



KIT Royal
Tropical
Institute



**KENYA OBSTRETRICAL
AND GYNAECOLOGICAL
SOCIETY**

Kenya Country Report

NEEDS ASSESSMENT ON SAFE ABORTION ADVOCACY

FOR THE KENYA OBSTRETRICAL AND GYNAECOLOGICAL SOCIETY (KOGS)

COMMISSIONED BY THE INTERNATIONAL FEDERATION OF GYNAECOLOGY AND OBSTETRICS (FIGO)

CONDUCTED BY: KIT ROYAL TROPICAL INSTITUTE – HEALTH UNIT

Joyce Olenja, Irene de Vries¹, Korrie de Koning

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KIT - Health

Mauritskade 63

1092 AD Amsterdam

Telephone +31 (0)20 568 8711

Fax +31 (0)20 568 8444

www.kit.nl/health

¹ The first and second author equally contributed to this report

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Executive Summary

This report describes the needs assessment set out to provide better and more in depth understanding of the capacity of the Kenya Obstetrical and Gynaecological Society (KOGS) and in particular to identify the main abortion advocacy needs that a forthcoming multi country project can address. The assessment attempted to provide more clarity on how FIGO can effectively strengthen the capacities of the society. The assessment involved conducting a literature review, a survey of members of the society key informant interviews with stakeholders at various levels with the majority being associated with KOGS as well as a stakeholder workshop for KOGS members and partners.

The literature review, the key informant interviews and the workshop confirmed that unsafe abortion and its complications is a major problem in Kenya, endangering the lives of many women. The practice of unsafe abortion is so rampant that the need for safe abortion to reduce this problem is urgent. Although the legal framework provides for abortion in exceptional circumstances, it remains largely illegal causing a dilemma for service providers. Safe abortion is therefore provided in a clandestine manner. Advocacy for safe abortion faces many challenges where traditional norms as well as entrenched religious beliefs do not support safe abortion. To strengthen advocacy for safe abortion requires the engagement of various stakeholders in dialogue to win them over. KOGS strong presence as a leader in technical knowledge has the opportunity to influence and network with like-minded organizations to advocate for and provide safe abortion services to women who require them.

Building its base as a safe abortion advocate, the association will require to address the various and potential challenges as were identified during the key informant interviews and the two day's workshop. This could include the following:

- Strengthening the management and organization of KOGS as a formidable for safe abortion advocacy
- Establishing a coordinated and vibrant network of associations that are supportive of safe abortion
- Transforming the social and gender norms at all levels regarding safe abortion but within the context of the Kenyan law
- Ensuring that the legal framework is consistent while conducting sensitization about the legal framework to stakeholders at all levels for harmonious interpretation.
- Ensuring a process for data generation and use for monitoring and planning for services

These recommendations, identified in collaboration with KOGS, are taken forward and translated into a preliminary action plan with tangible activities and outcomes. The action plan will be further developed in collaboration with KOGS and FIGO and be a source of inspiration for the development of a future program proposal for safe abortion advocacy in 10 countries (Kenya, Benin, Cameroon, Ivory Coast, Mali, Mozambique, Panama, Peru, Uganda, Zambia).

Introduction

This country report is the result of a needs assessment conducted by KIT Royal Tropical Institute with the Kenya Obstetrical and Gynaecological Society (KOGS) regarding Safe Abortion Advocacy. Kenya is one of the ten countries participating in a broader Needs Assessment for an upcoming multi-country FIGO-led project that aims to increase the capacity of national obstetrics and gynaecology societies to become national leaders in safe abortion advocacy work.

Needs Assessment Purpose

This Needs Assessment is the first phase of an upcoming safe abortion project and it should provide a better and more in depth understanding of the capacities and needs of KOGS. Subsequently, it will identify the main needs in relation to safe abortion advocacy that the following multi country project could address. Also, it should provide more clarity on how FIGO can strengthen more effectively the capacities of national societies, in this case KOGS. This includes the provision of recommendations on the content of the capacity building program by developing country action plans with budget, as well as a comprehensive program proposal for the whole ten countries.

Needs Assessment Objectives

The specific objectives are that by the end of the needs assessment in ten countries, FIGO should have:

- Insights on the situation of abortion in each country
- Understanding of the capacity and needs of each National Obstetrics and Gynaecology Society on abortion advocacy
- Plans of Action for each National Obstetrics and Gynaecology Society developed through a collaborative process
- Recommendations on FIGOs role to strengthen the capacity of the ten National Societies as abortion advocates, translated into a comprehensive proposal

Methodology

This Needs Assessment was formative of character and aimed for a highly participatory approach. Constant mechanisms of communication and feedback with KOGS took place in order to create mutual understanding and joint objectives.

The following methods were used in order to meet the objectives of the assessment:

1. Desk study review

A desk study review on existing literature and evidence was committed between February and March 2018 through a desk review tool. Academic databases and grey literature were searched for the relevant themes as addressed in the assessment framework (inception report). KOGS and key stakeholders were requested for relevant input.

2. Online survey

An online survey, using Survey Monkey software, was sent out to all 396 registered members of KOGS to ask them about their membership of KOGS, the position of the society towards safe abortion and their own professional and personal position towards safe abortion. While the preference was discussed to send out email invitations directly from the software², this appeared logistically not feasible and not preferred by the society due to privacy concerns. KOGS sent out the web link to their members on 12 February 2018. Despite several reminders to attain more responses, only 35 responses came back of which 30 were complete (completion rate 86%; three respondents did not continue after question 5, two more did not continue after Q20). The survey remained open for 4 weeks and closed on 19 March 2018. Analysis was done using the survey monkey software. All answers that were provided on all questions were included in the analysis.

3. Key Informant Interviews

A total of 14 key informants were interviewed on 15 and 16 February 2018. They included representatives from the Kenya Obstetric and Gynaecological Society (KOGS), Kenya Medical Association (KMA), Kenya Clinical Officers Association (KCOA), National Nurses Association of Kenya (NNAK), Reproductive Health Network (RHN), Ministry of Health (MOH) officials, IPAS, UNFPA, Christian Evangelical Association and Catholic Bishops representation. The interviews were conducted either within their offices or KOGS' office. With permission, the interviews were recorded as well as taking of notes. These notes were extended using the tape recordings. The notes were collated and organized along thematic areas as outlined in the findings section. The findings were analysed taking into account the various perceptions regarding safe abortion. These clustered around those in support, those who were somewhat neutral and those who were wholly opposed to safe abortion based on religious and personal convictions.

² During the inception phase it was agreed with FIGO that, in order for the survey to be submitted only once per member and to avoid the survey being forwarded to others who could then influence the outcome into a more positive or negative way, an invitation to the survey should preferably be sent out directly from the software to a list of email addresses; these invitations can be used only once. In case of this being not feasible, a password-secured weblink to the survey would be sent out by the society with the password in a separate email.

4. Stakeholder workshop

A two days stakeholder workshop took place in Naivasha on 19th -20th February. The purpose of the workshop was to identify the needs of KOGS for abortion advocacy and develop a plan of action for the next safe abortion advocacy proposal that will be developed for the National Societies of Obstetrics and Gynaecology in ten countries involved in the needs assessment.

The objectives were that by the end of the workshops participants have:

- Discussed and identified opportunities and barriers for providing safe abortion in the country based on the desk review presentation and own experience.
- Explored their personal and professional values related to abortion and identified activities for improving access to safe abortion and post abortion care based on professional ethics.
- Explored the implications of the national abortion law and policies for access to safe abortion.
- The ability to explain the concept and levels of advocacy and identify challenges and barriers of abortion advocacy.
- Identified the strengths and weaknesses of the national society in abortion advocacy.
- Formulated action points for an abortion advocacy programme.

A total of 22 participants attended, most (18) being present for both days, some attending only the first or second day. A full program of the workshop and list of participants can be found in Annex 1.

Challenges and Limitations

One of the main challenges perceived was to get responses to the survey. In general, as perceived by KOGS more often, there seems to be a low tendency in responding to surveys in general. The team, in collaboration with KOGS, took several actions to mitigate the limitation of a low response rate. KOGS members that participated in the workshop and had not filled out the survey prior to attendance were requested to fill in the survey immediately upon arrival on a laptop that was made available by KOGS. The survey was also promoted by KOGS during their annual conference directly following the workshop and several reminders were sent. While it was emphasized that KOGS is interested to hear the voices of all members, regardless of their position, it is expected that mainly those who have strong feelings about the topic took the effort to respond. With a total response rate of only 9% this survey cannot be seen as a reliable representation of the complete variety of KOGS members. The majority of the people who took the effort to fill in the survey were generally supportive of safe abortion. Strong opposing views were minimally represented.

The challenges experienced in relation to the interviewing were largely the time limitation to cover all the relevant key informants. Some interviews were cancelled because the interviewee not being available at the planned days. While new key informants would probably have given more insight, the interviewers also felt to have reached a certain saturation point. The team was not able to interview the Director of Medical services who would have shed more light on the issue of guidelines for safe abortion that remain unresolved.

In terms of the workshop the attendance was largely by those who were in favour of safe abortion. The participants expressed to have wanted to have those who are opposed to safe abortion so that they would share and debate the varied views. While KOGS members with opposite positions were invited, they did not attend. Some other key stakeholders that were invited, such as IPAS or Marie Stopes International, did not attend for unknown reason.

Findings

Literature review

Improving maternal health and reducing maternal mortality remains at the centre of global health initiatives. Globally, the annual number of maternal deaths reduced by 43% between 1990 and 2015 from 532,000 in 1990 to 303,000 in 2015 (WHO 2015). During the same period the approximate global lifetime risk of a maternal death fell considerably from 1 in 73 to 1 in 180. Majority of these deaths are among women from Sub-Saharan Africa. Majority of countries in Sub-Saharan Africa did not meet the Millennium Development Goal 5 whose target was to reduce maternal mortality by 75% (of the 1990 maternal mortality ratio). More than 80 percent of an estimated 289,000 annual maternal deaths are due to obstetric haemorrhage, obstructed labour, hypertensive disorders (e.g., severe preeclampsia or eclampsia), complications related to abortion, and postpartum sepsis (WHO 2014).

