CHIEF CONSPIRATORS IN UNSAFE ABORTION AND MATERNAL DEATHS IN KENYA

THE ROLE OF EXISTING LAWS AND POLICIES, HEALTH SYSTEMS AND DUTY BEARERS

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ACKNOWLEDGEMENTS

The Kenya Medical Association (KMA) wishes to acknowledge the technical and financial assistance extended to the organization by the Planned Parenthood Global Africa Regional Office (PP Global ARO) in the whole process of undertaking this study. Our sincere gratitude goes to all PP Global ARO staff for their time and facilitation. We especially thank Muthoni Ndung'u, Mitchelle Kimathi, Martin Onyango and Nerima Were for their contribution during conceptualization and review of the study and report.

We sincerely appreciate the following organizations: Center for Reproductive Rights, Kenya Obstetrical and Gynaecological Society (KOGS), International Planned Parenthood Federation Africa Region (IPPF-AR) and KELIN whose expertise and dedication contributed to making this study a success. Our appreciation goes to all technical staff of these organizations without whose contribution this initiative would not have been possible. Research conducted by the African Population and Health Research Center (APHRC) formed the bulk of the references used in this review.

Special thanks to our team of experts: Dr. Carol Odula-Obonyo, Prof. Stephen Olus Okeyo, Dr. Elizabeth Gitau-Maina, Julia Kosgei, Maria Tororey and Wangari Ireri for their technical support and contribution. Your invaluable technical input and unwavering support for this study are highly appreciated.

Finally, to the KMA staff who supported this study, keep up with the good spirit.

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FOREWORD

The KMA is the representative and umbrella professional society for Medical and Dental Practitioners in Kenya, with the twin mandate of advocating for the Welfare of Doctors and ensuring provision of the highest attainable standard of healthcare to Kenyans. KMA operates under thematic committees that include the Reproductive Health Committee (RHC) that envisions a Kenya where all women enjoy and access sexual and reproductive health and rights (SRHR) to the fullest extent possible as envisioned and enshrined in the laws. The committee's mission is to advocate for and ensure that policies, services, information and research on SRHR are people friendly and equitable to all irrespective of gender, age, social, cultural, religious and or economic class diversity.

According to a research carried out by the African Population and Health Research Center (APHRC) in collaboration with the Ministry of Health, on average, to treat a woman for complications from unsafe abortions requires 7.4 hours of health care personnel time. The average cost of a typical treatment was Kshs. 4,943 (approx. USD 5). In 2012, the treatment of unsafe abortions complications cost the public health system a total of Kshs. 432.7 million (approx. US$ 4.3 million) in health personnel salaries and medical supplies. In a 2013 report, 464,690 induced abortions occurred annually in Kenya, corresponding to an induced abortion rate of 48 abortions per 1000 women of reproductive age (15-49 years), and an induced abortion ratio of 30 abortions per 100 births. It also estimated that 157,762 women received care for complications of induced and spontaneous abortion in health facilities every year; 119,912 of who experienced complications from induced abortions.

There is need for all relevant laws and policies related to abortion services to be mapped out and their implementation status assessed. Where relevant, these laws and policies should be accelerated as per medical and legal requirements. "Chief Conspirators in Unsafe Abortion and Maternal Deaths in Kenya: The Role of Existing Laws and Policies, Health Systems and Duty Bearers" is a comprehensive and critical review and analysis of most relevant published and/or publicly available documents. The published and grey literature are drawn from research findings, meeting reports, government documents, regional and international conventions and declarations, charters, policy or strategic frameworks, statutes and judicial rulings that are related to abortion and unsafe abortion in Kenya. In the findings, the review notes a glaring legal provisions and implementation gap in the provision, and indeed in the access and utilization of sexual and reproductive health services by women and girls in Kenya. The restrictive legal environment that currently obtains in Kenya only serves to consign more women who require abortions to procure unsafe abortions from untrained providers in unclean environments. As a result, women and girls in Kenya continue to die and suffer irreparable emotional and physical damages resulting from complications of unsafe abortion. Yet, this need not be the case!

This report recommends that Kenya adopts and implements comprehensive abortion care while guaranteeing access to sexual and reproductive health services for all women and girls. By so doing, the country will address the high burden of maternal mortality, morbidity. Duty bearers and key actors, starting with the office of the Attorney General, the Ministry of Health, and the Kenya Medical Association are reminded to take stock and re-evaluate their roles in ensuring that women and girls in Kenya are guaranteed their sexual and reproductive health and rights, including access to safe and legal abortion services to the extent permitted by the Kenyan laws.

Dr. Onyino Were,

Hon. President, Kenya Medical Association

LIST OF ABBREVIATIONS AND ACRONYMS

APHRC	African Population and Health Research Centre
AU	African Union
AYF	Adolescent and Youth Friendly
CAC	Comprehensive Abortion Care
CEDAW	Convention/Committee on the Elimination of all Forms of Discrimination Against Women
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organization
D&C	Dilatation and Curettage
E/MVA	Electrical/Manual Vacuum Aspiration
FIGO	International Federation of Gynaecology and Obstetrics
FP	Family Planning
ICCPR	International Covenant on Civil and Political Rights
ICPD	International Conference on Population and Development
KMA	Kenya Medical Association
KOGS	Kenya Obstetrical and Gynaecological Society
LARC	Long-Acting Reversible Contraception
LMICs	Low- And Middle- Income Countries
MDGs	Millennium Development Goals
MPAC	Misoprostol for Post Abortion Care
NGO	Non-Governmental Organization
PAC	Post Abortion Care
PAFPC	Post Abortion Family Planning Counselling
SDGs	Sustainable Development Goals
SRHR	Sexual, Reproductive Health and Rights
SSA	Sub-Saharan Africa
UA	Unsafe Abortion
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organization

EXECUTIVE SUMMARY

Abortion fatality rates are relatively high in Kenya compared to other countries in sub-Saharan Africa partly due to the restrictive abortion laws, a key determinant of unsafe abortions. Nearly half a million induced abortions occur annually in the country, with over three quarters of these abortions resulting in moderate or severe complications [1]. Consequently, unsafe abortion is a significant health concern due to the large proportion of maternal deaths arising from the practice, and the catastrophic costs of management to individuals, their families and to the health care system. This review set out to identify the role played (or not played) by various duty bearers in promoting and protecting the rights of women and girls in adequately accessing and utilizing [quality] sexual reproductive and health services. The review also assessed the influence of the legal environment, and the extant laws and policies together with the health care systems in Kenya on the burden of unsafe abortions and the high maternal deaths in Kenya. Consequently, this report proposes adoption and full implementation of comprehensive abortion care in enhancing the quality of abortion care in Kenya.

The review relies on a synthesis of literature and analysis of data from published and grey literature on the magnitude and incidence of unsafe abortion in Kenya, the cost of treating complications arising from unsafe abortions and the quality of abortion care/post abortion care available in Kenya.

Unsafe abortion, based on the WHO definition, refers to "a procedure for terminating a pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both" [2]. Globally, nearly half (45%) of all abortions are unsafe [3], with 97% of these occurring in Africa, Asia and Latin America. Worldwide, abortion accounts for up to 13% of all maternal mortalities, 12% within the sub-Saharan Africa and an estimated 20% within eastern Africa [4]. The high rates of abortion-related maternal mortalities in eastern Africa has mainly been attributed to restrictions in accessing safe abortion services. Ironically, these restrictions have been shown not to reduce the number of abortions, but rather, push women requiring abortion services to seek unsafe abortion procedures mostly from unskilled service providers and in environments that do not meet minimum clinical standards. The majority of women also perceive that the unsafe abortion clinics are cheaper than formal health facilities [5]. Other reasons for the high rates of unsafe abortion include: stigma and conscientious objection by health-care providers; and unnecessary requirements such as mandatory waiting periods, mandatory counselling, provision of misleading information, third-party authorization, and medically unnecessary tests that delay care [5 6].

Unsafe abortion leads to complications which require specialized care, treatment and long hospitalization periods. This increases the costs of treatment and care to the individual, to their families and ultimately affecting the country's economic productivity when individuals are hospitalized or are rendered unproductive due to complications and disability arising from unsafe abortions. In Kenya, treatment for a typical case of complications arising from unsafe abortion would on average require 7.4 hours of medical professionals to manage at a cost of Kshs. 4,943 to the health care system[7].

The quality and access to abortion care is dependent on several factors among them access to knowledge and information by women on utilization of such services and socio-cultural, economic and demographic factors of the women such as their age, education level, marital status and socio-economic status. In addition, health care system determinants such as type of health facility ownership, availability of obstetric and gynaecological services within the facilities and presence of specialized medical personnel contribute to quality of abortion care services available. The stigmatization of abortion is another hindrance for women seeking access to safe abortion. Stigma from health care workers is especially challenging as their stigma

mirrors societal perspectives that abortion is a sin, and consequently women in need of abortion services fear being judged, detained or reported to authorities for seeking abortion care. Interventions to improve the quality of abortion care identified by this research include the implementation of the national abortion guidelines in their totality as well as continuous training of health care workers on comprehensive abortion care, taking into consideration newer and safer technologies available for service quality improvement.

Laws, policies and guidelines governing abortion within the region and in Kenya have continued to evolve for the better over time, in an attempt to lessen restrictions and to decriminalize abortion. The Maputo Protocol to the African Charter on Human and People's Rights Article 14 (2) affirms the importance of safe abortion services. In addition, various international human rights bodies have argued that denial of safe abortion care violates a range of human rights including the right to life and health, right to be free from torture and cruelty as seen by the committee against torture especially in cases of rape, incest and other forms of sexual violence [8].

In Kenya the right to abortion is protected under Article 43(1) of the 2010 constitution guaranteeing the right to health including reproductive healthcare and Article 26 (4) that permits abortion when in the opinion of a trained health professional there is an emergency or the health or life of the woman is in danger or if permitted by any other written law. Despite the constitutional protection of access to abortion care in Kenya, the Kenyan penal code still criminalizes abortion, penalizing a woman who obtains an unlawful abortion or anyone who acts with the intent to unlawfully provide an abortion for any such a woman. The Penal code only allows abortion where it is performed by a doctor in good faith and with reasonable care for preservation of the mother's life[1].

The provisions of the Penal code have been used to ambush, threaten and harass healthcare providers who offer safe abortion services even when a woman qualifies, due to unclear guidance as to what constitutes the preservation of the woman's life or health. An example of a judicial ruling that upholds legal provisions for safe abortion is the JMM case of FIDA Kenya vs Attorney General where the judges ruled that the Ministry of Health violated the law on rights to access to health for women of child bearing age.

There are, therefore, a myriad of strategies and tools that the Kenya Medical Association (KMA) can use to advocate and promote access to safe abortion services and quality sexual reproductive health and rights to women in Kenya. Whereas the association can deploy some of these tools and strategies, it is the responsibility of the government through the Ministry of Health and other stakeholders to ensure that the rights of women and girls are protected as provided for in national and international law. This report, calls for a deliberate effort towards the full implementation of existing national laws and guidelines on abortion and post abortion care, and calls upon the KMA to mobilize its membership to enhance their clarity on legal framework on abortion and post abortion care. Further, there is a need to replicate, in the 47 counties, national level efforts with respect to evidence generation and analysis to guide decision making and programming to address maternal mortality, enhance access to contraceptives and implementation of comprehensive sexuality education. Similarly, KMA can leverage on its institutional credibility as well as its strong membership network, while working closely with organizations like the International Federation of Gynaecology and Obstetrics (FIGO) to engage the government to address the public health implications of restrictive abortion laws, actively engage partners in the sexual and reproductive health and rights (SRHR) space to build their capacity in providing safe abortion services, design and implement quality improvement strategies for

[1] Sections 158 to 160 and section 240 of the Penal code cap 63 of the Laws of Kenya.

abortion and post abortion care and also undertake advocacy efforts for liberalization of abortion laws.

