KENYA

PAC-FP COUNTRY BRIEF

Postabortion care (PAC) provides a comprehensive approach to preventing morbidity and mortality caused by abortion complications (PAC Consortium, 2014). As per the U.S. Agency for International Development (USAID) PAC model, a critical component of PAC is providing access to family planning (FP) counseling and services. Providing these services helps meet the reproductive intentions of women who most clearly demonstrate an unmet need for FP, reduces unintended pregnancies, and prevents repeat abortions, thus reducing maternal deaths (Curtis, Huber, and Moss-Knight, 2010). The information below highlights the Republic of Kenya's investment in providing PAC and FP services to women in need.

POLICIES, LEADERSHIP, AND GOVERNANCE

The Republic of Kenya's national family planning (FP) and reproductive health (RH) policy is outlined in a number of documents, including the 2010 Kenyan Constitution, the National Roadmap for Accelerating Attainment of the Millennium Development Goals Related to Maternal and Newborn Health in Kenya (2010), the Reproductive, Maternal, Newborn, Child, and Adolescent Health Investment Framework (2016), and the Health Sector Strategic Plan (2006). The latter document deemed postabortion care (PAC) an essential service that should be provided in five of the six levels of public health facilities throughout Kenya (Center for Reproductive Rights, 2010).

The National Road Map, which includes PAC, is revised every three to five years. The Ministry of Health's Reproductive and Maternal Health Services Unit coordinates FP/RH at all health facilities, while the National Council for Population and Development in the Ministry of Devolution and National Planning coordinates public-sector policies as a national development agenda.

Legal Status on Abortion

Kenya's 2008 Penal Code states that abortion is illegal except to save the life of the woman. Kenya's 2010 constitution updated these legal terms to permit abortion when, in the opinion of a trained health professional, it is a necessary part of emergency treatment, if the life of the woman is in danger, or if it is permissible under another written law (National Council for Law Reporting, 2009).

PAC TRAINING AND STANDARDS

Kenya's National Postabortion Care Curriculum for Service Providers (2002) provides clinical guidelines for PAC and aims to standardize PAC training for service providers. The Ministry of Health supported development of this curriculum following its decision to allow nurses and clinical officers to receive PAC training, with specific emphasis on manual vacuum aspiration. Previously, only medical doctors received this training (Ministry of Health, 2002). The Nursing Council of Kenya further approved training of PAC service delivery by nurse-midwives in private practice (Extending Service Delivery Project, 2007).

PAC·FP THE POSTABORTION CARE FAMILY PLANNING PROJECT
Expanding contraceptive methods and informed choice to PAC clients

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STRENGTHENING SERVICE DELIVERY

Since 2012, Kenya has undergone a political transition where health functions have been devolved to county governments. While this has enabled health managers to be more directly involved in formulating health priorities, the national government continues to provide resources via the Health Sector Services Fund (FP 2020, 2016).

The primary method to treat incomplete abortion in Kenya used to be manual vacuum aspiration; however, the country introduced the use of misoprostol for PAC in 2008. Misoprostol for PAC provides women and providers with safe and cost-effective measures for PAC treatment where supplies and providers are limited. A pilot program implemented in 2009 in five health facilities (including a teaching hospital, a medical center, two district hospitals, and a nursing home) demonstrated effectiveness of misoprostol introduction for PAC and patient and provider satisfaction (Mulama and Mwanzo, 2010).

At the community level, international organizations are supporting PAC service delivery strengthening. For example, in partnership with Kenya's Ministry of Health and with funding from the U.S. Agency for International Development (USAID), EngenderHealth implemented the Community Mobilization for Postabortion Care (COMMPAC) project entitled in Kenya's Nakuru District from 2008 to 2014. Through COMMPAC, providers at lower-level health facilities (e.g., dispensaries) received PAC training. The project also enhanced women's knowledge and awareness of PAC and increased health-seeking behavior for PAC at the dispensary and community levels (RamaRao et al., 2013).

BARRIERS TO PAC

Women in Kenya face multiple barriers to accessing PAC and FP services. The sociocultural environment is a particular challenge to PAC and FP utilization. Many women encounter objections to FP use from their in-laws, husbands, and religious leaders in (RamaRao and Van Lith, 2013) and PAC is highly stigmatized for women accessing care and service providers.

In addition to demand challenges, the provision of PAC is also difficult. While Kenya is working toward increasing the number of health providers available to deliver PAC, there remains a shortage of adequately trained providers as well as a lack of essential PAC equipment (including manual vacuum aspirators) in facilities (Egesa et al., 2016; Osur et al., 2013).

FINANCING MECHANISMS

Kenya's national health insurance plan covers PAC only if the woman is a member of the National Health Insurance Fund. This includes FP for postpartum and postabortion women.

While the Kenyan national government budget for FP increased from $6 million to $8 million from 2011 to 2013 and budget allocations for FP commodities grew from $2.5 million to $6.6 million from 2005 to 2013, the majority of PAC services are only available through a private-sector midwife networks. This reduces access as the majority of women are unable to afford services provided by the private sector.

KENYA		Year	Source
Demographic/background indicators			
Country population	49,700,000	2017	World Bank[1]
Total fertility rate	3.9	2016	
Age at first birth	20.3	2014	Demographic and Health Survey, 2014
Maternal mortality per 100,000 live births	362		
Newborn mortality per 1,000 live births	22		
Infant mortality per 1,000 live births	39		
Under-five child mortality per 1,000 live births	52		
Facility-based deliveries	61%		
Proportion of women who attended at least one antenatal visit during their last pregnancy	96%		
Proportion of women who received a postnatal check within two days of live delivery	53%		
Abortion and FP-related indicators			
Number of abortions	464,960	2012	Guttmacher Institute, 2013
Abortions per 1,000 women	48		
Number of unintended pregnancies	956,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of women treated for complications related to induced and spontaneous abortions	157,762	2012	Guttmacher Institute, 2013
Number of unintended pregnancies averted due to use of modern contraceptive methods	2,095,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of unsafe abortions averted due to use of modern contraceptive methods	461,000		
Number of maternal deaths averted due to use of modern contraceptive methods	7,800		
Modern method contraceptive prevalence rate, all women of reproductive age (WRA)	42.7 %		
Knowledge of FP, all WRA	98.0%	2014	Demographic and Health Survey, 2014
Contraceptive use by type		2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Long-acting and permanent methods			
Sterilization (female)	5.6%		
Sterilization (male)	0.0%		
Intrauterine device	5.9%		
Implant	18.2%		
Short-acting methods		2017–18	
Injection (intramuscular and subcutaneous)	47.9%		
Pill	14.1%		
Condom (male)	7.9%		
Condom (female)	0.0%		
Other modern methods (e.g., cycle beads, and lactational amenorrhea method)	0.3%		
Unmet need for FP[2] (2018)	18%	2014	Demographic and Health Survey, 2014
Unmet need for spacing	10.0%		
Unmet need for limiting	8.0%		
Percentage of all women who received FP information during their last visit with a health service provider	28.4%	2017	PMA2020, R6

[1] https://data.worldbank.org/indicator/SP.DYN.TFRT.IN

[2] Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report either not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior.

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