In an effort to accelerate the achievement to MDG 4 and MDG 5, the UN Secretary-General's Global Strategy for Women's and Children's Health was developed and a high-level Commission on Information and Accountability (COIA) set up to promote "global reporting, oversight, and accountability on women's and children's health (The Commission on Information and Accountability for Women's and Children's Health 2011). Building up onto these efforts, the Sustainable Development Goals (SDGs) have been set up to establish a transformative agenda for ending preventable maternal deaths. Target 3.1 of SDG 3 is to reduce the global MMR to less than 70 per 100 000 live births by 2030. Achieving this significant reduction will require an average of 7.5% reduction of global MMR annually between 2016 and 2030; more than three times the 2.3% annual rate of reduction observed globally between 1990 and 2015.

Table 1: Demographic indicators for Kenya

Demographic and socio economic information	Vital Statistics
<ul style="list-style-type: none"> • Pop 2016: 48.46 million³ • Devolved Administration and Health System: 47 Counties as health undertakers⁴ • GDP per capita ppp 2,925 USD (2016)³ • Annual GDP growth rate 4.876.³ • Below poverty line (45.9)%⁵ • Health Insurance Coverage 25%⁶ • Per capita Health Expenditure Current US\$ 78.6⁷ • Out of pocket expenditure 54%⁷ 	<ul style="list-style-type: none"> • Life Expectancy total: 63.4 years⁸ • HIV prevalence (5.9)⁹ • IMR 39/1000 live births 2014¹⁰ • MMR 316 /100.000 live births 2014¹⁰ • Delivery with skilled attendants- 63%¹⁰ • Unmet need for family planning 18%¹⁰

³ World Bank Development Indicators, 2016

⁴ Kenya Constitution 2010

⁵ Society for International development and Kenya national Bureau of Statistics, 2013

⁶ Netherlands Enterprise Agency. Kenyan Healthcare Sector- Opportunities for the Dutch Life Sciences & Health Sector, September 2016.

⁷ Kenya national health Accounts, Financial year 2015/16

⁸ WHO (2015)

⁹ Kenya HIV Estimates 2015

¹⁰ Kenya Demographic and Health survey, 2014

Maternal mortality remains high in Kenya at 362 per 100,000 live births (KNBS. IFC Macro. 2014). A multidisciplinary, anonymous and confidential review of 484 maternal deaths that occurred in 2014 from the national and major referral hospitals revealed that most deaths occur due to obstetric haemorrhage (39.7%), non-obstetric complications (19.8%) and hypertensive disorders associated with pregnancy (15.3%). Pregnancy with abortive outcomes contributed to 8.3% of the maternal deaths (Ministry of Health 2017).

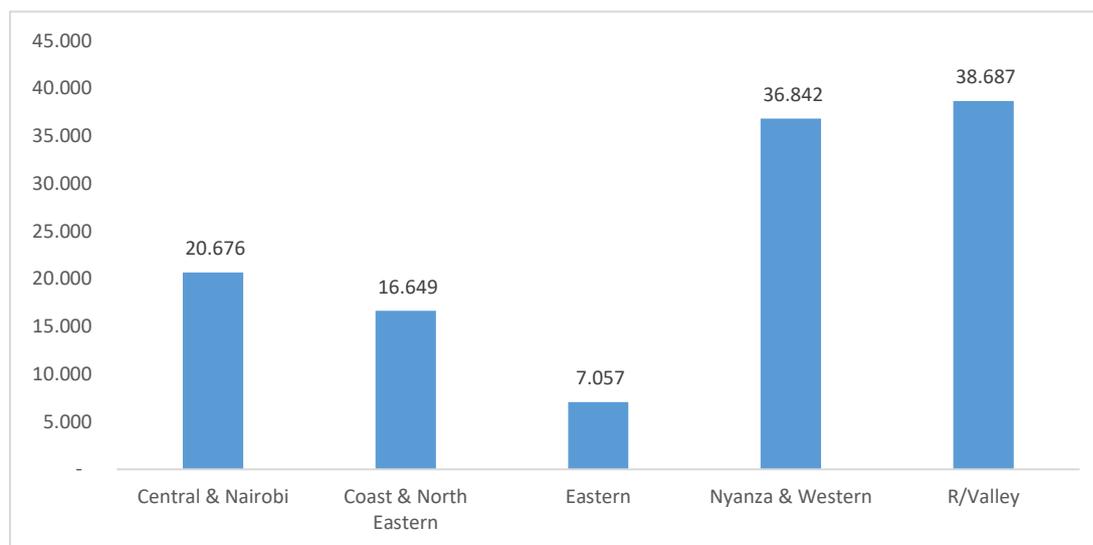
A national study conducted in 2012 involving 328 public and private health facilities reported that almost 465,000 induced abortions occurred in the year 2012, translating to a national abortion rate of 48 per 1,000 women of reproductive age (15- 49 years). A total of 120,000 women received care for complications resulting from unsafe abortions with three quarters of the women being treated for moderate or severe complications. Young women suffered disproportionately, as 45% of women aged 19 and younger who came to a health facility for post-abortion care, experienced severe complications (APHRC; MOH; IPAS; Guttmacher 2013). The data also shows that women who seek abortion related care are from a diversity of backgrounds in terms of demographics and social economic background. Significantly, more than 70% of women seeking post abortion care were not using a method of contraception prior to becoming pregnant (APHRC; MOH; IPAS; Guttmacher 2013).

The contraceptive prevalence rate (CPR) for Kenya is 58% with regional variations ranging from 73% central, Eastern 70% and the lowest 3% North Eastern. The urban and rural variations are 62% and 56% respectively. There has been a reduction in the family planning unmet need from 26% in 2008-09 to 18% in 2014. Unmet need is higher among rural women (20%) than among women living in urban areas (13%).

Unsafe abortion continues to pose a major public health challenge in Kenya because of the high proportion of women presenting for Post Abortion Care (PAC) with moderate to severe complications. Induced abortions are not occurring at the same rate throughout the country. High rates of induced abortion were reported in Nyanza-Western region and Rift Valley region compared to other regions in the country (APHRC; MOH; IPAS; Guttmacher 2013) (Figure 1). These higher rates could be attributed to poor women's health, higher poverty levels, gender-based violence and poorer access to family planning services in these regions. The high incidence of abortion is related to high levels of unintended pregnancy (Ipas Africa Alliance 2012).

Because abortion is highly stigmatized in Kenya, deaths and disability due to unsafe abortion are difficult to measure partly due to underreporting and that current data within Health Information System (Dhis2) in Kenya does not capture deaths and complications due to unsafe abortion. Findings from a study conducted in four poor urban settlements in Nairobi where women were asked about pregnancy and pregnancy loss, few reported voluntary termination. Of the 200 women who had experienced a pregnancy loss, fewer than 4% characterized it as a voluntary termination, and the vast majority (80%) reported that they had had a miscarriage (Ochako, Rhouné, Izugbara 2011)

Figure 1: No. of women treated for induced abortion complication in Kenya



Source: Incidence and complication of unsafe abortion in Kenya, 2013

Legal and Policy Context

According to The constitution of Kenya 2010 “abortion is not permitted, except, 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”. On the other hand, the Penal Code Cap 63, Laws of Kenya, sections 158-160 criminalises the procurement of abortion as well as the supply of drugs or instruments for procuring abortion. In 2010 Kenya ratified the Maputo Protocol (2013) committing to ensure that the right to health of women, including sexual and reproductive health is respected and promoted and appropriate measures shall be taken to protect the reproductive rights of women by authorising medical 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 foetus¹¹.

The Kenya Obstetric and Gynaecological Society (KOGS) in 2011 published proposed standards and guidelines for providing lawful safe abortion in Kenya (KOGS 2011). This was an adaptation of the WHO guidelines whose purpose was to ensure that women have access to safe abortion services to the fullest extent of the law. These guidelines outline the indications for legal safe termination of pregnancy and appropriate methods of pregnancy termination. The indications for legal termination of pregnancy includes: threat to life, emergency treatment, threat to physical health, threat to mental health, sexual violence, incest, rape and defilement, severe foetal abnormality, contraceptive failure, unplanned pregnancy in extremes of reproductive age (minor, peri-menopausal), severe social disruption.

The Ministry of Health in September 2012 published Standards and Guidelines for reducing morbidity and mortality from unsafe abortion in Kenya. However, these Guidelines were withdrawn in December 2013 through a government circular due to lack of consensus among stakeholders. Currently there are no Ministry of Health standardized medical guidelines on safe termination of pregnancy for use by

11 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. <http://www.achpr.org/>

health care providers. In June 2015, the Centre for Reproductive Rights filed a case in the High Court of Kenya at Nairobi that challenged the Ministry of Health's memo and the withdrawal of the Standards and Guidelines. Two organizations—East Africa Center for Justice and Kenya Christian Professionals Forum—have been granted permission to join the case as interested parties. The case is still in court (Ogembo 2018; Centre for Reproductive Rights 2015).

The Kenya Maternal and Newborn Health model recognizes Post Abortion Care (PAC) services as one of its pillars and one of the strategies to improving maternal survival. To this effect, the Ministry of Health has developed two documents: i) The National Post abortion Care training curriculum for health service providers (MOH 2012) and ii) The National Post abortion care reference manual (MOH 2013). These two documents were developed out of the need to equip reproductive health service providers with the necessary knowledge and skills to provide timely quality PAC services to reduce morbidity and mortality associated with complications of unsafe abortion. There has been skills transfer in Kenya whereby nurse midwives and clinical officers are trained to perform Post Abortion Care services.