1. BACKGROUND

Unsafe abortion is defined by the World Health Organization (WHO) as "a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimum medical standards, or both"2. Latest data from the WHO and Guttmacher Institute indicates that 45%, or 25 million abortions globally are unsafe [3]. The majority of these unsafe abortions (97%) occur in Africa, Asia and Latin America, and in locations classified as low- and middle- income countries (LMICs).

Unsafe abortion is a big public health concern. In 2008, unsafe abortion accounted for up to 13% of maternal mortality worldwide, with hundreds of thousands of survivors living with long-term complications, including infertility and chronic pain [4]. In sub-Saharan Africa (SSA), unsafe abortions account for up to 12% of maternal deaths [9-13]. In Eastern Africa an estimated 14% of all pregnancies end in abortion, and nearly one in five maternal deaths are due to unsafe abortion [14]. In Kenya despite pregnancy termination being highly restricted, induced abortions remain common, with high levels of complications resulting mostly from unsafe abortions are recorded. In 2012, close to half a million abortions were estimated, with 40% and 37% resulting in moderate and severe complications respectively [15].

The SSA region has been termed 'the most dangerous region for a woman to have an abortion'. This is because on-demand safe abortion services remain virtually unavailable to a majority of women [16], and about 90 percent of women of childbearing age are affected by restrictive abortion laws operational in these contexts [17-19]. Restricting access to [safe] abortions does not reduce the number of abortions, and in fact is the chief driver for unsafe abortions: contributing to 3 in 4 abortions, according to the WHO and Guttmacher institute [3].

Women living in contexts with restricted access to safe abortions resort to unsafe methods and procedures, usually from individuals lacking clinical skills necessary to carry out the procedures, and operating from environments that do not conform to the minimum acceptable clinical standards. Abortions procured in clandestine settings are unsafe because they are done using crude methods like insertion of foreign bodies like sharp sticks, or ingestion of caustic substances and use of traditional concoctions, and an overdose of prescribed medication[3]. Women facing restrictions in accessing and procuring abortions are also likely to delay securing abortions thus placing themselves at increased risk for complications when they attempt to do so at advanced gestation periods using procedures that are inappropriate. Unsafe abortions lead to the unnecessary death of women, while those who survive suffer severe disabilities or long-term complications which include infections and sepsis, severe bleeding and trauma [20-22].

[2] General Comment No. 22 on the Right to Sexual and Reproductive Health, UN doc E.C.12/GC/22
[3] World Health Organization. Preventing unsafe abortion: Key facts. Available at https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion

1.1. QUALITY OF CARE AND COST OF MANAGING AND TREATING COMPLICATIONS FROM UNSAFE ABORTIONS

Unsafe abortions are linked to socio-economic consequences to the affected individuals and their families, as well as to the economy. The immediate costs of treatment for abortion-related complications, and the costs of medical care for longer-term health consequences impact heavily on the families and the society, while businesses and economies experience loss of productivity [23].

Complications from unsafe abortions require specialized treatment accompanied by long periods of hospitalization. Patients usually require intensive care, and attendance by highly skilled yet scarce health personnel, factors that drive up the cost of providing care [24 25]. In Kenya, the cost to the health care system as a result of unsafe abortion has been estimated at an average of 4,943 Kenyan shillings (KShs) or 58 US dollars (US$) per typical case. Health care providers spend an average of 7.4 hours to manage one such case. At the national level, the cost to the public health care system of treating complications arising from unsafe abortion was KShs 432.7 million (about US$5.1 million) in 2012, and estimated to rise to KShs. 533 million (about US$ 6.3 million) in 2016.

Quality abortion care can be measured based on existing infrastructure to provide abortion care, competencies of the care providers, client-provider interactions (patient-centred care), range of services provided and positive health and survival outcomes [26]. Improving quality of abortion care based on these key indicators would lead to reductions in abortion-related morbidities and mortality [27-30] and post abortion contraceptive knowledge and uptake [31 32], as well as to abortion stigma at community-level [33].

The increased burden of unsafe abortion to the society in Kenya observed in the last decade points to the urgent need for health care systems to refocus their attention on expansion of comprehensive abortion care while improving the quality of existing post abortion care services [34].

1.2. INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT (ICPD) 1994 AND 2019

The International Conference on Population and Development (ICPD) held in Cairo in 1994 signalled a turning point where the global community identified unsafe abortion as a major public health issue due to its contribution to maternal morbidity and mortality. Several SSA states were part of the 179 countries represented at the event and consequently they pledged to ramp up efforts to increase the availability of family-planning services; ensuring that where abortion was legal, it was safe; and guaranteeing that in all cases, quality services for the management of abortion complications, including post abortion contraception counselling and provision of contraceptive commodities, were accessible to all women, regardless of the legal grounds for abortion in an effort to prevent unsafe abortions and associated morbidity and mortality outcomes [35-37].

In 2014, during the 29th United Nations General Assembly Special Session (UNGASS) on the follow-up to the Programme of Action of the ICPD Beyond 2014, member states further took cognizance of the slow

speed in the achievement of universal access to sexual and reproductive health and rights (SRHR) for women, globally. A resolution to fast-track the ICPD agenda was therefore made, with a focus on women inclusivity in advancing their own rights to health without any form of distinction or discrimination[4].

Half a decade later and over the 25 years since ICPD 1994, in 2019, delegates met in Nairobi to take stock of the program of action during the 'Nairobi Summit on ICPD25: accelerating the promise'[5]. It was reported during the meeting that progress had been made and a lot more women had access to sexual and reproductive services. The report added that fewer women were dying from maternal-related complications (as indicated in Figure 1). Despite the reported progress in the decline in maternal deaths over the years, it was agreed that much more still needed to be done to facilitate women's access to safe and quality abortion services and post abortion care. A worrying opinion that could derail efforts to fulfil these commitments are sentiments expressed by the United States government and their opposition to the use of 'ambiguous terms and expressions' such as sexual and reproductive health rights (SRHR), terms they insist 'do not enjoy international consensus and could be viewed as a renegotiation of the language of 1994 ICPD' which they term as a foundation to international action.

During the same conference, the president of Kenya in his address reiterated that the Government was committed to ensure an enhancement of the country's population and development programmes through increased budgetary allocations and the design and implementation of policies and programmes relating to sustainable development at national, county, and sub-county levels by the year 2030. The GoK further committed to ensure that all citizens attain the highest possible standard of health, key among these being the elimination of preventable maternal deaths. Additionally, GoK committed to ensuring a universal access to quality sexual and reproductive health services. The effective implementation of these commitments will result from a deliberate tracking and monitoring by the National Council for Population and Development.

In this day and age when unsafe abortions are still among the top five causes for maternal mortality in SSA, the entry of sustainable development goals (SDGs) and the philosophy of "leaving no one behind" provides an opportunity, and indeed a framework to further the efforts of the millennium development goals (MDGs) to ensure universal provision of safe and quality abortion and post abortion care to women and girls in Kenya. Providing safe and legal abortion is essential to fulfilling the global commitment to the SDG target 3.7 on universal access to sexual and reproductive health, which aligns with GoK commitment that all citizens attain the highest possible standard of health by 2030.

[4] ICPD Beyond 2014 — High-Level Global Commitments
[5] Nairobi Summit on ICPD25: Accelerating the promise http://www.nairobisummiticpd.org/

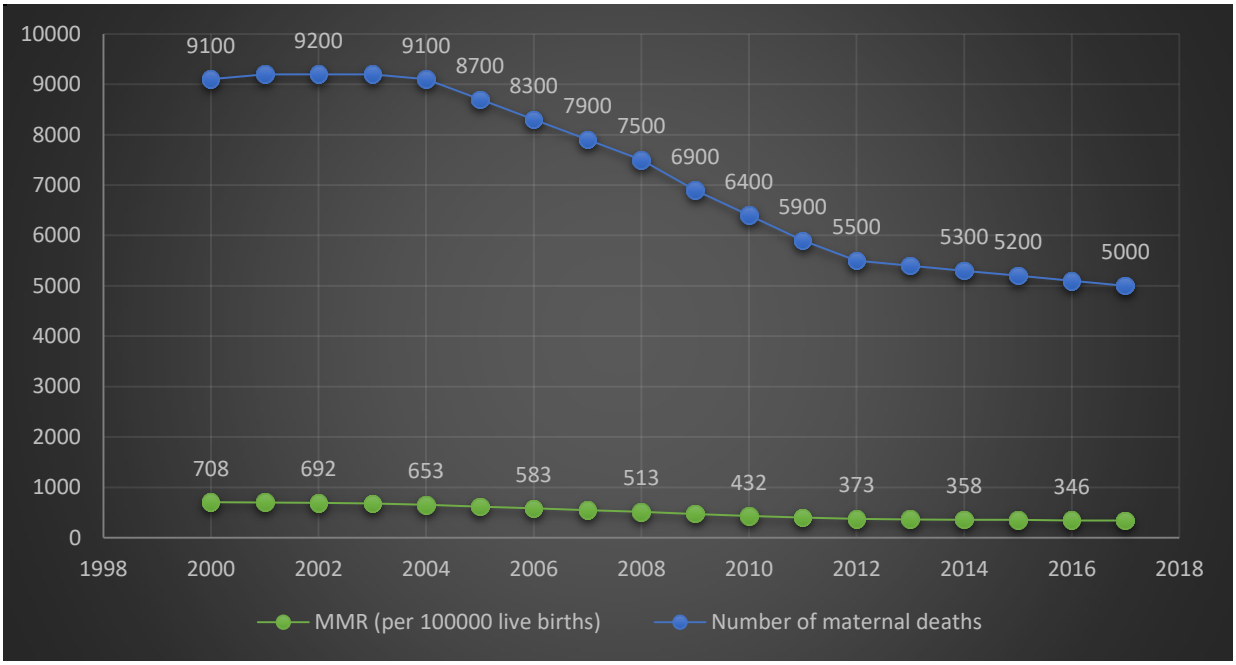

Figure 1: Trend showing a gradual reduction in maternal mortality (rate and total numbers) in Kenya between 2000 and 2017; Source: World Health Organization Global Health Observatory data repository

1.3. THE 2003 PROTOCOL TO THE AFRICAN CHARTER ON HUMAN AND PEOPLES' RIGHTS ON THE RIGHTS OF WOMEN IN AFRICA (MAPUTO PROTOCOL)

The Maputo protocol, as commonly known, advocates for African Union member states to develop and adopt policies and create institutional mechanisms to advance and guarantee women and girls the full enjoyment of their human rights, including sexual and reproductive health rights. Central to this cause is addressing cultural and religious practices, and exclusionary economic systems that systematically marginalize women and girls and deny them their sexual and reproductive rights. Even though the target was to achieve universal ratification by all 54 AU member states by 2020, this is yet to be achieved, with some countries among them Kenya, only ratifying the protocol with reservations on specific provisions such as marriage and the rights to health and reproduction control.

