Kuantumjournals
THE INTERNATIONAL RESEARCH COMMUNITY

Kuantum Journal Of Integrative Health And Medicine

Article Information

Received: June 11, 2024
Accepted: June 27, 2024
Published: June 29, 2024

Citation: Ruth Muia, et al. (2024) Assessment of Post-Abortion Family Planning Services access in Public Facilities in Kenya. ku J of Inte Health and Med.1(1): 4-20.

Copyright: ©2024 Ruth Muia, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Research Article

Assessment of Post-Abortion Family Planning Services access in Public Facilities in Kenya

Ruth Muia[1]*, Peter Bundi Gichangi[2], Emmah Kanini Matheka[3] and Abednego Ongeso[4]

[1]01Deputy Director, Nursing services, Ministry of Health, Directorate of Family Health, PO. Box 485-00202, KNH, Nairobi, Kenya
[2]Chair, Academic and Research Department, Technical University of Mombasa (TUM), Kenya
[3]Chairman, Department of Nursing Sciences, University of Nairobi (UON), Kenya
[4]Chair Midwifery Department & Chair Departmental Research Committee (DRC), School of Nursing and Midwifery Kenya, Aga Khan University (AKU), Kenya

***Corresponding author:** Ms. Ruth Muia, Deputy Director, Nursing services, Ministry of Health, Directorate of Family Health, PO. Box 485-00202, KNH, Nairobi, Kenya, Email: truth2005t@yahoo.com

1.Abstract

Introduction: This paper presents an assessment of post-abortion family planning (PAFP) services access through facility assessment, record reviews, and interviews with patients and service providers within public Health facilities in Kenya. An evaluation of healthcare facilities (n= 6) was conducted to assess their capacity to offer PAFP services. Patients' records were reviewed (n=385); Client exit interviews were conducted to evaluate satisfaction with the RH services (n=36).Service providers (n=20) completed self-evaluation on their performance. The study had obtained ethical approval; informed consent was obtained from the participants before interviews; confidentially and anonymity was maintained.

Results: All the facilities attained 100% score regarding their appearance, functional communication services, reliable electricity and backup services, and reliable, safe running water except for waste disposal (17%) and referral system (33%).Nurses comprised (47%) of all providers. Record reviews indicated almost half of all the patients were adolescents and youths aged 24-years and below. Only a small proportion of post-abortion patients received PAFP services (10%) and counseling (39%) with on 8% being referred. PAC registers lacked in all the facilities with all the recorded reported as incomplete. Service satisfaction was rated high and 90% of service provider appraised themselves as competent.

Conclusion: The assessment of PAFP services uptake identified best practices, barriers and gaps that need to be addressed to improve PAFP access.

Recommendation: Future research should focus on designing an effective strategic approach that could optimize access to PAFP services and contribute to reducing unintended pregnancies and improving women's reproductive health outcomes.

2.Keywords: Post abortion care, Family planning, Contraceptives, Post abortion family planning, PAFP Access, Immediate post abortion contraceptive, PAFP counseling, PAFP services

3.Introduction:

Immediate post-abortion family planning (PAFP) services play a crucial role in preventing unintended pregnancies, repeat abortion and reducing maternal

morbidity and mortality [1,2,4]. However, the uptake of PAFP services remains suboptimal. This aimed to assess the uptake of PAFP services and develop a participatory PAFP linkage and referral model to address existing barriers. The assessment includes facility assessment, record reviews, and interviews with patients and service providers.

3.1.Unsafe abortion

Unsafe abortion is a term that has been used to define a procedure used to terminate pregnancy, by unskilled persons and/or performed in an environment that does not meet the bare minimum standards recommended for carrying out such a procedure [4,5]. Reports indicate that 27 out of 100 women of reproductive age deaths are pregnancy related and abortion claims about 5% of this share [6]. Among all other causes of maternal mortality, hemorrhage has been reported as the highest [7]. Others include sepsis, hypertension, and obstructed labor and indirect causes. These global causes of maternal death mirror the Kenya situation in pattern and magnitude with the prevalence of abortion with at 4.8% in 2012 [8] an increase from 3.4% per live births in 2010 [9]. The magnitude of abortion in Kenya has remained high in the last decade with reports indicating that approximately 300,000 unsafe abortions occur annually [10,11]. Moreover, 40% of all the abortions in Kenya have been reported as induced, however most reports do not clearly differentiate miscarriages from induced abortions with 16% being repeat abortion.