The 2009 National guidelines on management of sexual violence in Kenya (MOH 2009) indicated that if a rape survivor presented with a pregnancy, which they felt was due to rape, termination of pregnancy may be allowed as outlined in the Sexual Offences Act, 2006. However, during the review of these guidelines in 2014, the guidelines prescribes that if a survivor intends to terminate a pregnancy which resulted from the sexual violence, this should be within the confines of the constitutional provisions (MOH 2014). This compounds the ambiguity that surrounds the clear definition of the exception where termination of pregnancy is allowed.

Characteristics of women who seek abortion

In Kenya, women who seek abortion and post abortion care services encompass a range of age group, socioeconomic status, marital status, education level, religion and urban or rural residence. In the study conducted by APHRC and MOH in 2012 about half of all PAC clients were less than 25 years of age with 17% aged 10-19 years old. The majority (59%) were from rural areas while 64% were married (APHRC; MOH; IPAS; Guttmacher 2013).

A majority of women who seek abortion are among the population that lives below the poverty line, suffer chronic hunger and deprivation as well as limited access to essential services including family planning. They are also exposed to gender based violence and unwanted pregnancies that often end up in unsafe abortion (Izugbara, Egesa, and Okelo 2015). In this study majority of the women had only primary level of education, casually employed and in petty business; increasing their social and economic vulnerability.

Barriers to safe abortion

There are several studies that have been conducted in Kenya to document barriers to accessing safe abortion services. The barriers identified include: limited knowledge of SRH information among women and girls, limited access to use of contraception, stigma associated with both unplanned pregnancies and abortion, lack of information about safe abortion methods, lack of understanding of provisions within the law that permit abortion, high cost of safe abortion services, negative health provider attitude. One study conducted in Nairobi, Kibera slums, summarizes barriers to seeking safe abortion services (Jayaweera et al. 2018).

Limited knowledge of sexual and reproductive health information especially among socially disadvantaged young girls and women who lack information on contraception and are exposed to gender based violence are likely to have unplanned pregnancy.

Stigma combined with limited access to and use of contraception. Although young women are aware of methods to prevent pregnancy and the availability of free contraceptives at public health facilities, fear of stigma and discrimination from health providers prevents them from seeking these services. In addition, health facilities frequently experience contraceptive stock-outs, causing gaps in their ability to provide methods and services (cited in Jayaweera et al. 2018).

Abortion stigma. Abortion is viewed by the community as being in conflict with the gendered social expectations of motherhood. Abortion stigma becomes a key driver in unsafe abortion (Izugbara, Otsola, and Ezeh 2009; Ochako, Rhoune. Izugbara 2011)

Lack information about safe abortion methods: most women are not aware of the different safe abortion methods available. The women are also not aware of the legal provisions that allow safe abortion so that one who qualifies for safe abortion still goes for unsafe abortion (Jayaweera, 2018: 8; Bosire, 2015: 44) .

Negative Health provider attitude: some health service providers were reported to discourage women seeking abortion and instead persuade them to keep the pregnancy. The providers may also threaten to hand the women over to the police. Stories from women who have experienced negative provider attitude indicate that high-profile health facilities and health providers respect the law and their work more than they respect women's needs and feelings. In discouraging women from accessing abortion services, providers inform women that abortion is very expensive, they should carry the pregnancy to term, abortion is illegal and they could be arrested. Health providers also shout at women, call them names and threaten to hand them over to the police. Women reported that as a result of mistreatment, they flee the clinic, consult friends and chemists operators for help (Izugbara, Egesa, and Okelo 2015)

Poverty affects women disproportionately. Female-headed households in Kenya experience higher incidences of poverty than their male counterparts, in both rural and urban areas (Institute of Economic Affairs 2008). In a country where almost 40% of the population lives on less than two dollars a day and 52% of the population lives below the national poverty line, safe abortion services are out of reach for many (UNDP & HDR 2010). In many instances poverty was given as one of the reasons that women seek abortion. In a research based in Central Kenya the motivation to seek abortion among women was largely driven by economic reasons. While older women saw abortion in rather pragmatic terms, as a response to the socio-economic burdens of having another child or having a child too soon; men generally viewed abortion as a woman's strategy to conceal the consequences of premarital or extramarital sex (Izugbara, Otsola, and Ezeh 2009).

Abortion stigma

Stigma has been described as spoilt identity applying to conditions that were regarded as against the norm and therefore attracting ostracism, rejection and avoidance as well as limiting social interactions. Stigmatization is a deeply contextual, dynamic social process; it is related to the disgrace of an individual through a particular attribute he or she holds in violation of social expectations. Stigma has been described as "an attribute that is deeply discrediting," reducing the possessor "from a whole

and usual person to a tainted, discounted one” (Goffman, 1963). Thus the social construct of stigma is one where there is discrimination due to labelling, stereotyping and separation. Abortion is viewed as an abnormal event such that women who procure are deviant (Kumar, 2013). Women experience rejection, exclusion or discrimination as a result of seeking abortion or when their abortion is in some way revealed to others (Shellenberg et al. 2011).

Within the general population induced abortion remains a common practice but also one that is stigmatized. In a paper that explored Kenyan women's perspectives on abortion stigma and safety as well as choice of pregnancy termination services, women interviewed stated that at least they knew a woman or a girl within their locality who had procured an abortion (Izugbara, Egesa, and Okelo 2015). Safe abortion is about the providers' expertise and the technical environment to conduct the procedure. On the other hand, women's notion of safe abortion lies largely in the privacy and secrecy of the procedure based on the recognition that abortion is illegal. Because of the ambivalence between illegality and legality, women chose the 'safer' path of operating in secrecy through established social networks to avoid stigmatization. Similar views were expressed in a qualitative study conducted in a slum setting in Nairobi where stigma operated at two levels. Unplanned pregnancies lead to stigma which in turn leads to unsafe methods to end the pregnancies in uttermost secrecy for fear of further stigma. Secrecy keeping and non-disclosure was an attempt to avoid abortion stigma (Jayaweera et al 2018).

Due to the fear of being stigmatized, women avoid going to the health facility or clinic to seek expert services for fear of information being leaked to the effect that they had an abortion. As a result, women seek abortion from less skilled providers, predisposing them to complications including death. A young woman in Machakos County explained why women opt for these unskilled methods:

“Somebody thinks that if I go to the hospital, they will monitor me....what has this person come to do here, so many people go for the traditional way so that no one knows. It becomes a secret such that you can't tell what happened to the person (woman, Machakos County).”

One man from Trans Nzoia County pointed out how the public stigmatization of women who have abortions drives them to seek unskilled procedures that in some cases lead to death: “We still go after these girls calling them names like, she is useless, she is terrible, and this makes the girl hate herself, that's why they hide and even die while aborting” (Yegon et al. 2016).

Bosire's (2015) study also points to women's preoccupation with procuring abortion in secrecy, and constantly concerned with who might get to know and the fear that they would be stigmatized. Due to social stigma young women aged between 10 and 19 years, with no education, with unwanted pregnancies and those referred from other facilities had longer delays before seeking care and consequently presented with the highest abortion complication rate. This goes to confirm that for a country where abortion is legally restricted the stigma associated with abortion may prohibit women from seeking promptly even when they are within the law (Mutua et al. 2015).

Research by the Centre for Reproductive Rights (2010) indicates that women are reluctant to seek help from qualified healthcare providers or counsellors because of the shame and fear of legal ramifications associated with abortion. As a woman in a focus group discussion in Mombasa explained,

—The problem is that abortion is not legal in Kenya and there is a lot of stigma surrounding abortion. You don't want to seek help publicly. You go to a private, unqualified hospital (Centre for Reproductive Rights 2010)

Health providers were also reported to be a source of stigma and it was given as one of the reasons why women declined or delayed to seek care. Clients' distrust of health workers stemmed from their knowledge that abortion is illegal and therefore they could easily be turned to the authorities. It is this fear that drives the decision making process regarding abortion and where it should be sought. Women and girls therefore seek abortion clandestinely and for those who develop complications are forced to turn to the formal health system for post abortion care (Izugbara et al, 2015).

Service delivery environment

The Government of Kenya has reaffirmed its commitment to improving access to maternal care services through the adoption of various policies. The enactment of The Constitution of Kenya's 2010 devolved most health functions previously held by the central government to 47 counties. Under the devolved structure, the health system is organized on two levels: national Ministry of Health (MoH) and national referral health facilities, and county. The core function of the MoH is to support the attainment of health goals by providing appropriate strategic frameworks and implementation guidance for health interventions. At the same time, the Ministry of Health and county governments, and partners have made substantial investments in training of health care workers, dissemination of guidelines, and availing equipment and supplies to improve the quality of maternal health services in health facilities (USAID; Measure Evaluation. 2017).

The proposed standards and guidelines for providing lawful safe abortion services in Kenya developed by KOGS in 2011 outlines the services and requirements for provision of safe abortion service in Kenya at the different levels of health care (KOGS 2011) (Table 1 in annex 2).

Availability and access to safe abortion services

Women access to safe abortion is determined largely by their ability to identify and reach a provider who offers safe abortion services as well as afford the cost of the procedure. Women qualifying for a legal abortion are rarely able to access a safe abortion in Kenya's public healthcare system. The limited number of healthcare providers trained to perform abortions also restricts women's access to safe abortion services—and magnifies concerns about provider barriers to access (Centre for Reproductive Rights 2010). To obtain a safe abortion, women must typically be referred to another healthcare facility where there is a trained provider or staff, creating logistical hurdles and increasing women's financial burden by adding transportation costs (Centre for Reproductive Rights 2010).

Safe abortion was reported to be only available in health facilities under the conditions strictly adhering to the confines of the constitution. The Reproductive Health Network (RHN) which has a nationwide representation with a membership of 400 health providers provides evidenced-based information and quality comprehensive reproductive health services through capacity building for service providers in comprehensive abortion care. Since its inception in 2010, a total of 209,911 girls and women have accessed services in all RHN supported facilities with 187,704 girls and women accessing family planning services (Reproductive Health Network 2018).