As a follow up to the 2003 Maputo protocol, 2016 was declared the Year of African Human Rights with a particular focus on the rights of women with a view to accelerating action.

The Kenya Government through several commitments made over the years commits to uphold the rights of its citizens, including the right to health care. The universal health care program envisages universal access to quality health care, including sexual and reproductive health, for all. Vision 2030 is a platform where several programs, including the Big 4 agenda, which aim for a globally competitive and prosperous country with a high quality of life by 2030 are coordinated. A key pillar of the Big 4 Agenda is affordable health care for all through removal of bottlenecks that hinder access to and utilization of healthcare in formal facilities. In a

synchronised effort, the Ministry of Health in Kenya has ensured that the necessary health policies and strategies that promote access to health care, including sexual and reproductive health, have been developed and operationalised. An example is the National Reproductive Health Strategy 2014-2018 that provides a framework for addressing sexual and reproductive issues and challenges in the country.

On the other hand, the Kenya Medical Association has analysed several health policies and strategic frameworks and conducted research on the state of maternal and sexual and reproductive health and rights in Kenya. Through its research on the knowledge, attitudes and practices on contraceptives and safe abortion services conducted in the slums of Nairobi [38], KMA made three-pronged recommendations touching on the policy, demand and supply sides. Policies, standards and guidelines for provision of safe abortion services be developed, while streamlining the role of different health care workers in providing safe abortion services. On the demand side, community awareness on the legal framework guiding the provision of and access to and utilization of contraception and safe abortion services, while at the supply side, it was the need to promote safe abortion procedure including relevant counselling for informed decision making and the need to advocate for provision of quality safe abortion services for those who need them.

2. OBJECTIVES OF THE REVIEW

The objectives of this review are to:

1. Assess what Kenya has done to ensure that her women and girls enjoy their full right to safe and quality sexual and reproductive health;

2. Analyse the missing and/or weak links, and barriers in the provision and access to quality SRHR;

3. Analyse the impact of a legally restrictive environment on the provision and access to safe abortion services, the growing burden of unsafe abortions, morbidity and mortality, and the runaway cost to the public health care system of treating complications resulting from unsafe abortions in Kenya

4. Make proposals/recommendations based on these findings to the Government of Kenya, the Ministry of Health and to the Kenya Medical Association as a professional medical body with the mandate to advise the government on matters regarding the health of the population.

Three key research questions formed the basis for the review:

1. What existing global, regional and national political, legal, socio-cultural and religious environments govern abortion and unsafe abortion in Kenya?

2. What systemic issues influence the burden and cost of unsafe abortion and its complications in Kenya?

3. What relationships exist between the increased cases of induced abortions, the high cost and poor quality of post abortion care services in Kenya and the lack of access to safe abortion-related services?

3. CONCEPTUAL FRAMEWORK

Several factors contribute to the growing burden of unsafe abortions in Kenya. First, restrictive legal environment deters women from seeking safe abortion services within the formal health care system, out of fear of being victimized. At the community level, socioeconomic factors that include prohibitive cost of care influence access to, and utilization of safe abortion services by women and girls. These factors also contribute to the delay in women reaching points of care when requiring abortion and post abortion care [6].

Secondly, health care system deficiencies in the type and range of services provided are a big impediment to access and utilization of abortion care. Public health care system is the worst affected as a consequence of a chronic lack of sufficient capital investment occasioned by lack of goodwill from politicians and policy makers. Although Kenya is a signatory to the Abuja declaration (2001) that proposed African Union member countries to allocate 15% of their annual budget to improve the health sector, an analysis of health care expenditure over the two decades that have followed the declaration shows that the government of Kenya has barely reached the target [39]. Where investments have been made, very little has been allocated for sexual and reproductive health services. Further, poor infrastructural capacity, especially in the public healthcare system, coupled with low technical skills and unwillingness or fear by health care providers to provide safe abortion services arising from own religious biases, misunderstanding of or misinterpretation of the laws and conscientious objections have made provision of sexual and reproductive health services a challenge in Kenya. A lack of clarity on existing legal provisions on safe abortion and post abortion care have made provision of these services problematic, even where health care providers are willing to offer them. Laws and policies are often vague, confusing and contradictory and in many occasions misinterpreted to deny women access to needed care [34].

Third, religious and sociocultural norms have pushed up stigma for abortion and abortion care, both from the demand and supply sides of abortion services. Women in need of these services are more likely to avoid seeking services in health care facilities out of fear of being branded as "sinners" or "uncultured" while health care providers desist from offering the care and services out of fear of either them or their practices being branded "murderers" [34]. The promotors of quality abortion care ideologies envisaged a situation where the community and the health care systems are better synchronized for the provision of the much-needed health education aimed at reducing the risks of unsafe abortion and creating awareness of the existence of safe legal abortion care services.

Fourth, and perhaps the most important issue limiting the provision of safe and quality sexual and reproductive health to women and girls in Kenya, is the suboptimal or lack of response from duty bearers (politicians, policy makers, health managers, health care workers, health care administrators) and their failure in upholding and protecting the right of women to access to safe and quality abortion and post abortion care. The said duty bearers have abdicated their core responsibility to uphold the right of women and girls to universal access to abortion care as a human right, in line with the Maputo protocol, and in keeping with the commitments of the nation to the ICPD program of action. Duty bearers have often and regrettably been seen as subdued by the unpopular push by the so-called pro-life crusaders which is often inconsiderate of the untold agony and pain that women often go through to individually and mostly, what pushes women and girls to situations that crudely manage their pregnancy crises.

Figure 2 below summarises the conceptual framework guiding this review.

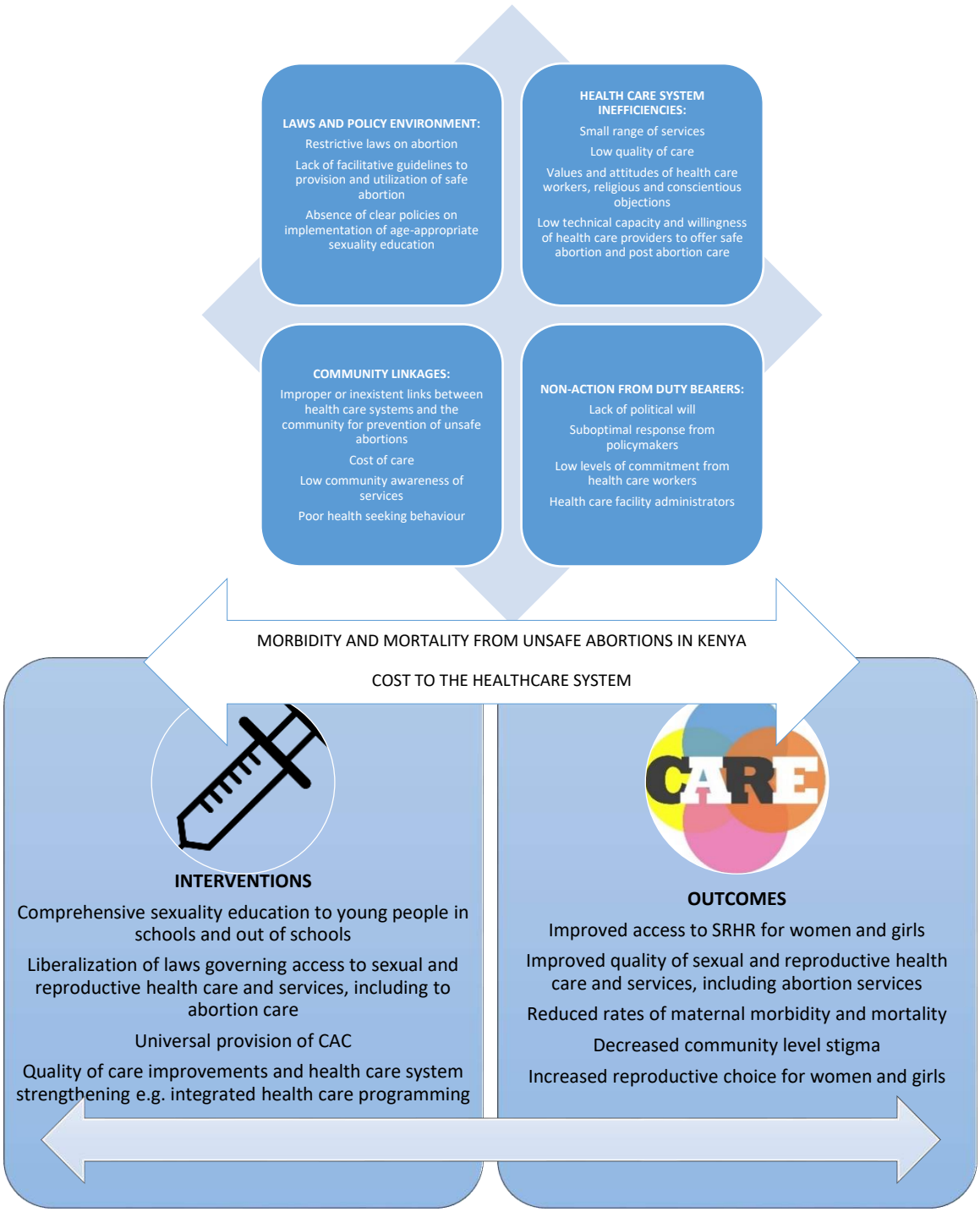

Figure 2: Determinants and interventions for unsafe abortion, severe disabilities, complications and maternal death in Kenya

4. METHODS AND APPROACHES

4.1. IDENTIFICATION AND COMPREHENSIVE REVIEW OF PUBLISHED AND GRAY LITERATURE

Key research and review questions were discussed and agreed on between the review team and the Kenya Medical Association. An extensive search of published articles was carried out in Google Scholar and in major electronic journal databases that included JSTOR, Web of Science, Science Direct, African Journals Online and Scopus. The search syntax used terms such as "Abortion" OR "unsafe abortion" OR "post abortion care" or "post abortion contraceptive counselling" together with "Kenya". From the resulting articles we searched for results on the burden, quality, cost of care and legal and policy issues on abortion and unsafe abortion in Kenya.

4.2. IDENTIFICATION AND REVIEW OF POLICY AND LEGAL DOCUMENTS

Key policy and legal documents and judicial pronouncements on abortion globally, regionally and in Kenya were identified through a review and analysis of published reports. The Kenya Law Review and several publications on the legal and policy environment governing abortion in Kenya, and their meanings, were reviewed. The review of these documents paid attention to their jurisdiction, reach and implication to the Kenyan setting.

4.3. QUALITY APPRAISAL OF DOCUMENTS AND SYNTHESIS OF FINDINGS

A liberal approach was used in appraising the quality of articles, reports, legal, policy and other documents included in this review. For published articles, the reviewers checked for scientific soundness based on a) representativeness and appropriateness of the study population in answering the study research questions; b) the appropriateness of the study design and timeliness; and c) definitions and clarity of outcomes and their measurements. Reports and other grey literature were included in the review based on relevance to the topic. Reports from key institutions working in sexual and reproductive health and rights were particularly referenced. Synthesis of findings was guided by the research questions and the conceptual framework.

