCOMES/COMPLIANCE INFORMATION RECORDED .....1 YES, START RECORDED.....2 NO.....3	
	121 (b)		YES, REGISTER/SCHEDULE OBSERVED .....1 YES, REPORTED, NO REGISTER/SCHEDULE SEEN.... .....2 NO 3	
	121 (c)	Reporting PAC data to KHIS/DHIS2/ Taifa Care/ Tibabu/ EMR	YES.....1 If yes specify..... NO 2	
	121 (d)	Disaggregation by age, method, complications, referrals	YES.....1 NO 2	

		EQUITY AND INCLUSION		
		Are Services available for		
M_C	122 (a)	Adolescents	YES .....1 (if yes, specify: .....) NO 2	
	122 (b)	Persons with Disability	YES .....1 (if yes, specify: .....) NO 2	
	122 (c)	Survivors of Gender based Violence	YES .....1 (if yes, specify: .....) NO 2	

SECTION J: OBSERVATIONAL CHECKLIST

- Observe PAC room setup/facility infrastructure for provision of PAC services
- Check availability and condition of MVA kits
- Review PAC register entries (last 3 months)
- Confirm availability of contraceptives

Interviewer's Notes: Include additional observations listed above

Supervisors Notes:

Adopted from: Harmonized health facility assessment (HHFA): Combined questionnaire Core. ©World Health Organization. 2021

Key Informant Guide – National MOH

Kaleidoscope Baseline and Scoping Study

Key Informant Interview Guide - National Level

Target Respondents: Senior MOH Officials (RH, Planning, M&E)

Background & Consent

I am Mr./Ms./_____, and I am part of the team conducting a baseline and scoping study for the Kaleidoscope Project. The study is commissioned by the Ministry of Health (MOH) in partnership with TICAH and consortium partners (K-MET, RHNK, Zamara Foundation, ADS-Nyanza, SRHR Alliance). The Kaleidoscope Project aims to achieve zero preventable maternal deaths due to abortion complications and contribute to reduction of maternal mortality rate in Kenya, by increasing access to accurate information on safe abortion, quality post-abortion care (PAC), and comprehensive sexual and reproductive health rights (SRHR) services.

The primary objective of this study is to conduct a comprehensive baseline and scoping study to assess the policy, systems, and service delivery landscape for Post-Abortion Care (PAC) and abortion complication management in Kwale, Samburu, Kilifi, and West Pokot counties.

You have been selected to participate in the study as a key informant who can provide valuable information that will contribute towards the scoping study. Your participation in this study is voluntary. If you choose to participate, you will be asked to sign a consent form. Even after signing the consent form, you are still free to withdraw at any time without giving any reason.

The interview is expected to take at least 1 hour or less.

If you agree to participate in the study, then I can proceed and administer the consent form before proceeding with the interview.

SECTION A: POLICY AND STRATEGIC DIRECTION

1. What is the current national policy on post-abortion care (PAC)? **Probe:** Is PAC integrated into broader reproductive health or maternal health strategies? Are there legal or regulatory constraints?
2. What are the MOH's strategic priorities for PAC service delivery? **Probe:** Are there specific goals for geographic coverage, adolescent access, or integration with family planning?
3. How does the MOH define essential PAC services across facility levels? **Probe:** Are there standardized service packages for primary, secondary, and tertiary facilities?

SECTION B: SERVICE AVAILABILITY AND READINESS

1. What criteria are used to determine which facilities should offer PAC services? **Probe:** Is this based on catchment population, facility level, or burden of unsafe abortion?
2. Are there national standards or guidelines for PAC service readiness? **Probe:** What are the minimum requirements in terms of staffing, equipment, and infrastructure?
3. How does the MOH monitor the availability and functionality of PAC services? ***Probe:*** *Is there a facility mapping system or readiness scorecard in use?*

SECTION C: HUMAN RESOURCES AND TRAINING

4. What is the MOH's approach to training health workers in PAC? What areas need improvement? *Probe: Are there pre-service and in-service training modules? Is task-shifting permitted?*
5. Are there certification or supervision mechanisms for PAC providers? Probe: How is competency assessed and maintained? Is mentorship part of the strategy?
6. What challenges exist in maintaining PAC-related skills across facility levels? *Probe: Are there gaps in rural areas or among lower cadres?*

SECTION D: COMMODITIES AND SUPPLY CHAIN

7. How are PAC-related commodities procured and distributed nationally? Probe: Are MVA kits, misoprostol, and infection prevention supplies part of the essential medicines list?
8. What systems are in place to monitor stockouts or supply disruptions? Probe: Is PAC integrated into the national LMIS? Are emergency procurement protocols available?
9. Are there known bottlenecks in the PAC commodity supply chain? Probe: Are delays due to funding, forecasting, or distribution logistics?