Safe abortion services are also provided by non-governmental organizations notably Marie Stopes who operate clinics in strategic areas both in the rural and urban settings. However, members of the

RHN are also likely to run Marie Stopes franchised clinics. Where these clinics are available women accessed and commended them for their quality as the following quote illustrates:

—Marie Stopes is just a walking distance from my work place. When I wanted to perform an abortion, I was referred there by a friend and I visited the place. I made an appointment the following day and in thirty minutes time, I was done with the procedure. It was very safe and I went back to work (Bosire, 2014).

In some parts of the country access to abortion medication has been through community based organizations where Misoprostol was distributed at the community for both abortion and management of postpartum haemorrhage using the harm reduction model. The focus was on prevention of maternal mortality. Through operations research there was a deliberate effort of giving information to women well in advance should they need to deal with an unwanted pregnancy. The distribution of the medication was leveraging on the distribution of reusable sanitary towels. Messages included what to do if worried about a missed period and the number of a helpline to call. The use of community pharmacies and traditional birth attendants to distribute the drug proved to be effective by increasing the coverage and drug availability at the community level. KMET contracted matatu (public transport) drivers to deliver misoprostol to women in rural communities in which pharmacists either had not stocked the drug or were unwilling to dispense it without a doctor's prescription. The partnership with matatu drivers facilitated same-day deliveries; greatly improving access to misoprostol (Coeytaux et al. 2014). However, some observers feared that increasing availability of abortifacient pharmaceutical drugs which permit women themselves to 'safely' terminate pregnancy in their own homes 'without the presence of a skilled provider and outside what formal providers would consider a hygienic or quality environment challenges the WHO definition of abortion safety (Winikoff and Sheldon 2012).

Unsafe abortion: Actors and methods

Qualitative studies (CRR 2010, APHRC, 2012) show that Kenyan women commonly obtain abortions using unsafe methods and unqualified providers. Some of the reasons that have been put forward to account for the high unsafe abortion rates in Kenya include a restrictive law, inability to pay for safe abortion services due to poverty, inaccessibility of health service, unavailability of safe abortion services, provider's negative attitudes, poor quality of services; and social, cultural, economic and religious pressures (APHRC; MOH; IPAS; Guttmacher 2013). Despite the legal restrictions and the health risks stemming from secretive abortion procedures, women in Kenya still obtain abortions from various sources including unqualified providers (Hussain 2012). The Kenyan National Commission on Human Rights (KNHRC) further concluded that restrictive abortion laws contribute significantly to high maternal mortality and morbidity in Kenya (KNCHR 2012).

In a review of client perspectives on use of unsafe abortion services (Izugbara, 2015) women seek care for services from providers with various abortion methods and from different locations. Women use different methods to carry out unsafe abortion. These include: deliberate physical exertion, special concoctions such as concentrated teas and coffee, and overdose of certain medicines which are considered effective abortifacients. In a related study women reported to use all manner of methods that were deemed to be inexpensive and therefore within their means. The two most commonly cited methods were ingestion of concentrated tea leaves, undiluted juices, or large amounts of soda. Other

methods cited included solvents and cleaning solutions such as bleach and laundry detergent and traditional herbal medicines.

Participants reported that these methods were relatively inexpensive (less than \$0.50 USD), widely available, and easy to obtain in small quantities (Jayaweera et al. 2018). In its 2012 public inquiry, the KNCHR found that women resort to “crude methods,” administered by unqualified persons to terminate pregnancies, due to the inaccessibility of safe abortion services in Kenya (KNCHR 2012)

Women’s perception and experience of abortion

Women know abortion to be illegal and are not clear about the provisions of the constitution. Unsafe abortions are regarded as a necessary option to get rid of unwanted or unplanned pregnancy. To them it cannot be procured legally. Due to lack of knowledge about the legal status of abortion women chose to procure abortion clandestinely for fear of being arrested. Because of its affordability, most women seek abortion from unskilled providers. Women are well aware of the dangers of induced abortion which include death or disability. In a study conducted in Nairobi, Kibera participants made references to women who had attempted and died in the process or those who lived to tell the tale but are traumatized by the aftermath of unsafe abortion.

Advocacy activities and actors

In Kenya safe abortion advocacy activities are spearheaded by non-governmental organizations, civil society and community based organizations. In 2010, The Reproductive Health Network (RHN), a network of health professionals committed to reducing maternal morbidity and mortality associated with unsafe abortion and postpartum haemorrhage in Kenya was formed. The professionals are drawn from both public and private health facilities and are members of four main professional associations; Kenya Medical Association (KMA), Kenya Obstetrical & Gynaecological Society (KOGS), National Nurses Association of Kenya (NNAK) and the Kenya Association of Clinical Officers (KCOA). The network provides evidenced-based information and quality comprehensive reproductive health services through advocacy and capacity building for service providers in comprehensive abortion care.¹² The Centre for reproductive rights has been instrumental in highlighting the plight of women and supports the view of allowing for women’s rights and in particular safe abortion (Centre for Reproductive Rights 2010).

In Kenya there has been a key debate between the ‘Pro-life’ and the ‘Pro-choice’ in relation to abortion. Pro-choice organizations (focusing on rights and health outcomes) have continuously advocated for policy changes so as to legalize safe abortion. They argue that women must be given a right of choice in fertility issues and that religious considerations should not be used as the basis of which national laws should be implemented (Lee 2004). On one hand, pro-life organizations (focusing on ethics, religion and moral value) are against abortion, instead, highlighting that much effort should be around preventing unwanted pregnancies in the first place. This group has argued that abortion violates the sanctity to human life and therefore there should be no compromise on the issue. The National Council of Churches of Kenya together with the Catholic Church fall under the pro-life group (Lee 2004). The anti-abortion groups see abortion as stemming from a broken social fabric that has failed women and therefore needs to be addressed with this in mind. Findings in a study conducted in Kibera (Bosire, 2014) show that religious leaders are categorical in stating that that abortion is not

¹²<https://rhnk.org/about-us/>. Accessed 9.02.2018

acceptable but are at least currently supporting contraception. The Christians protestant leaders also acknowledged that religion is against abortion.

Professional attitudes towards abortion

Attitude towards abortion varies among professional service providers guided by their moral and religious values. In a study conducted in Kibera (Bosire, 2014) some service providers stated that they are against abortion and therefore tried in as much as possible to discourage women from procuring abortions. One health provider was quoted as saying:

—Abortion is a sin and my religion does not allow me to perform such duties. It is stated clearly in the Bible that abortion is equated to murder. I believe that the government can work to reduce unintended and mistimed pregnancies by providing sex and reproductive education and also by providing contraceptives to women especially in the slums and rural areas. Abortion is not an option and I usually tell women not to procure abortions. I also don't refer them to other providers because; this means that I will be part of the sinful acts.

Online Survey

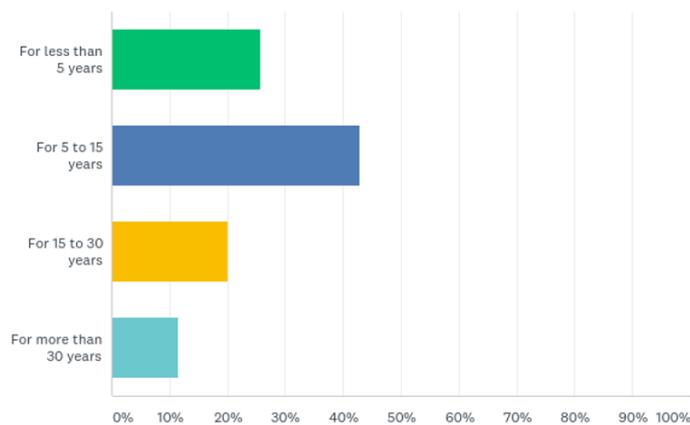
While the response rate of the survey was low and the outcomes cannot be taken as a reliable representation of the overall society, it provides some valuable information about the position KOGS takes and communication to its members. An overview of the outcomes of all questions of the survey can be found in Annex 3.

Member characteristics of respondents

Both older and younger gynaecologists responded to the survey. The majority had been an obstetrician/gynaecologist and a member of the society for 5 to 15 years.

Q2: For how long have you been a member of the Kenya Obstetrical and Gynaecological Society?

Answered: 35 Skipped: 0



Most of the respondents (91%) felt moderately to very involved with the society and a majority said to often attend activities of KOGS. Almost all (97%) respondents indicated to be member of any other professional body, in most cases being the Kenya Medical Association (KMA).

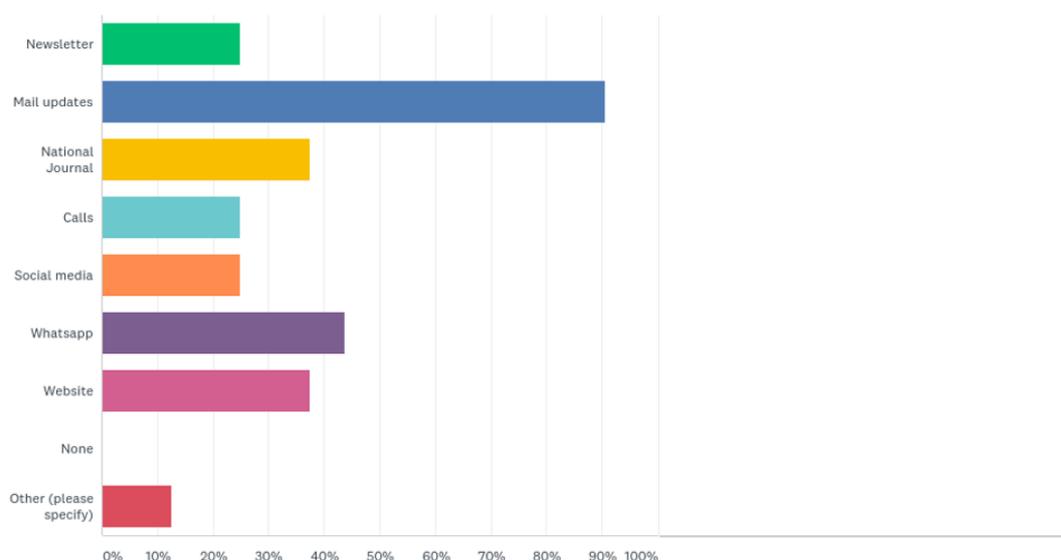
Communication between KOGS and its members

A majority answered to receive communication of KOGS through mail updates. Other routes of communication (newsletter, national journal, calls, social media, whatsapp and website) are recognized as such only by a minority of the respondents. Communication is perceived as infrequent or when the need arises.