5. FINDINGS

5.1. BURDEN AND MAGNITUDE OF UNSAFE ABORTION AND COMPLICATIONS IN KENYA

There is a high rate of documented morbidity and mortality from unsafe abortions in Kenya. In 2005, the projected annual number of women with abortion-related complications admitted to public hospitals in Kenya was 20,893, with a case fatality rate of 0.87% (about 182 annual deaths). The study further estimated an annual incidence of incomplete abortion and other abortion-related complications or three per 1000 women of reproductive age [40].

Research conducted by the African Population and Health Research Center (APHRC) in 2012 estimated that nearly half a million induced abortions occur annually in Kenya, corresponding to an induced abortion incidence ratio of 30 abortions per 100 live births; 48 of these abortions happening among 1000 women of reproductive age (15-49 years) [41]. About 3 out of every 4 of these abortions presented with moderate to severe complications [15]. A significant proportion of patients who present with abortion complications at health care facilities are young (48%) and single women (28%) [42]. Further, about 1 in 10 of young women seeking abortion-related care in Kenya have had a previous induced abortion, an indication of existing gaps in the quality of post abortion care, specifically regarding post abortion contraceptive counselling and the provision of effective pregnancy prevention methods before discharge from the health care facility [43]. Worryingly though, a substantial proportion (39%) of index abortions are late stage i.e. they occur after 12 weeks of gestation. Clinically, late-stage abortions come with severe complications [42] and it is therefore not surprising that a high rate of complications arising from unsafe abortions are recorded in Kenya [6].

In Kenyatta National Hospital in 2013, 38% of all the abortion complications treated at the facility were induced [44], while the commonest complications were haemorrhage (58.8%), sepsis (41.2%), and uterine perforations (11.8%).

5.2. ACCESS TO SAFE ABORTION SERVICES IN HEALTH FACILITIES IN KENYA

Access to safe abortion services in health facilities in Kenya is affected by the restrictive and punitive laws and the weak policy environment existing in the country. The prevailing laws only permit abortion when in the opinion of a trained health professional ,there is an emergency situation or when the life or health (physical or psychological or social wellbeing) of the woman is in danger and when permitted by any other law (read rape and defilement under the sexual offences act)[67]. At the individual level, prohibitive financial costs associated with accessing and utilizing safe abortion services is a key barrier. Societal attitudes towards abortion and gender inequality are community level barriers, while the [un]availability of safe abortion services and trained health providers are health care system barriers. Although Kenya has recorded significant improvement in nationwide supply of abortifacients in the recent years resulting to their increased availability, it is staring at another crisis: policy and health care system deficiencies owing to undirected and unsupervised self-administration that have led to the generalized and unregulated access to these drugs [34 45].

Universal access to safe abortion services is a right of women and girls of Kenya. As such, these services should be made available in the public and private sectors at a cost affordable to the women with greatest need. The services need to be safe, promptly available and delivered in a manner that is appealing especially to the younger and disempowered members of the society. In ensuring that the services are of high quality, health care facilities and workers in these facilities should be trained on provider-client interactions that enhance patient confidence in these services. With well-structured and thought-out training of health workers and consumers of services, it is possible to make the services more accessible through telemedicine and mHealth services. Clients can be empowered to consult health workers through mobile telephony and prescriptions of certain commodities provided or refilled without face-to-face meeting.

[6] Article 26(4) of the Constitution of Kenya 2010

[7] Petition 266 of 2015. *FIDA Kenya and three others vs the Attorney General of Kenya and others (JMM* case) in 2015. http://kenyalaw.org/caselaw/cases/view/175490/

5.3. BARRIERS TO ACCESS TO SAFE ABORTION IS LINKED TO GENDER INEQUALITY, HARMFUL CULTURAL NORMS AND RELIGIOUS INTERPRETATIONS

Lack of knowledge and information by women on where to access safe abortion care is a key barrier to the access and utilization of abortion services. When women know where they can get abortion care and contraception, there is potential in their enhanced utilization of the services [46]. But lack of understanding of the provisions in the law for abortion, and on their individual rights, coupled with conflicting cultural and religious messaging impact negatively on women's decision making on when and where to procure safe abortion services in Kenya [47].

The demographic that is most affected by the foregoing are the younger women, women with no or possessing low levels of education, unemployed women and women without proper referral systems. For instance, a study reported that majority of post abortion care patients seen at the Kenyatta National Hospital were below 30 years, and most (58%) were of low socioeconomic status [44]. Further, these classes of women are more likely to experience delays in seeking care following complications of unsafe abortion [6]. Another scourge is repeat induced abortions which are more likely to happen among separated, divorced or widowed women, and similarly among women with low levels of or without an education, and women experiencing unwanted pregnancies together with those using traditional methods of contraception such as withdrawal or calendar rhythm which have been associated with the highest contraceptive failure rate in the developing world [48].

Strategies like male involvement in the design and provision of sexual and reproductive health services are key in eradicating gender imbalances that drive inequities in accessing SRH services. But more importantly, when comprehensive sexuality education (CSE) is introduced early in life it empowers younger people with agency and understanding regarding gender rights, and for younger women, CSE has the potential to enhance the awareness of their rights to safe and high quality SRH care and services. In addition, properly designed and executed adolescent and youth friendly (AYF) health care services can enhance access to, and utilisation of safe abortion care among younger women.

5.3.1. SOCIO-CULTURAL DETERMINANTS OF ACCESS TO SAFE ABORTION SERVICES IN KENYA

Women with little or no knowledge about available formal abortion services are likely to doubt the effectiveness of such services, and to harbour unfounded fears on health consequences from such services [49]. Stigma and sanctions from and by the society also greatly serve to impede access to safe and quality abortion services [49] [50]. Research shows that contextualized definitions on what encompasses safe abortion is key to understanding the choices women make on when and where to procure abortion services. To some women, safe abortion implies pregnancy termination procedures and services that are secretive and conceal their abortions and shields them from the law, apart from being affordable. Other women consider safe abortions to be services that are easily identified through dependable social networks and referrals from friends and relatives. Such considerations could explain why formal health care providers that do not satisfy the requirements do not appeal and are shunned by women in Kenya, who instead resort to clandestine and back-of-the-street options [5]. The reasons why women patronise abortion services from untrained providers and quacks is the demand for secrecy to avoid society sanctions, as well as the uncertainty about what the law

says [51]. This situation is made more complicated by the paradox that service providers are more likely to offer services only to patients that they know, while patients prefer to get these services from service providers that are least known to the patient [5].

Cultural interpretations, myths and misinformation have caused resistance on the use of contraceptives for family planning in some communities in Kenya. Women from these communities lack the autonomy and decision-making on the number of children they can have, and are likely to experience multiple unplanned pregnancies. Stigma and loss of opportunities linked to unplanned pregnancies drive such women in seeking abortions [52] but stigma (still), and sanctions drive these women to unsafe abortions. Notably, these women suffer double stigmatization, based on unwanted pregnancies on one side and pregnancy termination on the other [53].

Evidence-based approaches, using locally generated data on the burden and cost of unsafe abortions in Kenya should be used to demonstrate how cultural positions are doing more harm than good. Society gatekeepers with the role of enforcing cultural and religious interpretations to issues of abortion should be engaged with this evidence, and used as agents of change to end stigma towards abortion at the community level and acceptance of the need and benefits accruing from safe abortion services to individuals and the community.

5.3.2. SOCIO-ECONOMIC AND FINANCIAL COSTS TO ACCESSING AND UTILIZING SAFE ABORTION IN KENYA

The perceived high cost of procuring an abortion in formal health facilities impede access to and utilization of safe abortion services, where they exist [50]. Women seek abortions from informal and untrained providers because they perceive such services to be cheap and affordable [51], never mind that many of these women end up paying the ultimate price for their decision. In addition to these direct costs that affect utilization of abortion services, indirect health costs to women seeking abortion services (cost of transport and food) are much lower in informal facilities (usually found in the patient's immediate locality) hence enhancing their utilization [34]. Programs like the free maternity care and universal health care access by the Government of Kenya are opportunities to remove the burden of catastrophic costs associated with utilisation of abortion services.

5.3.3. HEALTH CARE SYSTEM DETERMINANTS OF THE PROVISION OF SAFE ABORTION SERVICES IN KENYA

Within public health care facilities, the recurrence of service interruptions and inequitable access to care further exacerbates the incidence of unsafe pregnancy terminations at the community level. At the same time, lack of services and variable availability of these services in public health care facilities, including primary health care facilities like dispensaries and health centres, contributes a great deal to delays in receiving care and exacerbates the complications from unsafe abortion through the often non-specific and uncoordinated chain of referrals for common post abortion cases. Some health care facilities in Kenya lack efficient infection control measures, exposing women and their caregivers to nosocomial infections [45].

Additionally, type of facility ownership (whether private or public); availability of evacuation procedure rooms, presence of specialized obstetric-gynaecologist and provision (or not) of maternity services and the

number of contraceptive methods available in the facility are known to influence uptake of post abortion contraceptive methods and counselling [54], a key component of quality post abortion care. Training of health care providers on offering comprehensive and quality abortion care, and on value clarification and attitude transformation, equipping facilities to offer abortion care and enforcing application and use of existing guidelines can eradicate health care system barriers to the access and utilization of safe abortion services. Public and private health facilities should apply a common standard when providing safe abortion services.

5.3.4. CAPACITY CHALLENGES FOR HEALTH CARE PROVIDERS TO PROVIDE ABORTION SERVICES

One of the biggest access challenges is that even in circumstances where the law permits a health care worker to offer abortion services in Kenya, some health care facilities and health care workers lack requisite equipment and technical skills, respectively, to provide quality abortion care and manage abortion complications [45]. A majority of health care providers are also unaware of the legal framework governing the provision of abortion services and the circumstances under which abortion and post abortion care may be provided to women needing it in the country, leading to multiple referrals and consequently to delays by patients in accessing post abortion care following unsafe abortion, leading to fatalities and long-term sequela [34].

This situation is compounded by the unavailability of equipment and appropriate technology for service delivery, such as manual vacuum aspiration (MVA) kits and abortifacients in health care facilities in the country. As a result, the use of inappropriate methods and dosages for drugs of unproven efficacy and/or dangerous medications have been reported among PAC providers in public facilities in Kenya, including by qualified physicians [7] [55]. Across the country, public health facilities lack procedure (private) rooms where abortion services can be offered to the patients [45], hence prohibiting patients from seeking services in these facilities.

Health care workers need to be sensitized on the approved post abortion care guidelines to improve their confidence in providing post abortion services [45] and offer clarity to the county and national laws on abortion [56]. Additionally, policies on recruitment and exposure of health care workers to procedures such as infection control and procurement decisions which have an impact on the quality of post abortion care are needed so that only those adequately trained are charged with these critical responsibilities [34].

5.3.5. STIGMA, JUDGEMENT AND SERVICE PROVIDER ATTITUDES THAT DETER WOMEN FROM SEEKING SERVICES

Decisions to procure abortions made by younger and married women are highly stigmatized, with men being the biggest culprits propagating the stigma [57]. Women seeking abortion services cite stigma, isolation and shame as major hindrances to seeking abortion services at health facilities [58] and a motivation towards seeking services of untrained providers. Statements like "abortion is women's strategy for concealing their deviation from culturally acceptable gender and motherhood standards" [59] have come from men. Such sentiments are fuelled by widespread and unaddressed perceptions that abortion was illegal. The, fear of being arrested and prosecuted is largely the reason why women fail to utilize safe abortion services [60], or delay seeking for safe abortion and post abortion care [61].