SECTION E: FINANCING AND RESOURCES

10. How are PAC services currently financed and budgeted at both county and national level?

Probe: Proportion of allocation in health budgets; government financing vs development partners; ring fencing of funds, whether financing is purely

11. How would you describe the adequacy and predictability of funding for PAC/CAC services?

Probe: Tracking and reporting of PAC/CAC services within national/ county budgets.

12. What challenges or opportunities exist to improve resource mobilization and financial sustainability of PAC/CAC services?

Probe: Mechanisms for government engagement on budgeting; Potential development partners

SECTION F: DATA, MONITORING, AND EVALUATION

13. How is PAC service data captured and reported at the national level?
    Probe: Are PAC indicators integrated into DHIS2 or other national platforms?
14. What challenges exist in collecting accurate PAC data?
    Probe: Are there issues with underreporting, stigma, or private sector data gaps?
15. How is PAC data used for decision-making and planning?
    Probe: Is it used for budgeting, training needs, or facility upgrades?

SECTION G: STAKEHOLDER ENGAGEMENT AND EQUITY

16. How does the MOH engage communities and stakeholders in PAC policy and planning?
    Probe: Are youth, CSOs, and marginalized groups consulted? What platforms are used?
17. What strategies are in place to ensure equitable access to PAC services?
    Probe: Are there fee waivers, outreach programs, or adolescent-friendly services?
18. Are there partnerships supporting PAC service delivery or assessments?
    Probe: Which donors or NGOs are involved, and how are their roles coordinated?

Any recommendations for improving PAC/Post Abortion Complications management services

Key Informant Interview Guide – County Level

Target Respondents: County Directors of Health, Reproductive Health Coordinators, Health Records Officers, Facility Managers, and County Health Management Team (CHMT) members.

Background & Consent

I am Mr./Ms./_____, and I am part of the team conducting a baseline and scoping study for the Kaleidoscope Project. The study is commissioned by the Ministry of Health (MOH) in partnership with TICAH and consortium partners (K-MET, RHNK, Zamara Foundation, ADS-Nyanza, SRHR Alliance). The Kaleidoscope Project aims to achieve zero preventable maternal deaths due to abortion complications and contribute to reduction of maternal mortality rate in Kenya, by increasing access to accurate information on safe abortion, quality post-abortion care (PAC), and comprehensive sexual and reproductive health rights (SRHR) services.

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You have been selected to participate in the study as a key informant who can provide valuable information that will contribute towards the scoping study. Your participation in this study is voluntary. If you choose to participate, you will be asked to sign a consent form. Even after signing the consent form, you are still free to withdraw at any time without giving any reason.

The interview is expected to take at least 1 hour or less.

If you agree to participate in the study, then I can proceed and administer the consent form before proceeding with the interview.

SECTION A: STRATEGIC AND POLICY CONTEXT

1. How is post-abortion care prioritized within your county's reproductive health strategy? Probe: Is PAC integrated into RMNCAH, UHC, or adolescent health plans?
2. What policies or guidelines currently guide PAC service delivery in your county? Probe: Use of national PAC protocols, county-level adaptations, and dissemination efforts.
3. How does the county monitor and report PAC-related indicators? Probe: Use of KHIS/DHIS2, disaggregation by age, method, complications.

SECTION B: SERVICE DELIVERY AND FACILITY READINESS

1. What types of facilities currently offer PAC services in your county? *Probe: Public vs private, levels of care, geographic distribution.*
2. What are the main challenges facilities face in delivering quality PAC services? *Probe: Equipment, staffing, training, stock-outs, stigma.*

3. Are there any recent efforts to expand or improve PAC services?
   Probe: Training programs, mentorship, infrastructure upgrades.

SECTION C: HUMAN RESOURCES AND CAPACITY

4. Do facilities have staff trained in PAC procedures and counseling?
   Probe: MVA, misoprostol, infection prevention, adolescent-friendly care.
5. What mechanisms exist for continuous professional development in PAC?
   Probe: On-the-job training, county-led mentorship, external partnerships.

SECTION D: EQUITY, ACCESS, AND COMMUNITY ENGAGEMENT

6. How accessible are PAC services to adolescents, rural populations, and marginalized groups?
   Probe: Outreach, referral systems, fee structures, cultural barriers.
7. What role do community health volunteers (CHVs) or local leaders play in PAC awareness or referrals?
   Probe: Linkages, stigma reduction, health education.

SECTION E: DATA USE AND DECISION-MAKING

8. How is PAC data used to inform planning, budgeting, or service improvement?
   Probe: Feedback loops, quarterly reviews, integration with RMNCAH dashboards.
9. What gaps exist in PAC data collection or reporting?
   Probe: Completeness, accuracy, timeliness, facility-level challenges.