A vast majority (78%) said communication is acceptable, but can be strengthened. Most accompanying comments related to the need for more regular updates, better utilization of communication routes (WhatsApp, social media/Facebook/twitter, email alerts through mobile phones and strengthening of the website), strengthening two-way communication/feedback mechanism, decentralization of communication ('Nairobi chapter is quite active but other County chapters not quite') and issues being missed ('At times there is no quick response about the position of KOGS on public interest issues in RH').

Q8: What are the existing routes of communication between the Kenya Obstetrical and Gynaecological Society and its members?

Answered: 32 Skipped: 3



About KOGS' position towards safe abortion

Most respondents answered that KOGS does not have (53%) or that they don't know about (19%) a clear position of KOGS towards safe abortion. Of the 28% that knows about KOGS' position on safe abortion, the majority answered that it follows the constitution and that they agree with that (33% agree, 56% strongly agree). A minority of 47% said that KOGS informs members about new evidence on abortion, abortion laws, policies and practices and almost all (97%) would like to receive more information, especially regarding the law, medical abortion and updates about practices, policy and evidence.

About respondents' position towards safe abortion

On average, respondents to the survey felt quite informed (score 3-4 on a scale of 5) about the following abortion topics:

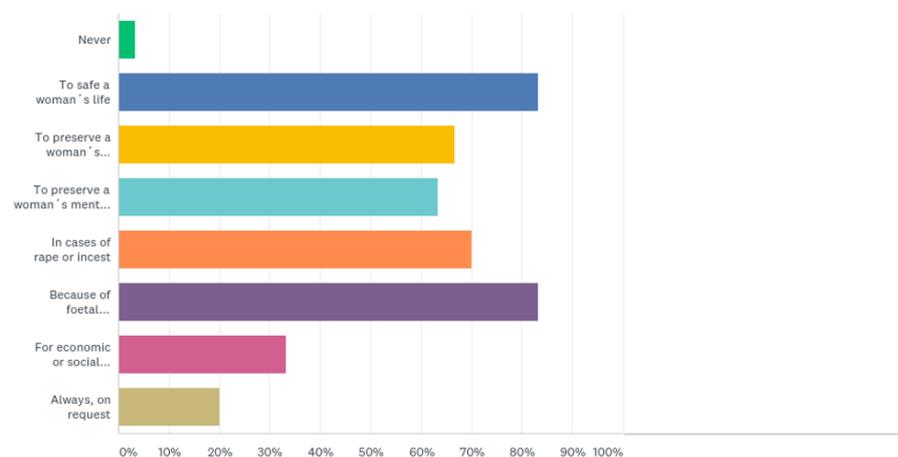
	NOT INFORMED	SLIGHTLY INFORMED	MODERATELY INFORMED	INFORMED	VERY INFORMED	TOTAL	WEIGHTED AVERAGE
The national laws on abortion	3.33% 1	6.67% 2	16.67% 5	36.67% 11	36.67% 11	30	3.97
International guidelines on safe abortion	0.00% 0	20.00% 6	30.00% 9	36.67% 11	13.33% 4	30	3.43
National Policies on safe abortion	10.00% 3	10.00% 3	36.67% 11	30.00% 9	13.33% 4	30	3.27
Practical information related to the practice of safe abortion (guidelines, recommendations, procedures)	6.67% 2	26.67% 8	23.33% 7	16.67% 5	26.67% 8	30	3.30
International guidelines on post abortion care	3.33% 1	20.00% 6	20.00% 6	20.00% 6	36.67% 11	30	3.67
National Policies on post abortion care	0.00% 0	16.67% 5	13.33% 4	30.00% 9	40.00% 12	30	3.93
Practical information related to post abortion care (guidelines, recommendations)	0.00% 0	20.00% 6	13.33% 4	26.67% 8	40.00% 12	30	3.87

However, 10-20% felt not or only slightly informed on these topics.

A majority felt that abortion should be permitted to save a woman's life, to preserve a woman's physical health, to preserve a woman's mental health, in cases of rape or incest and/or because of fetal impairment. A minority felt that abortion should be permitted for social or economic reasons or always, on request. One respondent felt abortion should never be permitted.

Q22: Under which circumstances do you think safe abortion should be permitted/legal?

Answered: 30 Skipped: 5



A vast majority of the respondents agreed with the following statements:

- Safe abortion is part of healthcare and should not be separated from the rest of medicine (10% agree, 63% strongly agree)
- Health workers opposing to perform safe abortion should be obliged to refer women to other health workers that will perform a safe abortion (17% agree, 60% strongly agree)
- Health workers have role to play as advocates for safe abortion (20% agree, 57% strongly agree)
- Post abortion care is part of healthcare and should not be separated from the rest of health care (13% agree, 77% strongly agree)
- Health workers should be obliged to provide post-abortion care to all women, no matter if the abortion was legal or not (7% agree, 80% strongly agree)

And disagreed with:

- Safe abortions should be only performed in private clinics, not in the public health system (67% strongly disagree, 27% disagree)

On the following statements there was a variety of opinions and a significant majority for either agreement or disagreement was not found:

- Specialized health workers (Obs-Gyn) should be obliged to perform safe abortions in cases where it is permitted by law
- Health workers should have the right to decide whether to perform or not safe abortions according to their personal values and positioning towards abortion
- Health workers should report to the respective authorities cases with signs of illegal abortion

A vast majority of the respondents said to support KOGS in advocacy for safe abortion.

Key Informant Interviews (KII)

A total of 14 key informants were interviewed for this assessment. They included representatives from the Kenya Obstetric and Gynaecological Society (KOGS), Kenya Medical Association (KMA), Kenya Clinical Officers Association (KCOA), National Nurses Association of Kenya (NNAK), Reproductive Health Network (RHN), Ministry of Health (MOH) officials, IPAS, UNFPA, Christian Evangelical Association, Catholic Bishops representation (*Table 2*).

Table 2: Key Informant Interview participants

No.	Association/ Society/Organisation	No of Respondents
1	Kenya Obstetric and Gynaecological Society (KOGS)	3
2	Kenya Medical Association (KMA)	1
3	Kenya Clinical Officers Association (KCOA)	1
4	National Nurses Association of Kenya (NNAK)	1
5	Reproductive Health Network (RHN)	2
6	Ministry of Health (MOH) officials	2
7	IPAS	1
8	UNFPA	1
9	Christian Evangelical Association	1
10	Catholic Bishops representation	1
	TOTAL	14

Data collected from the key informant interviews were analysed based on the following broad thematic areas:

- Safe abortion environment
- Professional associations' position on safe abortion
- Level of influence on policy change
- Relationship between professional societies
- Personal position on safe abortion
- Obstacles to safe abortion advocacy
- Opportunities for strengthening safe abortion network
- Current role in safe abortion advocacy.

Safe abortion environment

The constitution of Kenya 2010 states that “abortion is not permitted, **except**, wherein 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”.

All respondents acknowledged the fact that unsafe abortion contributes to maternal deaths in Kenya. From the interviews, one draws the conclusion that the legality of safe abortion services is open to interpretation depending on one’s position on safe abortion. The service environment is guided by the law that is engrained in the constitution, the Health Act and national guidelines that are provided by the Ministry of Health.

There still exist contradictions in the law governing safe abortion services in Kenya. The application of the “except” rule is not well defined. Persons who support the provision of safe abortion services interpret the “except” as providing the grounds for safe abortion – *where there is need for emergency treatment or the life or health on the mother is in danger*. They also indicate that there is no ambiguity

to the “except” in the law since the decision to provide safe abortion is based on professional judgement.

“Our constitution is ambiguous; ‘improve SRHR’ and ‘life starts at conception’. Two points of view within the same document. It is not black or white, it is grey. So the interpretation is from where you start.”-
(Ministry of Health Official)

For the protagonists, the policy environment of safe abortion services is seen to be restrictive, uncertain and hostile to health care providers who are in fear of constant police harassment and arrest. For the antagonists of safe abortion services, while recognizing that unsafe abortion is a major contributor to maternal mortality, they disagree with the “except” clause and state that abortion is not permitted and hence illegal. They also are of the opinion that the high maternal mortality is not solely due to unsafe abortion and prevention of unsafe abortion needs different interventions (counselling to change woman’s mind, adoption etc.).

Position on safe abortion by different institutions

Ministry of Health: The Ministry of Health provides guidelines on service delivery according to the constitution but its position is neutral with regards to safe abortion. In government health facilities, abortion is not permitted, unless in the exceptions. However, there are no guidelines to support these exceptions.

“The ministry is neutral. We are at the operational level. We don’t make the laws, but the laws affect us. You can provide abortion through the law, but prosecutions are still intact. Health workers are still prosecuted” (Ministry of Health Official).

In 2013, the Ministry of Health launched the **Standards and guidelines for reducing morbidity and mortality from unsafe abortion in Kenya**. However, these guidelines were withdrawn by the Director of Medical Services through a government circular due to the strong influence of the pro-choice movement. In addition, it was noted that government level of involvement during the development of the guidelines was minimal and came in a little too late.