Stigma coming from health care workers is by far the most damaging on the chances of women utilizing safe abortion services at health facilities. When compared to older married women, young single women seeking abortion services report higher levels of stigma from health providers [60]. In a study conducted in Kisumu, health care providers considered abortion by a young woman a sin, they proceeded to add that if allowed, the young woman would 'make a habit out of it'. Stigma was extended to contraceptive use, with providers associating it with promiscuity. Other health care providers, perhaps due to lack of knowledge or conflicting it with repeat induced abortions, believed that contraceptive use may cause infertility [62].

Women in need of abortion services will most likely shy away from visiting health facilities for fear of being judged or detained and reported to the police [63]. In an effort to deflect the blame, some health care providers have been quoted laying the blame on young women for their own difficulties in accessing abortion services while considering induced abortion among young women as especially, objectionable [64] [65]. Even more worrying is the institutionalization of abortion stigma, as demonstrated by the Ministry of Health's withdrawal of standards and guidelines for abortion through a circular to health care workers in 2013 [66].

5.4. COST OF TREATING UNSAFE ABORTION IN KENYA

Unsafe abortion and the provision of post abortion care exerts considerable financial and other costs on individuals, households, and public health care systems in the region [67]. A recent review on PAC in SSA shows that the cost of treating unsafe abortion to individuals and their families and to the health care systems remains an underexplored area, and more evidence is required to clearly understand this issue.

That said, in Kenya, the cost to the health care system as a result of unsafe abortion was estimated to cost an average of 4,943 Kenyan shillings (Kshs) or 58 US dollars (US$) per case, which would take health care providers an average of 7.4 hours to manage. At national level, the cost to the public health care system of treating complications arising from unsafe abortion was estimated to be as high as Kshs 432.7 million (about US$5.1 million) in 2012, and was projected to rise to Kshs. 533 million (about US$ 6.3 million) in 2016. The scenario is not different in other African countries. In Ethiopia, Rwanda, Uganda, and Zambia, for instance, the annual public health care system cost of treating complications of unsafe abortions stands at US$8.9 million, US$2.3 million, US$13.9 million, and US$1.4 million respectively [68-71]. These costs are not limited to health care systems alone. A study in Uganda reported that women seeking PAC following complications from unsafe abortions spent on average US$49 in out-of-pocket expenditures [72].

Indirect costs linked to unsafe abortion come about when women (and their families) incur costs such as transport, bribery, and other hospitalization costs such as food and lodging, over and above the commonly-registered direct costs associated with abortion care. When women die, funeral expenses are a direct expense due to their families, while in many instances these families lose economically productive individuals who would contribute to their incomes.

Costs to the public health care system resulting from unsafe abortion can be averted by first tackling the root causes of unsafe abortion, and unintended pregnancies. Investing in the provision of family planning services and a choice of contraceptives methods to deter unintended pregnancies and the need for unsafe abortions is one such strategy. Top of the envelope analysis shows that providing modern methods of contraception to women with an unmet need costs a small fraction of the average expenditure on PAC: one year of modern contraceptive services and supplies cost only 3–12% of the average cost of treating a PAC patient [73]. Medication (typically misoprostol) for treating incomplete abortion, instead of MVA, can lower PAC costs by

up to one-sixth. Implementing task-shifting and task-sharing (where non specialist health care providers are deployed to provide PAC services) and decentralising PAC provision to lower-level facilities can also reduce the cost of PAC in SSA[74].

Addressing the costs linked to PAC is especially important now in the era of the expanded gag rule. Kenya should find ways to plug the deficit gap in the funding for sexual and reproductive health services occasioned by the expanded gag rule in response to its commitment to promoting the rights of its people to access safe and quality services. Training of health care providers in counselling and advising clients on existing contraceptive choices is key in enhancing effective provision of contraceptive commodities.

Existing government-led programmes aimed at eradicating costs that form barriers to access and utilisation of sexual and reproductive health services, for example the free maternity care, the universal health care access and Linda Mama can lower PAC costs to the individual. Abortion, and indeed comprehensive abortion care services should explicitly be listed in the package offered by these programmes, and the public sensitised on the same. To make this a reality, resources, both financial and human, should be allocated to these programs.

5.5. QUALITY OF ABORTION CARE IN KENYA

The quality of abortion and post abortion care provided in Kenya varies between type of health care providers (physicians and non-physicians) and across facilities (private or public) [5]. For instance, the use of appropriate, safe and essential technology for PAC e.g. manual vacuum aspiration (MVA) is used much more in public facilities compared with private facilities that still use the unsafe and outdated technologies like dilatation and curettage (D&C) [75]. Similarly, unavailability of certain services/facilities within a health care facility, such as evacuation procedure rooms as well as a wide range of contraceptive commodities and services are common in private facilities thus affecting the quality of PAC offered in these health facilities.

High quality of abortion care guarantees positive physical and mental health outcomes. Strengthening the health care infrastructure to offer comprehensive abortion care, empowering health care providers with technical capacities and ensuring their willingness to provide abortion care, and promoting patient centeredness in abortion care will go a long way in enhancing access to and utilization of quality abortion care in Kenya. Enforcing standards as prescribed by the WHO, as well as operationalizing the post abortion care guidelines passed and approved in Kenya in 2019 will also be critical in fostering provision of and access to quality abortion and post abortion care in the country. A sure way of guaranteeing quality of abortion care is the adoption and implementation of comprehensive abortion care (CAC), as discussed below.

5.5.1. ENHANCING QUALITY OF ABORTION CARE: ADOPTING AND IMPLEMENTING COMPREHENSIVE ABORTION CARE

Comprehensive abortion care aims to address maternal mortality, morbidity, and repeat abortions through enhanced access to reproductive health care for all women of child bearing age. The key components of CAC include:

- Provision of safe induced abortion using safer methods like the E/MVA through 12 completed weeks of pregnancy and by medical methods through nine completed weeks of pregnancy.
- Treatment of complications arising from unsafe or incomplete abortions, which are in most cases

emergencies. Specifically, abortion case management may include use of E/MVA, standard infection prevention measures, informed consent, appropriate pain management, sensitive physical and verbal patient contact as well as provision of follow-up care [76].

- Counselling of women seeking abortion care to help identify and address broader emotional and physical health issues, with an aim to provide them with emotional support through their post abortion visit, ensuring that patients receive the correct information on their concerns and allowing them to make informed choices on their preferred post abortion care plan as well as enabling the service provider to address their concerns more intently [76].
- Contraceptive and family planning services to women seeking abortion care to help them practice appropriate birth spacing, prevent future unwanted pregnancies and unsafe abortions and consequently achieve their reproductive goals [77].
- Providing reproductive and other health services at the same facility (integrated services) or via referral to other facilities coupled with patient follow-up for completion of referral. Such services may include STI prevention and education, screening for sexual or domestic violence and treatment required, infertility diagnosis and treatment, nutrition education among others[8] [76].
- Community and service provider partnerships among community members, lay health workers, traditional healers and formally trained service providers with an aim to provide information on risks and consequences of unsafe abortion, family planning and contraceptive use. These efforts will support women to make informed decisions about sexual and reproductive health services available as well as mobilize community resources to ensure women suffering incomplete abortions or any related emergencies receive the care they need [76].
- Training service providers on CAC enhances post abortion contraceptive counselling skills and results in improved uptake of long-acting reversible contraception (LARC) methods [78].
- Community engagement and service-strengthening interventions [79] are other critical ingredients to improve provision of CAC in Kenya.

5.5.2. POST ABORTION CARE

Post abortion care (PAC) provided as part of CAC involves the prevention and treatment of complications to those who have had an unsafe abortion. The critical issues that must be addressed in order to avail quality PAC services include:

- Types of abortion services and where they can be provided.
- Essential equipment, supplies and medications and facility capabilities to provide care.
- Service provider capacity and value clarification and attitude transformation for non-judgmental service provision.
- Referral mechanisms, processes and guidelines that create the essential linkages with other reproductive health services within the facilities and within the health care system.
- Respect of women's informed decision making, autonomy, confidentiality and privacy, with attention to the special needs of adolescents.
- Special provisions for women who survive rape and other forms of sexual violence.

In the recent past, there has been a campaign for increased use of misoprostol for medical post abortion care

[8] Introduction to post abortion care. https://www.postabortioncare.org/sites/pac/files/CompendiumIntroPAC.pdf

(MPAC), a method that is easy to use, cost-effective, and one that frees up provider time and health facility resources traditionally necessary for provision of PAC with uterine aspiration that must be completed at health facilities [80]. Medical PAC is also known to improve patient autonomy and to avail the much-needed privacy in PAC service delivery.

5.5.3. POST ABORTION CONTRACEPTIVE COUNSELLING AND PROVISION OF ADOLESCENT AND YOUTH FRIENDLY SERVICES

Post abortion contraceptive counselling as part of PAC promotes contraceptive use and has the potential to prevent repeat abortions and future unwanted pregnancies [81 82]. Research shows evidence of high unmet need for contraception among clients seeking post abortion care services (up to 70%), irrespective of age [83 84]. When providing PAC, a wide range of contraceptive methods including long-acting reversible contraception (LARC) and emergency contraceptive should be made available for patients. When PAC patients are properly counselled, they are more likely to choose an appropriate contraceptive method [85]. Additionally, stocking and making contraceptive commodities more readily available facilitates the use of highly-effective LARC methods [55 86]. The reality, however, is that in many instances post abortion contraceptive counselling is the weakest link of PAC service provision, as it lacks the requisite comprehensiveness necessary to guide patients on contraceptive choices available to them [85].

Another cog in the provision of CAC is the adolescent and youth friendly (AYF) services. The performance of AYF services in Kenya are at best sub-optimal, resulting in the observed low utilization of safe abortion and post abortion services by this sub-group. For example, upon discharge, fewer abortion patients between the ages of 15 and 24 receive a contraceptive method when compared to their adult counterparts [87]. Targeted strategies are therefore required to reach younger PAC patients with counselling on contraceptives [88]. One such strategy in enhancing the utilization of and the quality of AYF services is the training of health care providers on the how, accompanied by supportive supervision. Extant research shows that when such an approach is taken, it has the potential to enhance the quality of abortion care and post abortion family planning counselling (PAFPC), and leads to enhanced uptake of LARC by clients receiving the upgraded services [89 90].

5.5.4. LINKING COMPREHENSIVE ABORTION CARE TO UNIVERSAL HEALTH COVERAGE AND FREE MATERNITY PROGRAM

The government of Kenya buoyed by Vision 2030 is working towards universal health coverage by 2030. Top on the priority is addressing financial hardships that are a barrier to the access and utilisation of health care services, including SRH services. The Bill of Rights in the Kenyan constitution guarantees the right to life and the right to the highest attainable standard of health, including reproductive healthcare and emergency treatment[9]. It is therefore incumbent upon government to ensure wide coverage and availability of quality essential interventions and elimination of costs that pose access barriers to health care, including access to sexual and reproductive health care. *The right to comprehensive abortion care falls within this stipulation*[10].

[9] Articles 26 and 43(1) of the Constitution of Kenya 2010.
[10] Article 26(4) Constitution of Kenya

Therefore, abortion care cannot be considered comprehensive if it is not universal!