3.2.Post abortion family planning

Post-abortion care, including PAFP services, is vital in preventing repeat unintended pregnancies and improving women's reproductive health outcomes [12,13,14]. Contraceptive use during the post-abortion period can reduce the risk of repeat abortion and maternal morbidity [12,15,16]. Various barriers can hinder the uptake of PAFP services, including limited knowledge about contraception methods, misconceptions and concerns about side effects, cultural and social factors, provider biases, and lack of access to services [16,17,18].

4.Materials and Methods

This study employed a quantitative research design. It utilizes quantitative ethods to assess the facilities. Data collection was by facility assessment checklist that were completed through observations, records review and questionnaire for both service providers and client exit interviews. The study aimed at assessing the uptake of post-abortion family planning information, counseling, and services within healthcare settings and improve women's health outcomes in line with the overarching goal of the research. These measurements were collected from all study facilities forming a baseline survey/ situations analysis. It entailed facility assessment and participants' structured interviews (Service providers, facility managers, and client exit interviews).. Data was then analysed using simple descriptive statistical approach, reported and finding dissemination.

4.1.Study population and Sampling

4.1.1.Study population: The study population was Post abortion clients seeking care at county health facilities that provided both PAC and FP services.

4.1.2.Facility sampling: To select the 6 facilities for the study, purposive sampling was applied. In this study, 44 facilities that met the inclusion criteria were identified and from these facilities 6 facilities were purposively based on their workloads.

4.1.3.Participants sampling for records review: The prevalence of abortion in Nairobi County is currently unknown, and a sample size was determined by using 50%. We utilized Fischer et al. (1985) exact formula to calculate the appropriate sample size with a 95% Confidence Interval and a precision level of 5%. The resulting sample size is 385 participants were obtained as follows;

n=Z2 pq/d2 = Z2pq/d2 = 1.962(0.52)/ 0.052 = 385 participants

Where n is the sample size, Z2 the critical value of the normal curve that cuts off an area at the tails (1 - equals the desired confidence level e.g., 95%) or found on the table as the Z value of 1.96 on the normal table, d desired level of precision, p the prevalence being studied, and q = 1-p. Therefore, 385 participants will be selected and recruited for the study.

To select the study participants of 385 from the 6 facilities, using a simple random sampling, ensured every individual in the study population had an equal chance of being selected for the sample. Only the consenting respondents who meet the selection criteria were interviewed. The records review of the participants for the past 6 months was conducted. Purposive sampling was used to select the service providers, managers and clients for the client exit interviews.

4.1.4. Procedure for recruitment, participation, and data collection

4.2. Recruitment

4.2.1. Sampling procedure/recruitment strategy clients for the exit interviews: Recruitment for this particular study was focused on post-abortion clients aged 15-49 years who were seeking services at the health facility's various RH service delivery points, MCH, FP,PAC & Maternity departments. The process began with the first consenting client and continued until the desired sample size was reached. Clients visiting the outpatient department were able to access routine consultations for the day before being recruited. Inpatient clients, on

the other hand, were only recruited once they provided consent and were in a stable condition.

4.2.2. Sampling for service providers working at the facility: During the study period, health workers such as nurses, clinical officers, and doctors who offered PAC and family planning services were eligible to participate in a voluntary basis through completing the service providers questionnaire.

4.2.3. Sampling for the facility-based assessment: The selection of specific PAC and FP service delivery points for baseline assessment was intentional. These facilities were purposely chosen based on the inclusion of PAC clinics, the FP clinic, Maternity, outpatient department (OPD) and HIV/AIDS comprehensive care centers (CCC). The assessment aimed to evaluate the supporting services for providing quality FP and PAC services, including general facility infrastructure, availability of equipment, supplies, drugs, and commodities, number of service providers, range of FP/PAC services provided, integration of HIV-related services, and quality of care aspects such as documentation, privacy, and infection control measures.