The government trains health workers on post-abortion care, which includes aspects of contraception and infection prevention. However, it does not mention the safe abortion options. The government has recently released two documents 1) guidelines on post abortion care and 2) the cost of unsafe abortion in Kenya.

Kenya Obstetric and Gynaecological Society (KOGS): There is no common position of KOGS on safe abortion. There are two divergent views/opinions on safe abortion among gynaecologists in Kenya. There are those that support safe abortion and those that do not support the safe abortion discussion.

Gynaecologists who support safe abortion are of the opinion that safe abortion should be provided within the confines of the law and that implementation of what is allowed within the law is dependent on the guidance provided by KOGS leadership. Some voices of gynaecologists are of the opinion that the constitution permits abortion and imply that as a professional association, they would promote abortion on demand.

“The position of the society is that safe abortion should be available according to the law. Although the Penal Code has not changed and criminalizes abortion but sections 158/159/160 and lastly 240

acknowledges special circumstances – if performed in good faith based on the professional judgement of the health service provider,”(KII KOGS Member)

“We as KOGS wanted abortion not to be restricted; even we would promote abortion on demand. The compromise [-of the Constitution of Kenya 2010-] was that life starts at conception and abortion is permitted only in exceptional cases. So interpretation depends on where you stand. You may perform abortion when health or life [-of the mother-] is at risk, according to the provider, (KII KOGS Member)

“The current KOGS leadership are not convinced that abortion should be legal. KOGS should have a common position. Three officials need to decide: the chair, secretary and treasurer. If these people agree, that will be enough to decide our standpoint on safe abortion,” (KII KOGS Member)

Gynaecologists who do not support safe abortion are often deeply rooted in the Christian faith and the Catholic Church. Some are officials and members of the Catholic Doctors Association. The belief is that life begins at conception and that performing abortion is similar to killing a baby. The church was deeply involved in the drafting the Constitution of Kenya 2010 and they ensured that the clauses of “life begins at conception” and that “abortion should not be permitted” were included in the articles of the Constitution. In cases where one gets pregnant as a result of rape, the feeling among the evangelical practitioners was that it was better for the girls to carry the baby to term than undergo safe abortion and that they would refer a client who becomes pregnant after rape for abortion services. This would be like asking someone else to “kill for you” if you are unable to do so.

“I was deeply involved from the faith based organization. Article 26 - the spirit of our constitution. We fought hard to get in the constitution: life starts at conception. You will be killing a human being that already exists. Why you must not interfere with the life from conception. 26.4 starts with ‘abortion is illegal in this country..... Our constitution is against abortion, based on principles, not on details,” (KII KOGS member).

“Rape is a traumatic experience but carrying the baby to term is the better option than abortion. There are options of adoption and fostering while also focusing on the reintegration of the girls into the community,” (KII KOGS member).

Kenya Medical Association (KMA): This is the umbrella association for all the doctors. Often members of KOGS are also members of KMA. There is a reproductive health committee within KMA that gives direction on reproductive health matters whose membership is comprised of obstetricians. Like KOGS, within KMA there are also two divergent views with regards to safe abortion; those for and those against.

UNFPA: Organizations such as UNFPA support the government position on safe abortion. Since abortion is known to be illegal in Kenya, UNFPA Kenya does not support the advocacy of safe abortion in Kenya. UNFPA’s standpoint is to approach what causes or precipitates unsafe abortion which is unintended pregnancy, supports the development of guidelines, discussions around access to quality reproductive health services as well as support efforts to ensure the provision of quality post-abortion care.

Kenya Nurses Association and Kenya Clinical Officers Association: from the discussions with officials of these associations, their position on safe abortion is neutral. They are not strong advocates for safe abortion although they would like to engage in safe abortion advocacy activities together with KOGS.

Clinical officers are beginning to be advocates for safe abortion while working with county governments, for example in Kisumu County. Clinical officers are often the first point of contact for patients who need safe abortion and post abortion care services. Clinical officers are working closely with organisations such as Marie Stops and DKT International health care who train them on the provision of safe abortion services.

Personal position of key informants

On one of the key questions, where respondents were asked to what their personal position on safe abortion is, three positions emerged. There are those who unequivocally support safe abortion based on the conviction that unsafe abortion creates untold suffering and preventable deaths. These were largely members of organizations that were already providing safe abortion services and supporting initiatives up to community level in an environment that is not fully accepting to safe abortion. The second set of service providers were those whose personal opinion was neutral or non-committal. They were more committed to service provision and were willing to support service providers. They relied heavily on the prescriptions of the law and were likely to change their personal views if the law was less restrictive. They also referred clients to practitioners who could provide the service if their personal convictions could not allow them not provide the service yet they felt that the life of the client was in danger. The third group consisted of service providers who were totally opposed to safe abortion based on their religious beliefs and convictions. This was so much so that even if the life of the client was in danger and even include death their conscious would be clear. They would also not refer the client to a service provider who would provide the service but they would offer advice to the client that discourages them having an abortion. As one put it:

“It is like saying I cannot steal so go and steal for me or I cannot kill so go and kill for me”

Although this category of service providers is much fewer they wield great influence and are the main obstacle to safe abortion. They have great influence on the Ministry of Health and were reported to be behind some of the actions taken by the Ministry of Health specifically regarding withdrawal of national guidelines for safe abortion.

Relationship between professional societies

From the interviews it was evident that there are several societies that focus on reproductive health but may not be necessarily working together for a common goal. For example the Clinical Officers Association or National Nurses Association (NNAK) represent a cadre of health service providers who operate at the lowest level and are the first point of contact with clients but tend to work alone when in fact working with other associations would be more incremental. It was reported that there is little interaction between the leadership of KOGS and Clinical Officers Association, yet there is a greater potential for training and service provision for safe abortion. KOGS works well with Reproductive Health Network (RHN) as members of both organizations are largely the same and reflect a national coverage. The National Nurses Association of Kenya (NNAK) reported to work on a smaller scale with KOGs but noted that this could be better and strengthened since, like the clinical officers, they have a good national coverage.

Level of influence

The combined level of influence of the organizations is based on the national presence of some of the organizations such as RHN which has a network of clinics nationwide; and KOGS which is in the

forefront in pushing for liberal abortion laws. Potentially KOGS wields power to change or influence policy direction as well as build champions for safe abortion advocacy. Members of evangelical churches wield greater influence on the policy direction of safe abortion than KOGS. This is evidenced by the withdrawal of the national guidelines on safe abortion even after the guidelines had been launched by KOGS at FIGO.

KOGS leadership has an upper hand in advocating and providing guidance on defining situations where the “exception” applies as stated in the constitution. This will carry weight if all the leadership of KOGS together with the majority of its membership. Although members of the Reproductive Health Network (RHN) provide safe abortion services, this is done in secret and it’s not recorded as such. Since they operate in a hostile environment they may not go out openly and advocate for safe abortion services.

Opportunities for strengthening safe abortion network

Across the societies and organizations there are opportunities for advocacy. For example Reproductive Health Network (RHN) is already involved in sensitization and education of members of the police force and engaging the media. A combination of interventions such as values clarification for MOH officials, sex education in schools and inclusion of comprehensive abortion care (CAC) in pre-service medical training curricula for health care workers (nurses, clinical officers and doctors) is the first step in addressing issues of reproductive health but more specifically recognizing the need for safe abortion. KOGS in particular is well positioned and already has a niche in policy formulation and development and has members committed to safe abortion as well as the clout to reach out to significant stakeholders such as politicians. KOGS role in capacity building has the pivotal role of bringing together all the networks that are engaged or have the potential to provide safe abortion services. While working together with the Ministry of Health, KOGS is able to provide guidance in the development of national guidelines and defining the extent to which safe abortion can be provided within the confines of the constitution and the law.

Current role in safe abortion advocacy.

Despite the legal restrictions for safe abortion, there has been advocacy at various levels including the development of guidelines and training of health care providers. At the community level there has been training of youth in sexual reproductive health and rights (SRHR) and community based programme on access to the use of misoprostol. Within the context of devolution of health services to the county level societies such as the clinical officers association have engaged the county health management teams to begin discussions on safe abortion. This was reported to be already happening with the county of Kisumu. Recognizing the important role of media, training of media officers on how to report on safe abortion has been one of the priority areas for RHN.

Stakeholder workshop

Throughout the sessions of the workshop, four overarching themes emerged: improve legal dimensions; transforming social norms at all levels; improve inclusivity; ensure a process of generation and use of evidence for action. The bullet points under each theme below are examples of needs that came up throughout and could be integrated into the action plan.

1. Improve legal dimensions

- Decriminalize issues around abortion (reconcile penal codes with the constitution)
- Clear guidelines from the government & sensitizing the community
- Address the gap of contraceptive failure in the guidelines
- Address the legal implications of GBV
- Strengthen linkages with other sectors (lawyers, police)

2. Transforming social norms at all levels: national policy level, county policy level, professional network, facility level, community level etc.