In 2013, the government of Kenya though the Ministry of Health and other governmental and non-governmental stakeholders introduced free maternity care services with the aim of enhancing health facility delivery and reduction in deaths of women from obstetric complications. This free maternity care program was meant to drive up the demand for health facility deliveries and use of other maternal services. Evidence from Gem, Nyanza indicates that post abortion care is one such service whose uptake improved following the implementation of the free maternity program [91]. There is a huge opportunity to enhance access to sexual and reproductive health services, and especially to comprehensive abortion care, with universal health coverage and the free maternity care programs.

Through these programs, health care providers can benefit from continuous and on-job training in medical abortion, post abortion care and contraceptive counselling, as well as the use of newer and safer technologies like E/MVA. Additionally, supportive supervision, and minimal reorganization of services to ensure patients' rights to privacy and confidentiality can also be factored in [92].

5.6. REGIONAL AND NATIONAL POLITICAL, LEGAL, SOCIO-CULTURAL AND RELIGIOUS ENVIRONMENTS THAT GOVERN ABORTION AND UNSAFE ABORTION IN KENYA

The colonial-era Penal Code (1963) criminalizes abortion under Sections 158, 159 and 160. However, Kenya's Constitution 2010 overrides the Penal code and makes significant provision for enactment of relevant and congruent laws for its operationalization. These policies and laws include Sexual Offences Act (2006), the Health Act 2017 and the Standards and Guidelines for Reducing Mortality and Morbidity from Unsafe Abortions (2012).

The 2010 Constitution under Article 43(1)(a) provides for "every person has a right to the highest attainable standard of health, which includes the right to health care services, including reproductive healthcare". In Article 26(4) abortion is permitted when in the opinion of a trained health professional, there is a) need for emergency treatment, or b) the life or health of the mother is in danger, or c) if permitted by any other written law. This is the foundational protection of the right to access safe abortion.

Allowing for universal access to safe abortion guarantees the realisation of other rights provided for in the Constitution of Kenya, among them the right to health including reproductive healthcare (Article 43(1) right to equality and non-discrimination (Article 27), and the right to be free from torture, cruel and inhuman treatment (Article 29). It is therefore the legal duty of a registered and licensed health professional to inform a woman when she qualifies for safe abortion under the law.

When read together with the Health Act of 2017; section 6(2), the Constitution of Kenya provides for the recognition of wider range of health workers (doctors, nurses, clinical officers and midwives) and not only specialist doctors as "trained health professional". These health care providers can independently determine when circumstances are right to offer abortion services to women that require the service within the provisions of the law. Additionally, this clause provides for a widened coverage and availability to the services since this broader category of trained professionals can be found in primary health care facilities.

Because ratified treaties have the force of law in Kenya under Article 2(5) of the Constitution, duty bearers

should refer to the recommendation by the Committee on Elimination of Discrimination Against Women that stipulates that "it is essential for legal provisions for access to abortion to include a mechanism for rapid decision making, with a view to limiting to the extent possible risks to the health of the pregnant mother, that her opinion be taken into account, that the decision be well-founded and that there is a right to appeal"[11], and by so doing put in place procedures and processes to make abortion services safe, available and accessible to women without any form of discrimination.

Among the national laws, guidelines and codes of ethics that regulate, and advance or make a provision for safe abortion and post abortion services in the country include:

1. The Constitution of Kenya 2010.
2. The Sexual Offences Act 2006.
3. The Health Act 2017.
4. The National Guidelines on Management of Sexual Violence in Kenya[12].
5. Ministry of Health National Guidelines for quality obstetrics and perinatal care.
6. The Code of Professional Conduct and Discipline for Doctors, 6th Edition (MPDB 2012).
7. The Code of Professional Conduct for Clinical Officers 2012.
8. Standards of Nursing education and practice, Code of Ethics and Conduct and Scope of Practice for Nurses in Kenya.
9. The Ministry of Health 2012 Standards and Guidelines for Reducing Mortality and Morbidity from unsafe abortion.
10. The Ministry of Health 2019 Post abortion Care Guidelines.
11. The Ministry of Health PAC Reference Manual 2003.

Despite the existence of such elaborate laws and guidelines, and the safeguards they provide, little to no implementation in the provision of sexual and reproductive health care services in the country has been observed. Similarly, although the Ministry of Health approved post abortion guidelines in 2019 for health care providers on handling complications resulting from abortions, training on post abortion care in majority of public health facilities and among health care workers is minimal. The consequence of this inadequate training of health care providers is that integration of post abortion care with other family planning services at health facilities remain weak.

5.6.1. REGIONAL AND INTERNATIONAL CONVENTIONS OR DECLARATIONS ON ABORTION OR WOMEN'S RIGHTS

Regional and international laws, policies and guidelines that have been domesticated in Kenya and that support women's right to safe abortion services include:

1. The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol);
2. WHO Safe Abortion: Technical and Policy Guidance for Health Systems Second Edition 2012

[11] Center for Reproductive Rights. Decision L.C. vs Peru. https://reproductiverights.org/document/decision-lc-v-peru
[12] https://www.law.berkeley.edu/wp-content/uploads/2015/10/Kenya_Natl-Guidelines-on-Mgmt-of-Sexual-Violence_3rd-Edition_2014.pdf

3. WHO Guidelines on Health worker roles in providing safe abortion care and post abortion contraception
4. The International Federation of Gynaecology and Obstetrics (FIGO) initiative for the prevention of unsafe abortion.
5. International Covenant on Economic, Social and Cultural Rights.
    a. General comment no. 14 (2000), the right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights).
    b. General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights).
6. Convention on the Elimination of All Forms of Discrimination against Women.

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, also known as the Maputo Protocol 2003, was among the first human rights treaties to call on African governments to provide access to abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus13.

The United Nations Committee on Elimination of Discrimination Against women in the L.C Vs Peru case proposed that the state reviews its legislation with a view to decriminalizing abortion when the pregnancy results from rape or sexual abuse[14].

Other international treaties that have been ratified by Kenya include the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child, the Convention Against Torture and other cruel, inhuman or degrading treatment or punishment, the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights. Provisions of these conventions have been domesticated by several domestic legislations such as the National Gender and Equality Commission Act, the prohibition of female genital mutilation Act of 2011, protection from domestic violence Act, Children's Act, Basic Education Act which are also made in compliance with the Constitution of Kenya, 2010.

These legislations and treaties protect the fundamental right to life, right to the highest attainable standard of health, right to liberty and security of person against arbitrary arrests and imprisonment as well as the right to freedom from torture and cruel, inhuman or degrading treatment, right to Equality and Non-Discrimination, Right to Dignity, right to information, right to privacy and family, right to effective judicial action [93].

5.6.2. IMPACT OF SECTION 6 OF THE HEALTH ACT 2017 ON ACCESS TO SAFE ABORTION IN KENYA

The Health Act was passed in May 2017 to operationalise Articles 26(4) and 43(1)(a) of the Constitution of the Republic of Kenya (2010) that guarantee the right to the highest attainable standard of health including the right to sexual and reproductive health. Section 6 of the Health Act safeguards the right to access to reproductive health information and services, and treatment for pregnancy conditions including any medical condition exacerbated by pregnancy that may threaten the life and health of the mother. Abortion is however

[13] Maputo Protocol, 2003: Article 14
[14] Center for Reproductive Rights. Decision L.C. vs Peru. https://reproductiverights.org/document/decision-lc-v-peru

not explicitly mentioned as one of these conditions. The rider to the provision of the said treatment is that the pregnancy conditions are 'notifiable'. This begs the question if abortion is one of the envisaged pregnancy conditions, is it considered a 'notifiable condition' as provided for in the Public Health Act and if so, what is the impact of such a requirement on access to abortion services by women and girls that deserve? Further, what is the impact on the service provider of the requirement to notify? Could the obligation for notification constitute an infringement of the privacy of women accessing abortion services?

An analysis done by KELIN[15] on the questions raised above which relate to section 6(1) (c) of the Health Act concludes that the vagueness regarding permissible pregnancy conditions, and the requirement that abortion is provided 'under certain conditions' may be problematic. The lack of explicit mention of abortion as an accessible service may limit the applicability of the Act in safeguarding the rights of women and girls to access sexual and reproductive services, including abortion.

5.6.3. NATIONAL AND COUNTY POLICIES AND PROGRAMS TO ENHANCE ACCESS TO SAFE ABORTION CARE

A number of County Governments in Kenya, in an effort to tackle the consequences of unsafe abortions, have formulated laws in line with the provisions of the Kenya Constitution to govern abortion care seeking and service provision. The Makueni County Assembly, for instance enacted a maternal new-born child health Act which recognizes termination of pregnancy under circumstances such as rape, foetal abnormality as well as mental incapacity by the pregnant woman to appreciate the pregnancy. The Kilifi County maternal new-born child health Act restricts access to safe termination of pregnancy only to emergency situations, while Kakamega maternal child health and family planning Act of 2017 does not include any provisions that regulate termination of pregnancy. While the inconsistencies in these acts remain noticeable, spreading such piecemeal efforts across more counties only serves to provide better access to safe abortion care services to women from within these specific progressive counties as well as to women in other neighbouring counties.

5.6.4. STATUTES AND JUDICIAL DECISIONS ON ABORTION IN KENYA

Several judicial decisions on abortion care and sexual reproductive health rights uphold the Kenyan constitutional provisions on abortion. In the case of *FIDA Kenya and three others vs the Attorney General of Kenya and others (JMM* case) in 2015[16], the High Court ruled that the Ministry of Health violated the rights to access to health of women of child bearing age by withdrawal of the safe abortion standards and guidelines, thereby endangering their lives. Further, banning of training of health professionals denied them of their right to information that would be useful in the provision of safe abortion services as provided for by the law. While adopting the WHO definition of health[17], the court further re-emphasized that abortion as a right is allowed in cases of emergency treatment, to save the life or health of a pregnant woman and as provided by any other written law.

However, there are instances when judicial decisions highlight the gaps in the legal instruments for safe

[15] Unpublished Report. KELIN. An Analysis of Section 6 of The Health Act 2017 and Its Impact to Safe Abortion in Kenya

[16] Petition 266 of 2015. http://kenyalaw.org/caselaw/cases/view/175490/

[17] The WHO defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. https://www.who.int/about/who-we-are/frequently-asked-questions

abortion. In the case of *Republic vs John Nyamu and 2 others*, the court ruled that there was no evidence of murder of the two foetuses in that case, as per section 214 of the Penal code. There was therefore lack of evidence as to whether the two foetuses had been born dead and were therefore not persons capable of being killed, citing that abortion could not therefore be proved in this case.

5.6.5. THE POLITICAL AND RELIGIOUS DISCOURSES ON THE LEGALITY OF ABORTION IN KENYA

Political and religious proclamations on abortion due to lack of information suggest that it is immoral and sinful to obtain or offer abortion services in Kenya. Religious doctrines view life as sacred, and abortion as evil. Thus, despite various provisions in law governing abortion in Kenya, many women and girls make decisions that are directly or indirectly influenced by their or their relatives' religious beliefs, community norms and cultural traditions, which almost always discourage the practice. Religious and sociocultural norms deny women the opportunity to seek safe abortion services, and drive women to seek abortion services from unskilled providers in clandestine settings, the result of which are high rates of morbidity and mortality from complications of these unsafe abortions. Similarly, health care providers and health facilities are hesitant to offer safe abortion services for fear of being branded as abortionists or abortion clinics [45].

