



The Kaleidoscope Initiative

Reclaiming Sexual And Reproductive Health And Rights And Justice For All

Management of Post-Abortion Complications

Scoping Study Summary



01. CONTEXT AND PURPOSE

Post-Abortion Care (PAC) is a lifesaving intervention and an essential pillar of Kenya’s Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) framework, legally permitted as emergency treatment for complications arising from miscarriage or unsafe abortion. Kenya’s maternal mortality rate stands at 355 deaths per 100,000 live births, with unsafe abortions a major contributor. The national abortion incidence rate is 57.3 per 1,000 women of reproductive age.

The Kaleidoscope Project, led by the Trust for Indigenous Culture and Health (TICAH) in partnership with the Ministry of Health, commissioned this scoping study to assess PAC service readiness, access, and quality across four priority counties: Kilifi, Kwale, Samburu, and West Pokot.

Study Objectives

- Assess the policy and legal environment for PAC at national and county levels
- Map service delivery capacity and identify gaps affecting access to PAC
- Analyse workforce readiness and provider attitudes toward PAC clients
- Evaluate health information systems and identify PAC reporting gaps
- Map key stakeholders for PAC implementation across the four counties



02. METHODOLOGY

The study was conducted between September and December 2024 using a mixed-methods cross-sectional design. Quantitative facility assessments measured infrastructure, workforce capacity, commodity availability, and financing mechanisms. Qualitative interviews and focus group discussions explored provider perceptions, barriers to access, and community dynamics.

42

Health Facilities Assessed

62

Key Informant Interviews

4

Focus Group Discussions (CHPs)

4

Counties Covered

Facility Type	Number 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%)
Public Facilities	39 (93%)
Rural Facilities	19 (45%)



3. PAC UTILIZATION TRENDS (KENYA, 2020-2025)

National KHIS data shows an upward trend in PAC service utilization over five years, peaking at 43,646 cases in 2023-24 before declining to 39,298 in 2024-25. The average annual PAC caseload nationally is approximately 39,510. Adolescent (10-19) utilization declined steadily from 6,816 to 4,516, suggesting reduced access or undercounting. In the four study counties, Kilifi consistently recorded the highest caseloads across all age groups.

Age Group	2020-21	2021-22	2022-23	2023-24	2024-25
Adolescents (10-19 yrs)	6,816	5,658	5,369	5,090	4,516
Youth (20-24 yrs)	8,766	14,051	14,042	14,073	12,274
Adults (25+ yrs)	13,343	22,715	23,846	24,483	22,508
TOTAL	28,925	42,424	43,257	43,646	39,298



04. KEY FINDINGS

4.1 Policy and Legal Environment

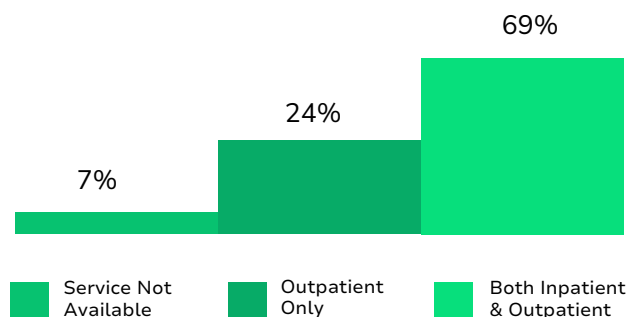
Kenya’s legal framework for PAC is grounded in the Constitution (2010) and the Reproductive Health Policy (2022-2032). PAC is constitutionally mandated as emergency treatment. However, the ongoing conflation of PAC with comprehensive abortion care (CAC) at the frontline generates provider fear, hesitancy, and inconsistent implementation.

- National PAC guidelines and SOPs exist but dissemination to frontline facilities is irregular and largely partner-dependent
- Samburu and Kwale conducted their first structured dissemination of PAC quality standards in 2024, supported by the Kaleidoscope Project
- None of the four counties has a county-specific PAC policy; all rely on national frameworks
- A 2025 High Court ruling reinforced constitutional protections for women, reducing legal ambiguity for providers

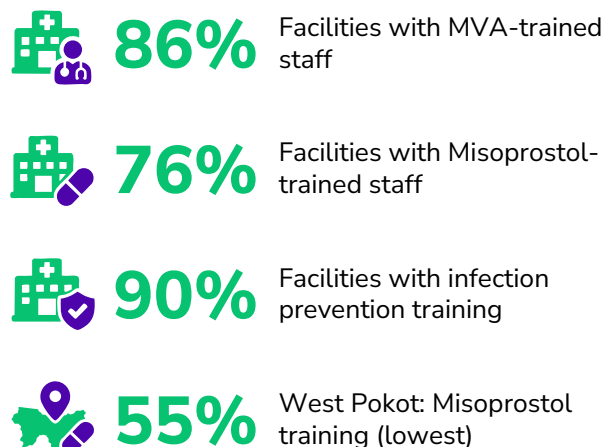
4.2 Service Availability

PAC services are broadly available across facilities, but readiness is heavily stratified by facility level. Level 4 and 5 facilities demonstrate strong capacity; Level 2 and 3 facilities face critical gaps in staffing, commodities, and infrastructure, creating referral bottlenecks that disproportionately affect rural women.

Emergency PAC Service Mode Across All 42 Facilities



4.3 Workforce Readiness and Training



Despite these headline figures, PAC capacity is not institutionalized, it depends on one or two trained individuals per facility. In Samburu, only 15 healthcare workers were trained through partner support across the entire county. VCAT (Values Clarification and Attitude Transformation) training is limited and uneven, leaving providers in West Pokot, Kilifi, and Kwale to act on personal religious or cultural beliefs that compromise care quality, particularly for adolescents.