SECTION E: FINANCING AND RESOURCES

10. How are PAC services currently financed and budgeted at both county and national level?

Probe: Proportion of allocation in health budgets; government financing vs development partners; ring fencing of funds

11. How would you describe the adequacy and predictability of funding for PAC/CAC services?

Probe: Tracking and reporting of PAC/CAC services within county budgets.

12. What challenges or opportunities exist to improve resource mobilization and financial sustainability of PAC/CAC services?

Probe: Mechanisms for government engagement on budgeting

SECTION F: INNOVATIONS AND OPPORTUNITIES

13. Are there any innovative models or partnerships supporting PAC in your county?
    Probe: NGO collaborations, digital tools, youth-friendly centers.
14. What opportunities do you see for strengthening PAC services in the next 1–2 years?
    Probe: Policy shifts, funding, training, community engagement.

SECTION G: REFLECTIONS AND RECOMMENDATIONS

15. What would you recommend to national stakeholders to better support counties in delivering PAC?
    Probe: Policy, financing, capacity-building, monitoring.

FGD GUIDE - COMMUNITY HEALTH PROMOTERS

Introduction

Purpose: To understand CHWs' experiences, perceptions, and roles in supporting PAC services at the community level, and to identify gaps in service delivery, referral systems, and community engagement.

Participants: 6–10 CHWs per session, (Representing different wards)

Duration: 60–90 minutes

- Facilitator Materials: Consent forms, note-taking sheets, audio recorder
- Opening and Consent (10 min)
- Welcome and introductions
- Purpose of the discussion
- Confidentiality and voluntary participation
- Consent to participate and record

Background & Consent

I am Mr./Ms./_____, and I am part of the team conducting a baseline and scoping study for the Kaleidoscope Project. The study is commissioned by the Ministry of Health (MOH) in partnership with TICAH and consortium partners (K-MET, RHNK, Zamara Foundation, ADS-Nyanza, SRHR Alliance). The Kaleidoscope Project aims to achieve zero preventable maternal deaths due to abortion complications and contribute to reduction of maternal mortality rate in Kenya, by increasing access to accurate information on safe abortion, quality post-abortion care (PAC), and comprehensive sexual and reproductive health rights (SRHR) services.

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You have been selected to participate in this Focus Group Discussion because you can provide valuable information that will contribute towards the scoping study. Your participation in this study is voluntary. If you choose to participate, you will be asked to sign a consent form. Even after signing the consent form, you are still free to withdraw at any time without giving any reason.

The interview is expected to take at least 1 hour or less.

If you agree to participate in the study, then I can proceed and administer the consent form before proceeding with the interview.

SECTION 1: AWARENESS AND UNDERSTANDING OF PAC

1. What do you understand by post-abortion care (PAC)?
   Probe: What services are included? Who provides them?
2. Are PAC services available in your catchment area?
   Probe: Which facilities offer them? Are they public or private?
3. How do community members perceive PAC services?
   Probe: Is there stigma? Are services accepted or avoided?

SECTION 2: REFERRAL AND LINKAGES

4. Have you ever referred someone for PAC services?
   Probe: What was the reason? Where did you refer them?
5. What challenges do you face when referring clients for PAC?
   Probe: Transport, facility readiness, client resistance?
6. Are there clear protocols or tools for PAC referrals?
   Probe: Referral forms, registers, feedback mechanisms?

SECTION 3: KNOWLEDGE AND TRAINING

7. Have you received any training on PAC or related topics?
   Probe: Who provided it? What did it cover?
8. Do you feel confident identifying PAC needs in the community?
   Probe: What signs or symptoms do you look for?
9. What additional training or support would help you in this role?
   Probe: Clinical knowledge, counseling, referral systems?

SECTION 4: BARRIERS AND COMMUNITY REALITIES

10. What barriers do women face in accessing PAC services?
    Probe: Cost, distance, stigma, lack of information.
11. Are there specific groups who struggle more to access PAC?
    Probe: Adolescents, unmarried women, rural populations.
12. How do cultural or religious beliefs affect PAC service uptake?
    Probe: Are there taboos or misinformation.

SECTION 5: CHW ROLE AND RECOMMENDATIONS

13. What role do CHWs play in supporting PAC services?
    Probe: Education, referral, follow-up, counseling?

14. What would help you better support PAC in your community? *Probe: Tools, supervision, community dialogues?*
15. What recommendations do you have for improving PAC services? Probe: Facility readiness, community engagement, policy support?
16. Final thoughts or questions?

Appreciation and next steps

- County profiles
- Ethical approval documentation
- References