5.7. SPECIFIC GUIDELINES FOR LEGAL REFORMS NECESSARY TO CREATE AN ENABLING ENVIRONMENT FOR ACCESS AND PROVISION OF SAFE LEGAL ABORTION CARE SERVICES IN KENYA

The WHO to which Kenya is a member, has proposed a number of strategies to create an enabling environment for the access and provision of safe abortion services globally that apply to Kenya. These strategies are effective if they aim to prevent unintended pregnancies which are a precursor for unsafe abortions. Accordingly, ending unwanted pregnancies requires that countries must develop and implement supportive policies and make financial commitments to provide:

1. Comprehensive sexuality education in schools
2. A wide range of contraceptive methods, including emergency contraception
3. Accurate contraceptive counselling
4. Access to safe and legal abortion

To this end, the WHO provides global technical and policy guidance to states on the use of contraception to prevent unintended pregnancy, on safe abortion, and the treatment of complications from unsafe abortion. These guidelines, if well domesticated and implemented will significantly reduce the need for unsafe abortions and consequently lead to a reduction in maternal deaths resulting from unsafe abortions.

5.7.1. GUIDELINES FOR HEALTH WORKER ROLES IN PROVIDING SAFE ABORTION CARE AND POST ABORTION CONTRACEPTION

Among the guidelines provided by WHO is a description of the role of the health worker in providing safe

abortion care and post abortion contraception[18]. This guideline proposes a number of strategies to support health workers in providing safe abortion care, in the management of complications from unsafe abortion and for post abortion contraception counselling. Major among these strategies is the planned and regulated task shifting and task sharing to ensure a rational optimization of the available health workforce, address health care system shortages of specialized health care professionals, improve equity in access to health care and increase the acceptability of health services. The broadening of 'trained health professionals' in the Kenyan constitution to include nurses, midwives and clinical officers is a clear example of task sharing and shifting in provision of abortion care.

These guidelines were updated with the publishing of the WHO Medical Management of Abortion in 2018[19] to facilitate high-quality health care for all pregnant individuals who seek a medical abortion. Extant evidence from elsewhere shows that training and supportive supervision boosts the willingness and capacity of non-physician providers to offer PAC, reduces delays in the management of patients, and expands access to PAC [94-98].

5.7.2. THE WHO GUIDELINES, POLICIES AND HEALTH STANDARDS ON ABORTION CARE

The WHO and the Population Division of the United Nations Department of Economic and Social Affairs provide an open-access database of laws, policies and health standards on abortion in countries worldwide. The database aims to promote greater transparency of abortion laws and policies, as well as to improve countries' accountability for the protection of women and girls' health and human rights.

The Clinical Practice Handbook[20] for safe abortion provides guidance to health care workers in different geographical and legal settings, on providing safe abortion and/or treating complications of unsafe abortion. 'The Safe abortion: technical and policy guidance for health systems,'[21] gives the public health and human rights rationale for safe abortion care, how to provide clinical care for women undergoing abortion, and legal and policy considerations with a focus on women's health and human rights.

Despite all these commitments with the WHO guidelines, the Government of Kenya has not fully implemented these guidelines towards protection of health and rights for women and girls.

6. RECOMMENDATIONS

Various institutions and agencies in Kenya need to act decisively and deliberately in order to ensure, promote, protect, guarantee, advance and improve access to and quality of sexual and reproductive health, including family planning and safe abortion services. Based on the situation as reviewed and the findings of the analysis

[18] WHO, human reproduction programme. Health worker roles in providing safe abortion care and post-abortion contraception. https://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion-task-shifting/en/
[19] Medical management of abortion – World Health Organization. https://www.who.int/reproductivehealth/publications/medical-management-abortion/en/
[20] https://apps.who.int/iris/bitstream/handle/10665/97415/9789241548717_eng.pdf?sequence=1
[21] https://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf?sequence=1

a number of "know what" and "know how" emerge. The following sectors and/or agencies and institutions are targeted by the specific recommendations:

1. General recommendations to the Government of Kenya
2. Recommendations to the Attorney General's Office for the protection of human rights
3. Recommendations to the Ministry of Health
4. Kenya Medical Association and other health professional associations (HPAs).
5. Human rights organizations and associations
6. Other relevant organizations: media, funding agencies, human rights protection and monitoring bodies (globally and regionally).

6.1. GENERAL RECOMMENDATIONS TO THE KENYA GOVERNMENT

Kenya, having ratified several legally binding international treaties, that include: International Covenant on Economic, Social and Cultural Rights (ICESCR); International Covenant on Civil and Political Rights (ICCPR); Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW); Convention on the Rights of the Child (CRC), Banjul Charter; African Charter on the Welfare of the Child and in keeping with the observation by treaty monitoring bodies that restrictive abortion laws violate women's right to life, health, dignity, equality and non-discrimination, should comply with and be accountable for these treaties.

- Kenya should ratify the treaties that it has signed. This includes ceding its reservations on the Protocol to the African Charter on Human and People's Right on the Rights of Women in Africa (Maputo Protocol, especially Art 14.2 (c).
- Ensure (and enforce) the Bill of Rights provision in the Constitution including making/providing quality health, reproductive health and abortion services as per the conditions stipulated in Article 43 and Article 26 (4).
- Develop legislative and policy frameworks that recognize, promote, protect and enhance the rights of women as contained in international and regional human rights treaties and international conference resolutions documents that have been signed and/or ratified by Kenya.
- Incorporate these legal and policy frameworks into various sectors including education, public health, social services, internal security and law enforcement, justice, criminal justice system at both national and county levels.
    - The officials of different ranks including the executive, legislative and judicial arms of government as well as legislative and civil society organizations concerned with women's welfare and health should be involved.
- Promote inter-sectoral and interdisciplinary commissions composed of professionals from the health sector, legislators and representatives of women's organizations, including Maendeleo Ya Wanawake, and human rights bodies.
    - The commissions should review Kenyan laws to detect and isolate discriminatory provisions with special emphasis on restrictive laws in area of SRHR, and recommend measures to address the magnitude, complications and high cost of unsafe abortions.
- Initiate, promote and organize public engagement and debate on various nationwide abortion discourses and create room for multiple perspectives and points of views from different sectors, stake owners and stake holders on SRHR and abortion.
- Review laws, policies, guidelines and standards that address provisions that discriminate against

women, adolescent and young people, and propose bills and policies to address those structural factors that act as obstacles to the full enjoyment and exercise of economic and social rights on the part of Kenyan women particularly young, low-income and those who reside in marginalized and informal settings.

- Towards realization of Agenda 2030, the national government should fully embrace the sustainable development goals 3, 4 and 5 which are relevant for providing safe abortion.
- Government of Kenya should commit to:
    - Providing universal access to SRHR, either within the universal health coverage initiative, the free maternity care program or the Linda Mama initiative.
    - Developing enforceable legislation for gender equality in access to health care services including SRHR.
    - Identifying and addressing specific challenges related to human resources for health, including setting the right policy environment for effective task-shifting in SRHR service delivery.

6.2. RECOMMENDATIONS TO THE ATTORNEY GENERAL'S OFFICE FOR THE PROTECTION OF HUMAN RIGHTS

- Study and address the need to reform the provisions of the Penal Code (Sec 158, 159, 160) as a violation to human rights of women.
- Repeal the Penal Code's provisions on abortion in Kenya which are archaic, having been adopted from the statutes in force in England on August 12, 1897 and which have since 1967 been repealed in the country of origin and replaced by the Abortion Act.
- In collaboration with the Office of the Director of Public Prosecution (ODPP), advise the public prosecutors and courts to read the Penal Code (Sec 158, 159 and 160) with the necessary alterations, adaptations, qualifications and exceptions to bring it into conformity with the constitution.
    - The law enforcement officers must ensure that health care professionals - doctors, clinical officers, nurses and midwives who provide safe abortion services within the precepts of the supreme law of Kenya are not harassed through spurious prosecution.
- Follow up pending and concluded cases on abortion in the ODPP to ensure that rights of women, especially vulnerable ones, are not violated.
- The leadership of the National Police Service (NPS) should sensitize police officers on the law regulating access to abortion services in Kenya to ensure clarification of values and destigmatize the police service.
- Monitor Kenya Government's fulfilment of international and regional treaties that protect women's rights.
- Promote and enhance the implementation and advocate for adoption of comprehensive sexuality education curriculum in schools by counties. This approach can have a multi-pronged approach, at the national level for policy and legal reforms as well as at county level of enactment of specific county-relevant by-laws and their implementation.

6.3. RECOMMENDATIONS TO THE MINISTRY OF HEALTH IN KENYA

- The Ministry and all County Governments should communicate to all health workers the reinstatement of, widely disseminate and implement fully, monitor and evaluate the 2012 standards and guidelines for management of unintended, risky and unplanned pregnancies.

- Reinstate the national training of nurses, clinical officers, midwives and doctors on provision of safe legal abortion services and post abortion care including the use of medical abortifacients.
- Invite and partner with members of CSOs - particularly women groups - to contribute to formulation of national policies and plans that affect SRHR.
- Prioritize the implementation and evaluation of activities in the National Reproductive Health Strategy.
    - Use indicators that show the quality of services provided to women, adolescent and young people, particularly with regard to their human rights.
    - Use accountability tools (dashboards, score cards) to monitor service provision.
- Address, document and track the magnitude, complications, impact on maternal mortality and morbidity and cost of unsafe abortion in Kenya. In effect, all health facilities at all levels should collect abortion-related data as part of the routine health management information services in the DHIS II.
- Disseminate information on SRHR and increase access to SRH services through social media, mass media, considering the specific needs of most vulnerable groups.
- Prioritize PAC service provision to women suffering complications from abortion performed in very dangerous/unsafe conditions (such as self-terminations, home-made remedies and use of traditional birth attendants for management of complications).
    - The services include free maternity (including free safe abortion) services and appropriate counselling and provision of contraceptives.
    - The public health care system should provide necessary and appropriate equipment (such as use of MVA for first trimester abortion and not dilatation and curettage), supplies and training to post abortion health care providers.
- Ensure the fulfilment of reproductive health plans and programmes targeting adolescent and young people (AYP) and high-risk groups (AYP living with disability, survivors of sexual and gender-based violence, key populations, and very young adolescents).
    - In this context it is of utmost importance to initiate campaigns aimed at disseminating information on SRHR and contraceptive services and to guarantee access to SRH.
- Be intentional to remove barriers to the provisions of abortion services to ensure that conscientious objection by health professionals does not prevent women of child bearing age from accessing health services including abortion, but rather measures should be introduced to have the women referred to alternative health providers.
- Promote public-private partnerships for advocacy, public education, and enhanced access to SRH services.
    - Evidence indicates that a majority of the post abortion cases are managed within the public health facilities while private service providers lead in the provision of safe pregnancy terminations. There is therefore, need to synchronize these services in order to ensure continuous quality enhancement across the wide spectrum of service delivery and for the sector-wide availability of quality and comprehensive abortion care services.
- Support Counties in establishing effective systems for provision of safe abortion care and post abortion care services in various levels of health facilities.
    - One way in achieving this is through strengthening of pharmacy-delivered medical abortion [99] [100] as well as equipping all levels of health facilities with both the capacity and infrastructure to provide care for women presenting with first and second trimester abortions.
- Health care providers must be able to discuss pregnancy termination with clients in a non-directive and non-judgmental way and be able to refer women to safe legal abortion services.