- Community Health Promoters (CHPs) play a critical frontline role in referrals but lack formal PAC training protocols
- CHPs in all four counties routinely use personal funds to cover emergency transport for clients — an unsustainable practice

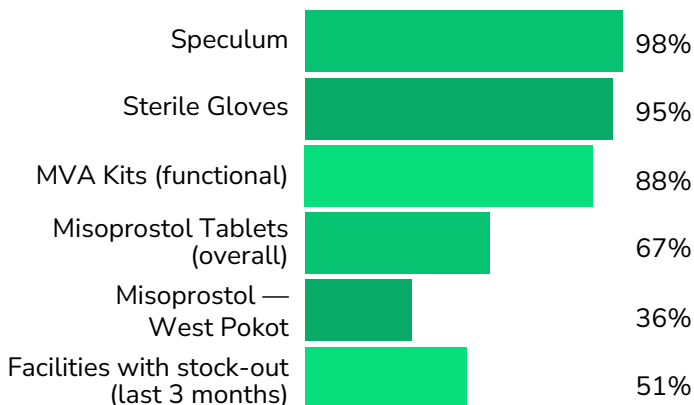
4.4 Infrastructure

Infrastructure Indicator	Availability (% of 42 Facilities)
Dedicated PAC room	36% overall (Kwale & Samburu: 50%; West Pokot: 18%)
Privacy ensured (visual & auditory)	72%
Running water	71% (Kilifi: 100%; West Pokot: 27%)
Handwashing station	89%
Waste disposal (sharps/ biohazard)	95%

In the absence of dedicated PAC spaces, procedures are performed in shared maternity wards, compromising confidentiality and causing psychological distress, especially for adolescents. Even in facilities with water access, plumbing rarely reaches the PAC procedure room, requiring manual water transport.

4.5 Equipment and Commodities

Key PAC Commodity Availability (% of Facilities, n=42)



Misoprostol had the lowest availability at 67% nationally and just 36% in West Pokot. Over half of all facilities (51%) reported a commodity stock-out in the previous three months, with providers frequently directing patients to purchase drugs externally. MVA kit wear-and-tear and sterilisation bottlenecks further disrupted service delivery.

4.6 Health Information Systems

HIS Indicator	Finding
Facilities reporting PAC data to national systems (KHIS/DHIS2)	71% overall; West Pokot: 18%
Facilities with PAC registers capturing both stats and outcomes	43%
Facilities with no PAC register at all	37%
Facilities disaggregating data by age, method and complications	64% overall; West Pokot: 27%

PAC data is reported through national systems in most counties, but quality and consistency vary significantly. West Pokot shows the most critical data gaps across all indicators. Age-disaggregated data, essential for identifying adolescent needs, is absent in most lower-level facilities. PAC is rarely reviewed in county data meetings, reducing its utility for programming decisions.

4.7 Financing

PAC financing is embedded within broader RMNCAH budgets with no ring-fenced budget lines at county or facility level, making PAC expenditures financially invisible. Funding is inadequate and unpredictable, relying on a hybrid of government insurance (SHA/SHIF), partner support, and out-of-pocket payments.

- SHA/SHIF reimbursements are delayed and do not consistently cover PAC procedures, diagnostics, or emergency interventions
- Adolescents and uninsured women bear the greatest financial burden; informal waivers exist but are unsustainable
- Partner support for commodities is time-bound, creating service disruption risks when donor priorities shift
- Outstanding county payments to KEMSA contribute directly to recurrent PAC commodity stock-outs



05. CONCLUSIONS

Kenya has a supportive national framework for PAC, yet significant gaps persist between policy and practice. PAC services remain concentrated at higher-level facilities, leaving primary-care networks underprepared and forcing reliance on emergency referral chains, disproportionately affecting rural women, adolescents, and economically vulnerable populations.

Service readiness is constrained not primarily by infrastructure, but by human resource capacity and attitudes. Limited VCAT training and provider stigma represent a fundamental barrier to equitable, rights-based PAC delivery. Community Health Promoters, while critical, remain structurally under-supported. Weak data systems and invisible PAC financing further undermine accountability and sustainability.



06. PRIORITY RECOMMENDATIONS

Area	Priority Actions
Policy & Legal	Harmonize PAC guidelines with County Development Plans; clarify PAC/CAC legal distinction to reduce provider fear; institutionalize PAC indicators in performance contracts; establish dedicated PAC budget lines
Service Delivery	Expand PAC to all facility tiers; ensure dedicated PAC rooms in Level 3-5 facilities; integrate post-PAC family planning as standard of care; strengthen referral pathways with harmonized tools
Workforce	Scale up health worker training on updated PAC guidelines; roll out VCAT for all cadres; embed PAC in nursing pre-service curricula; establish county mentorship networks; formalize CHP roles in PAC referral
Commodities	Integrate misoprostol and MVA kits into KEMSA procurement and LMIS; address county billing arrears; standardize emergency procurement protocols for PAC supplies
Health Data	Distribute standardized PAC registers nationwide; digitize records and integrate into KHIS/DHIS2; ensure age-disaggregated reporting; conduct quarterly county-level data reviews
Financing & Equity	Advocate for ring-fenced PAC budget lines; expand SHA/SHIF coverage for PAC procedures; implement formal adolescent fee waiver mechanisms; leverage Kaleidoscope and Pamoja consortia for sustained advocacy

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Conducted by: Trust for Indigenous Culture and Health (TICAH) in partnership with the Ministry of Health, Kenya

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