- Professional society guidelines on safe abortion and build a network of support
- Clarify the abortion law, inform about access & safe practices, address the misconceptions and warn for the danger of quacks
- Facilities should be clear about the guidelines from a professional perspective
- Facilities to formulate group norms
- Need for job aids & communication skills
- Ensure updates/CME with providers
- Address stigma, both at supply and demand side
- Community empowerment in addressing gender norms and values
- Look at best practices (e.g. Ethiopian Society of Obstetrics & Gynaecology) and adapt these to own situation
- Learn the language of the media and appropriate use of language for community reach

3. Improve inclusivity: networking, partnerships, comprehensiveness and holistic coverage of issues and needs

- Ensure a Comprehensive Abortion Care (CAC) approach which also focusses on prevention of unintended pregnancies and unsafe abortion.
- Build champions who are able to share their stories – platform for advocacy - network
- Involving traditional healers, pharmacists and other stakeholders in abortion
- Build capacity of PHC facilities to provide safe abortion services or refer (functional referral system)
- Focus on a balanced debate with both pro-choice and the contrary opinion included
- Need for synergy in pro-choice network/alliance

4. Ensure a process of generation and use of evidence for action

- Evidence on the burden of unsafe abortion and the link to maternal mortality
- Evidence on the link of mental health to both unsafe and safe abortion
- Clear documentation on the cases of safe abortion within the fullest extent of the law; make the hidden unhidden
- Improve quality of data collection in HMIS and DHS; including private clinics
- Address and notify gaps in commodities and communicate them

5. Cross-cutting issues

- Strengthen leadership
- Increase advocacy skills
- Use consistent and agreed terminology

Discussions on terminology addressed both the use of 'pro-life' for abortion opponents and the use of 'safe abortion'. It was agreed that the term of pro-life should not be used as all sides on the debate spectrum are in favour of life. The use of 'contrary opinion to abortion' was preferred. The discussion on the use of 'safe abortion' entailed the worry that 'safe abortion' produces a lot of resistance as it is interpreted as actively promoting termination of pregnancy. In general people feel more comfortable with 'comprehensive abortion care'.

Social Networks

During group work social networks for safe abortion were identified. Annex 4 provides a summary of allies and networks where potential allies could be found. This should be seen as a dynamic table. Along the way new allies can be identified and potential allies can move.

Strengths, Weaknesses, Opportunities and Threats

The main outcomes of the SWOT analysis can be found in Annex 5.

Action plan

As a final exercise, groups started on defining objectives and activities for an action plan on safe abortion advocacy. The action plan has the overall objective to improve the capacity of KOGS on abortion advocacy to then, ultimately, increase the access to safe abortion and reduce morbidity and mortality as a result of unsafe abortion. Activities should serve to reach the objectives and will include the different advocacy levels and social networks addressed during the workshop.

After the stakeholder workshop the consultancy team continued to develop the action plan, including deliverables. The action plan will continue to be developed in consultation with KOGS and FIGO.

A preliminary action plan can be found in Annex 6.

Conclusions

The literature review, the key informant interviews and the workshop confirmed that unsafe abortion and its complications is a major problem in Kenya, endangering the lives of many women. The practice of unsafe abortion is so rampant that there is a call for safe abortion to reduce this problem. However advocacy for safe abortion faces many challenges where traditional norms as well as entrenched religious beliefs do not support safe abortion.

This study highlights some of the challenges that face safe abortion advocacy.

- **The restrictive laws for safe abortion** in Kenya. The constitution of Kenya states that life begins at conception and abortion is not permitted except in the opinion of the health provider, the health and life of the mother is in danger. However, these exceptions are not well defined and it's open to interpretation depending on one's point of view.
- **Lack of clear guidelines on safe abortion:** the withdrawal of national guidelines on safe abortion in Kenya has left a vacuum for safe abortion service provision. The Ministry of Health has in place national guidelines for post abortion care but these guidelines do not mention the safe abortion procedure.
- **Hostile political and social environment:** Because of the above clauses in the constitution, health providers who perform safe abortion are often harassed and face arrest especially if a complication or death occurs which is linked to the safe abortion procedure. There is also great opposition from two main organizations that influence health service provision in Kenya; USAID and the Church. Generally there are two groups of opposing views on safe abortion; 'pro-choice' and 'pro-life'. The 'Pro-life' groups are persuasive with large following. The Policy level teams are afraid of annoying Pro-life factions. Religious organizations have more voice and influence at the policy level and the law making process.
- **Opposing standpoints/views within KOGS:** there are divergent strong views on safe abortion within the professional association; those for and those against. Therefore the society may experience difficulties in taking position and advocating for safe abortion especially from gynaecologists who oppose safe abortion. The current KOGS leadership has a weak capacity in safe abortion advocacy and there is a lack of technical working group on safe abortion. Communication to and feedback from members could also be improved.
- **Providing the services in secret:** there is a lot of disguise around the provision of safe abortion services. Health providers who perform abortion cannot come out openly and talk about the services they are providing.
- **Lack of data on safe abortion:** for health providers who perform safe abortion, because of fear of arrest, this is not recorded as such. There is therefore lack of sufficient data that can be used for safe abortion advocacy.

To strengthen advocacy for safe abortion requires the engagement of various stakeholders in dialogue to win them over. KOGS strong presence as a leader in technical knowledge has the opportunity to influence and network with like-minded organizations to advocate for and provide safe abortion to women who require the service.

Recommendations for future program

Building its base as a safe abortion advocate, the society will require to address the various and potential challenges as were identified during the key informant interviews and the two day's workshop. This could include the following:

- Strengthening the management and organization of KOGs as a formidable for safe abortion advocacy
- Establishing a coordinated and vibrant network of associations that are supportive of safe abortion
- Transforming the social and gender norms at all levels regarding safe abortion but within the context of the Kenyan law
- Ensuring that the legal framework is consistent while conducting sensitization about the legal framework to stakeholders at all levels for harmonious interpretation
- Ensuring a process for data generation and use for monitoring and planning for services

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Annex 1 Program and participants of stakeholder workshop

Due to time constraints the program was adapted during the days. Starting time was later and some components were skipped (crossed below).

Time	Content
8.30– 9.10	Introduction: Welcome and prayers Getting to know each other, expectations, purpose, objectives, agenda, facilitator's participant roles, group norms, evaluation process, housekeeping
9.10-10.20	Presentation preliminary country results; validation of analysis; Dialogue about reasons for abortion and what needs to improve to meet women's need for safe and legal abortion
10.20-10.35	Break
10.35 -11.00	Presentation and discussion results of group work dialogues
11.00-11.30	Implications of national abortion laws on access to safe abortion.
11.30-12.30	Share positions and personal beliefs and discuss professional responsibilities
12.30-13.30	Lunch
13.30-14.00	What is advocacy: concept, levels and challenges
14.00 -14.30	Advocacy perspective, risks and benefits in advocacy
14.30-15.00	Roles in advocacy
15.00-15.15	Break
15.15 -16.00	Roles in advocacy continued
16.00-16.25	Power dimensions in advocacy
16.25-17.15	Advocate for safe abortion care
17.15 –17.30	Evaluation of the day
Day 2	
8.30-9.00	Welcome and prayers Recap of day 1 by 2 volunteer participants identified day before
9.00-10.00	Social networks and reaching different audiences
10.00-10.30	Break
10.30-11.00	Address parked issues
11.00-12.30	Presentation of achievements weaknesses barriers and opportunities of previous abortion project. Then: strengths, weaknesses, opportunities and threats of the national society for abortion advocacy.
12.30-13.00	Lunch
13.00-15.00	Develop an action plan for abortion advocacy in small groups
15.00-15.15	Break
15.15 -16.00	Continue develop action plan
16.30-17.00	Presentation and discussion action plans in plenary
17.00-17.30	Evaluation and goodbye

Elaboration on Content of the workshop

The workshop contained eight components:

1. **Introduction:** a session where the background and objectives of the needs assessment and the stakeholder workshop were explained, logistics of the facilitations process, roles and group norms were discussed. Dr. Anne Kihara opened the day and gave a presentation on KOGS journey on abortion.
2. **Presentation of draft country results and identification of women's needs for safe and legal abortion:** a session where the preliminary results of the desk review on country background, legal and political context, abortion stigma, service delivery environment and advocacy activities in the country were presented and validated with the participants. In a second part of the session case studies about women having obtained unsafe abortion were discussed and analysed in groups. Needs from the perspective of the woman were identified with respect to availability, access to and quality of safe abortion services, environmental and legal dimensions.
3. **Share positions and personal beliefs; discuss professional responsibilities:** a session where personal barriers and motivations to provide safe abortion were explored, with the emphasis that everybody has a right to personal beliefs, which are not questioned. Personal beliefs were benchmarked against professional responsibilities and FIGO's resolution on conscientious objection was discussed in the light of remaining barriers (such as limited professionals available in the country).
4. **What is advocacy and why providers as advocates:** a session to define advocacy and emphasize health providers' unique strength for advocacy, based on: first-hand experience, trustworthiness, extensive network, intermediary client-provider, prestige and status.
5. **Three roles of an advocate:** a session to explore one's advocacy role as an educator, witness or persuader within different advocacy scenarios: provider-client, provider-provider, provider-professional network, provider-media, provider-policymaker.
6. **Social networks and reaching different audiences:** a session to explore social networks for advocacy on safe abortion, identify current and potential allies and ways to reach them.
7. **Strengths, weaknesses, opportunities and threats (SWOT) analysis:** to the abortion advocacy capacity of KOGS.
8. **Development of an action plan:** a session to, based on the outcomes of the previous session components, identify objectives and activities for the next proposal on safe abortion advocacy.