6.4. RECOMMENDATIONS TO THE KENYA MEDICAL ASSOCIATION AND OTHER HEALTH PROFESSIONAL ASSOCIATIONS

- Partner with other health professional associations including KOGS, NNAK, KMWA, KCOA and human rights organizations and associations (RHRA, KELIN, CRR, FIDA-Kenya on SRHR to advance SRHR.
- Create forums where doctors, gynaecologists, nurses, clinical officers and other health care providers who support women's SRHR can speak publicly on abortion as a public health problem, and rope in the managers, leadership and general membership of the HPAs as a way of wading off repercussions, reprimands from the association or leadership.
- Encourage dialogue on abortion legislative reform, incorporating FIGO and WHO recommendations.
- The areas of dialogue and engagement include archaic, restrictive and punitive abortion legislation, contributing/identifying specific or special cases (e.g. when life of the woman is endangered by pregnancy, in cases of incest).
- KMA should take lead in advocating for liberalization of abortion laws and making sure that unsafe abortion is recognized as a major contributor to maternal mortality by policy makers, health care workers and among faith-based leaders.
- Working in collaboration with religious leaders in different communities, KMA can further engage with and aim to increase awareness of the risks of unsafe abortions and availability of safe options for those faced with pregnancy crisis.
- Engage with and advocate for county governments to prioritize provision of SRHR – propose, support and sponsor county level legislations and programs on SRHR for adolescent and young people and women.
- Respect the right to privacy of women who need PAC, those who need safe abortion services and maintaining professional doctor-patient relationship based on patient centred care and confidentiality of private patient information.
- Assist/facilitate reviewing and revising codes of medical and nursing ethics with the relevant regulatory councils: KMPDC, Nursing Council of Kenya, Pharmacy and Poisons Board, and Clinical Officers Council that violate women's rights.
- Identify other institutions and individuals that can act as allies in advocating for SRHR (media, donor/funding agencies, human rights protection and monitoring bodies (universal, regional human rights systems). In Nakuru the German Foundation for World Population (DSW), STRIVE, Mumbi, Human Rights Committee, and the Committee on Elimination of Discrimination Against Women.
- Support efforts by these partner organizations and individuals in promoting the awareness of SRHR at the community level, and in ensuring that women and their partners know their options and can exercise their constitutional rights on access to health, including SRHR.
- Actively engage civil society bodies and non-governmental organizations working in SRHR with specific interest groups e.g. adolescents, young people, commercial sex workers, gay and lesbian and queer societies as well as women in the 47 counties to build their capacity in providing safe abortion services.
- Support programs by civil society organizations that aim to involve men in SRHR in an effort to break sociocultural barriers that affect uptake and freedom to use contraceptives, and practice birth spacing.
- Demand for, respect, protect, guarantee and promote civil, political, economic and social rights that in turn guarantee the highest level and quality of SRHR for women, as well as greater power of decision

over reproduction free from discrimination, coercion and violence as per Cairo, Beijing and Nairobi global conferences on population and health.

- Design and implement monitoring and evaluation programs on the implementation and adoption of policy guidelines for SRHR at the national and county levels and consistently share these key findings with other relevant national and county actors for action and accountability tracking.
- Design and disseminate quality improvement strategies for comprehensive abortion care, including expansion and quality improvement of existing post abortion care services.
- KMA should, through a technical working group (TWG) develop an advocacy and accountability matrix for monitoring human rights and public health response by different layers and players through a score card or a dashboard with a clear outline of all the key organizations or layers. The TWG formation must take into account the divergence of approaches for these players to ensure a full scope on service provision, advocacy, research, capacity strengthening, and development among other focus areas.
- KMA should use both public health and human rights arguments to advocate for implementation of the provisions of Kenya's constitution and reform or repeal the provisions of the penal code sections 158, 159 and 160 that are restrictive and punitive to access to safe abortion. Through a deep and well-informed understanding of abortion, the public health and human rights principles, KMA should articulate the rights-based and public health-based approaches to the abortion issue.
- KMA should in addition forge strategic partnerships with other social movements, in particular those working in the areas of HIV/AIDs, social justice, globalization, poverty eradication and economic, cultural and social rights. Linking women's access to safe abortion to broader debates about the right to health as provided for in the constitution and the country's Big 4 agenda and universal health coverage, the need to eradicate poverty as part of Vision 2030 and the importance of promoting gender equality is critical.
- KMA should articulate to policy makers, health managers, health care providers and women and the population at large the grounds under which abortion is permitted to the full extent of the law.

To be able to effectively carry out their mandate, KMA can, and will benefit from properly thought-through strategies in their engagement with policy makers and key stakeholders. The KMA commands respect as a medical professional body, and can leverage on its strategic networks, technical capacity, long-standing credibility and working relationships with other key partners and stakeholders including the MoH to advocate for provision of safe abortion services. These networks comprise some of the much-needed service providers who currently provide safe abortion and post abortion care services in one of the vaguest legal and policy environments globally.

The strategies that KMA can apply towards the realization of enhanced access to SRHR for women and girls in Kenya include but are not limited to.

a) In collaboration with other global and regional medical associations, gynaecology associations, engaging government to draw more attention to the need to address the public health implications of restrictive abortion laws in Kenya. Already, the International Federation of Gynaecology and Obstetrics (FIGO) is working with the Kenya Obstetrical and Gynaecological Society (KOGS) to build capacity among its members to advocate for enhanced access of women to safe abortion to the extent permitted by law [101]. However, these efforts need to be further enhanced through more targeted engagements geared towards increasing the government's accountability for improved access to safe abortion services. This engagement should be further coupled with performance tracking towards specific milestones.

b) Through the more elaborate membership network in KMA, engaging members and all medical and clinical practitioners in Kenya to clarify the legal framework on abortion and post abortion care, with the aim of enhancing competency in decision making, and equipping health care providers with key and updated skills necessary to provide high quality comprehensive abortion care and post abortion care services.
c) Evidence generation and analysis on abortion for appropriate policy development and decision-making. By so doing, there will be use of locally generated evidence on the burden of unsafe abortion and complications from unsafe abortion, to inform necessary context specific interventions. This process could also involve identification of key actors in evidence generation as potential knowledge partners of the MoH and working together with these partners to strategize on the nature and type of evidence needed to build more scientific sense of the much needed research output on abortion, specific to the Kenyan context.
d) Consequently, the evidence generated should be used to demonstrate the link between unsafe abortion and unnecessary maternal deaths, highlighting counties and regions where the burden is heavy, while proposing key context-specific and pragmatic interventions to reverse the trend.

6.5. PROPOSED INTERVENTIONS TO PREVENT UNSAFE ABORTIONS AND THEIR COMPLICATIONS IN KENYA

Key tried and tested interventions that will be critical to addressing unsafe abortions, complications, morbidity and mortality arising from unsafe abortions in Kenya are highlighted below, and are summarised in Figure 4:

i. Liberalization of abortion laws, as proposed by Benson [46], posits that utilization of safe abortion services, and, ultimately, a reduction in maternal mortality, is best achieved when abortion restrictions are loosened and when there is an improved availability and distribution of safe abortion services.
ii. Enhanced access to safe and legal abortions includes ensuring improved access to CAC, leading to increased access to a wider range of safe abortion methods (MVA and medical abortion). This strategy further entails increased emergency care for abortion related complications which can be achieved through task-shifting to mid-level health care providers (nurses, midwives, auxiliary nurses, and clinicians). For instance, emerging evidence from research conducted in Kenya shows that if midwives are trained, they are as proficient in using MVA to treat incomplete abortion as physicians when outcomes are measured [102].
iii. Comprehensive sexuality education will empower young people, girls especially, with the knowledge, life skills and the agency to negotiate for their sexual rights, become gender empowered, and make appropriate and responsible choices on contraceptive use.
iv. Provision and use of effective contraception through sensitizing women on available contraceptive choices and the benefit of LARC to prevent unwanted pregnancies.

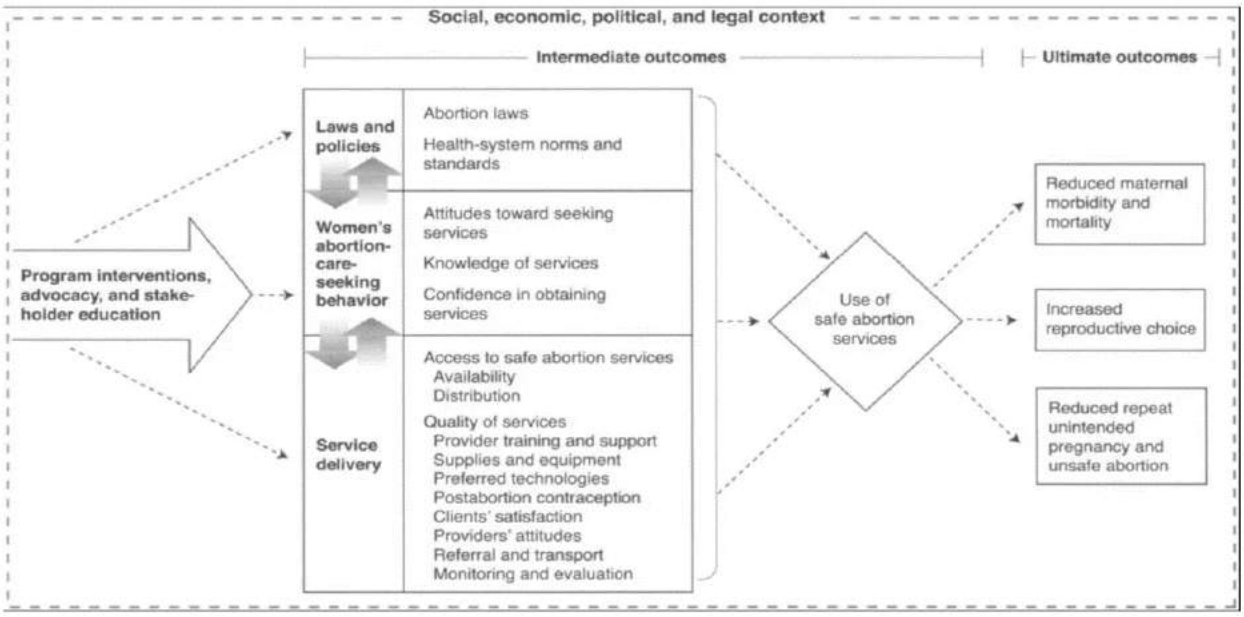

Figure 3: Benson's (2005) framework for enhanced utilization of safe abortion services

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8. APPENDICES

8.1. APPENDIX 1: KENYA'S ABORTION PROVISIONS

The Constitution of Kenya (2010) Article 26(4): Right to Life

Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.

The Penal Code, Laws of Kenya, Cap. 63, Revised Edition (2009), Articles 158-160, 228 and 240

Article 158. Attempts to procure abortion

Any person who, with intent to procure miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a felony and is liable to imprisonment for fourteen years.

Article 159. The like by woman with child

Any woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a felony and is liable to imprisonment for seven years.

Article 160. Supplying drugs or instruments to procure abortion

Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman whether she is or is not with child, is guilty of a felony and is liable to imprisonment for three years.

Article 228. Killing unborn child

Any person who, when a woman is about to be delivered of a child, prevents the child from being born alive by any act or omission of such a nature that, if the child had been born alive and had then died, he would be deemed to have unlawfully killed the child, is guilty of a felony and is liable to imprisonment for life.

Article 240. Surgical operation

A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.