The following sources were used for development of the workshop activities:

- Ipas | Providers as advocates for safe abortion care: A training manual. 2009
<http://www.ipas.org/en/Resources/Ipas%20Publications/Providers-as-advocates-for-safe-abortion-care-A-training-manual.aspx>
- Ipas | Abortion attitude transformation: A values clarification toolkit for global audiences. 2011
<http://www.ipas.org/en/Resources/Ipas%20Publications/Abortion-attitude-transformation-A-values-clarification-toolkit-for-global-audiences.aspx>

Participants of the workshop

Name	Where from	Designation
Joseph Karanja	University of Nairobi	Professor of Obs/Gyn
Anne Kihara	University of Nairobi	Obstetrician and gynaecologist and Senior lecturer at the University of Nairobi, Former President of KOGS
Elly Odongo	Moi Eldoret referral Hospital	Obs/Gyn. Current President of KOGS
John Nyamu	RHN	Obs/Gyn. Safe abortion activist. Chair, Reproductive Health Network
Simon Mwangi	RHN	Safe abortion activist, Honorary Secretary of RHN
Nelly Munyasia	RHN	Programmes Manager
Wilson Bunda	FHOK	Project Manager, Focal person for safe abortion
Nalika Robai	Busia County Hospital	Specialist Obs/Gyn and Technical advisor on safe abortion
Ambuchi Jane rose	Busia County Hospital	Consultant Obs/Gyn; County Director of medical services, Busia County and Reproductive Health Coordinator
Jennifer Othigo	Mombasa County	Consultant Obs/Gyn FIGO focal person on safe abortion in Kenya
Alice Kaaria	Reproductive Health Services	Consultant Obs/Gyn, SRHR specialist, Safe abortion focal person
Millicent W. Mathu	Private Service provider	Nurse/ midwife
Joseph Liko	MTRH, Eldoret	Consultant Obs/Gyn, Safe abortion focal person
Claire Kinuthia	Prime care Health Services	Specialist OBS/Gyn, Consultant at AKUH Outreach clinics, Safe abortion advocate
Hassan Mohammed	Private practitioner	Specialist OBS/Gyn, Former head of Family Health, Primary health care, CEO of NHIF
Kagwiria Kioga	PPFA	Senior Programme Officer
Thorne	AMPATH	Medical Doctor, Consultant
Mitei Paul	Kisumu County Hospital	Obs/Gyn Consultant
Alfred Obengi	NNAK	Chair, NNAK
Leah Muriuki	Kenya Clinical Officers Reproductive Health service(KCORHS)	Treasurer
Kariuki Wanjohi	The Mater Hospital, Nairobi	Obs/Gyn Consultant
Wanjala	KOGS	OBS/Gyn

Annex 2 appendix to literature review

Table 1: Essential requirements for provision of safe abortion services by level of health care

Requirements	Level 1 (Community)	Level 2&3 (dispensaries and health centres)	Levels 4,5&6 Sub-county, county and tertiary referral hospitals
Staffing	Community Health Extension Workers Community Health Workers Community Midwives	Clinical officers Nurse/midwives	Clinical officers Nurse/midwives Medical officers Registrars Obstetrician gynaecologists
Type of abortion services to be provided at this level	Health education on reproductive health, including family planning and safe abortion services Recognition of complications of abortion, sexual violence and prompt referral Community based FP services Community midwives may also provide PAC services	All services given at the community plus Comprehensive PAC (includes MVA and counselling) All FP services Prompt referral for abortion complications and those requiring safe legal terminations beyond the competency of the facility Screening for STI and HIV	All services for level 1-3 plus Surgical contraception Management of all abortion complications Comprehensive abortion care Services Training of health care providers Development of training materials, clinical guidelines and protocols Supervision guidance and support to lower level health facilities Conduct operations research Contribute to development of county and national policies
Equipment, supplies, medications and other commodities	Contraceptive commodities – condoms, oral contraceptives & EC For community midwives – injectable, IUCDs, implants Misoprostol for PAC	As for Level 1 plus MVS kits Analgesics and antibiotics IUCDs, implants and injectables Misoprostol	As for level 1-3 plus D&E for 2 nd trimester surgical evacuations Theatre facilities with GA Blood bank Laboratory services Medications – prostaglandins, misoprostol, Methotrexate, and Mifepristone Ultrasonography

Women's perceptions and experiences of unsafe abortion

—I totally have no clue of what the constitution talks about in relation to abortion. What I know for sure is that abortion is —Haram”— illegal in Kenya. When you talk of safe abortion services, I get confused even more. All I know is that abortion is a crime. Even our Islam religion does not allow it (Bosire, 2014).

Maybe what you are going to do there might bring you problems, sometimes you go and sit with the doctor thinking that he is going to assist you, you tell him everything and at the end of the day you are arrested (Participant from FGD 5). Participants further described the perception that anyone who helped women obtain abortions would be imprisoned (Jayaweera et al 2018: page 10).

A good thing with the unsafe providers is that their prices are manageable and they are easily available. They sell their concoctions in the open market. The only unfortunate thing is that sometimes when the pregnancy is past 6 months, chances of deaths and complications are very high; but these providers will never warn a client

In fact, we have one old abortionist woman in this village who risks women's life every day. In a month, there must be a death case from his black market in abortion. The most surprising thing is that, whenever this old woman is arrested, she makes her way out of the police custody through bribery means. Her abortion cost charges around Ksh.200 to500.

-----On our way I convulsed and later collapsed. I did not know what happened. I regained consciousness after 3 days and found myself in Kenyatta National hospital ward. When I asked the hospital nurse what had happened, she explained to me everything and the painful thing she told me was that they had removed my uterus because it was severely damaged. She confirmed to me that I could never give birth again. I was only 24 years at that time. I got well and my extended family discharged me from the hospital. Up to date, I feel the pain of having lost my womanhood due to unsafe abortion. It hurts me the most especially when I know that I am not a woman enough since my uterus was removed. Unsafe abortion is terribly painful and no one should procure an abortion (cited in Bosire, 2014)

“A friend of mine got pregnant after clearing college and she died because of unsafe abortion. Her mother gave her pills to terminate the pregnancy and she later fell ill for like two months. When we saw her she was very weak and when taken to hospital, the doctors said she had terminated a pregnancy and because she had not been cleaned, her uterus had rotten. She later died and it's her mother who had done it {unsafe abortion}.”(KMA/Reproductive health and rights Alliance, 2014.

Annex 3: Overview of outcome online survey

The summary of responses to the online survey comes in an additional file, in PowerPoint format.

Annex 4 Social Networks

Level	Allies	Potential allies
International level	<ul style="list-style-type: none"> • FIGO • Global Doctors for Choice 	<ul style="list-style-type: none"> • African Union • East African Community (EAC) • African Federation of Obstetrics and Gynaecology (AFOG)
Professional network	<ul style="list-style-type: none"> • Reproductive Health Network & Reproductive Health Services • University of Nairobi • National Nurses Association of Kenya (NNAK) • Kenya Clinical Officers Association 	<ul style="list-style-type: none"> • Kenya Medical Association (KMA) • Kenya Medical Women's Association (KMWA) • Kenya Private Sector Alliance (KEPSA)/ Kenya Healthcare Federation (KHF) • Kenya Medical Practitioners, Pharmacists and Dentists' Union (KMPDU) • Pharmacists
National policy level		<ul style="list-style-type: none"> • Ministry of Health/Ministry of Education/Ministry of gender & youth • Kenya Women Parliamentary Association (KEWOPA) • Kenya Medical Supplies Agency (KEMSA) • Health committee of parliament • National Council for Population and Development (NCPD)
County policy level		<ul style="list-style-type: none"> • Council of Governors
NGO's, bi- & multilaterals and networks	<ul style="list-style-type: none"> • African Network for Medical Abortion (ANMA) • IPPF African Region • Family Health Options Kenya (FHOK) • Planned Parenthood Global/PPFA • IPAS • Marie Stopes • KMET 	<ul style="list-style-type: none"> • UNFPA regional/UNFPA Kenya • WHO • DFID/SIDA • Tunza Family Health Network/PSI Kenya
Legal network	<ul style="list-style-type: none"> • Kenya Legal & Ethical Issues Network (KELIN) 	<ul style="list-style-type: none"> • Federation of Women Lawyers (FIDA) • Police
Religious network	<ul style="list-style-type: none"> • Catholics for choice 	<ul style="list-style-type: none"> • Christian Health Association of Kenya (CHAK) • Kiotas (professional Christian group)? • Christian Professional Association • Other church groups?
Community	<ul style="list-style-type: none"> • Trust for Indigenous Culture and Health (TICAH) • CBO's 	<ul style="list-style-type: none"> • Youth groups • Schools • Men/male groups
Media		

Annex 5 SWOT analysis

SWOT analysis of national society capacity for safe abortion advocacy	
<p>Strengths</p> <ul style="list-style-type: none"> • Historical background on abortion agenda (constitution, criminal cases, health bill) • National membership; huge pool of professionals • Key informant for MoH; role in policy making • Elaborate networks & international partners (FIGO, AFOG) • Engaged in academia and research and policy formulation • KOGS members are providers of abortion care at highest level; role models; educators, 1st hand witnesses for the effects of lack of safe abortion 	<p>Threats</p> <ul style="list-style-type: none"> • Strong Opposition; fraction within the society • Loud opposition in the media • Lack of political goodwill • Lack of enabling legal, policy and program environment • Resource mobilization: Sustainability and scale up of activities • Social norms (stigma among providers, beliefs outweighing professional responsibilities, the argument on morality) • Global gag rule
<p>Weaknesses</p> <ul style="list-style-type: none"> • No pro-active role or uniform/collective vision on abortion • Understanding the legislative mandate for safe abortion • Finding space for meaningful engagement with opposition; fear of stigma • Fragmented approach to abortion care- amongst practitioners; lack of integrated approach with other SRHR services • Lack of inter-sector/multidisciplinary approach e.g. police harassment, age targeted comprehensive abortion care; lack of connection with county level • Communication strategy/skills and use of media platforms; information on safe abortion not well packed in a persuasive manner • De-linkage between treaties, constitution, penal code and professional code of conduct; Conscientious objection not clarified amongst all providers • Lack of data repository for evidence for action • KOGS organizational capacity, low staffing, regular change of leadership • No sustained inclusivity/partnerships – tied to grants • Same ‘old faces’ in advocacy for safe abortion; no new crop of advocating obstetricians 	<p>Opportunities</p> <ul style="list-style-type: none"> • Formation of prochoice coalition; inter-sector approach • Provide leadership in abortion care with a national coverage and county presence for inclusivity • Strengthening of organizational capacity • Professional training on advocacy; KOGS unique position for an advocacy role • Engage new members; new audience (college, university students) • Stronger engagement with media • Potential receiver of funds • Could take center stage in giving policy briefs/direction • Engage men: policy makers, social support system, community

Annex 6 Country action plan

A preliminary country action plan will come in a separate file in excel format.