4.3. Inclusion for participation in the study

Inclusion/exclusion criteria was given for the various categories of participant as follows;

4.3.1. Inclusion criteria for facilities that was selected for study

Public facility

Providing PAC and FP services

Exclusion: Private facilities and those not providing Post abortion care and FP services

4.3.2. Inclusion criteria for post abortion patients that was recruited for study

15-49 years of age

Consent to participate in the study

Exclusion: Those not meeting the above not meeting the above age criteria and not consented for the study

4.3.3. Inclusion criteria for health workers

Working in the selected facilities

Consent to participate in the study

Exclusion: Those not working in the selected facilities and not consented for the study

4.3.4. Inclusion criteria managers

Consent to participate in the study

Exclusion criteria: Those not consented to participate in the study

4.4. Data collection procedures

4.4.1. Post abortion patients records reviews: To assess the Post abortion service uptake, data was abstracted from 385 clients records on some selected indicators (Biodata, PAFP counselling, method acceptance, referral with observation on records completeness.

4.4.2. Client exit interviews: To gather feedback from RH clients after their consultation or discharge, questionnaires were employed that focused on their experiences, perceptions and satisfaction with the services.

4.4.3. Health worker questionnaire: It included their opinions and perceptions of the services they provide, administrative support, the competencies and their own satisfaction.

4.4.4 Health facility assessment: A comprehensive tool, in the form of a structured checklist, was employed to assess the health facilities. This evaluation encompassed a range of critical components, including the availability of essential drugs and supplies, family planning commodities, referral directorate, and equipment. Furthermore, the tool effectively measured the presence of qualified personnel, access to training opportunities, essential documents and records, and reporting tools such as job aids and relevant policy guidelines.

Table 1: Data Collection approach.

Ref	Study component	Sample size (n)
1	Facility assessment	6
2	RH Client satisfaction Exit Interview	36
3	RH service providers performance Self-evaluation	20
4	PAC client Records reviews	385

4.5. Data analysis plan

4.5.1. Data analysis strategy: The data was analyzed concurrently and simple quantitative descriptive analysis was applied to describe several indicators that answered research questions. This included description of variables by proportions, means, modes, and median

Ref	Study component	Data Analysis Strategy			Analysis Outcome
		Data Collection tool	Analysis	Rationale	
1	Facility assessment	Facility Checklist	Quantitative Descriptive	Context, services & capacity assessment	Determination of service uptake
2	RH Client satisfaction Exit Interview	Structured Questionnaire	Quantitative Descriptive	Clients perception on services	Client satisfaction with Service
3	RH service providers performance Self evaluation	Structured Questionnaire	Quantitative Descriptive	Service providers perception on performance	Self-performance evaluation

5. Ethical Considerations

Before conducting the study, ethical clearance and approval had been obtained from the Kenyatta National Hospital-University of Nairobi Ethics and Research Committee (KNH-UoN ERC) and the Ministry of Education, Science and Technology. Anonymity of the participants was assured and maintained throughout the study, and no names were used. Instead, we used codes to conceal the facilities and initials on the interview tools [19,20]. Participants were provided with all the necessary information about the study and obtained an informed signed consent from them. The study was conducted on individuals aged between 15-49 years, and we had made arrangements to address any participants who were under 18. The team had been trained to handle such cases carefully, and participation in the study was authorized only by their adult caretakers. The participants were given the freedom to withdraw from the study at any time without having to explain themselves. They were provided them with an information sheet with our contact details to seek clarification on any aspect of the study.

During the study, priority was given to the management of abortion-related emergencies and complications. Only stable patients were enrolled in the study upon consenting, and critically ill patients were referred for appropriate care. Prior arrangements had been made to handle any psychological distress observed during the study and appropriate referrals were done for the warranting cases.

The research assistants underwent pre-survey training, where they learned about ethical elements in research and expressed their commitment to upholding the confidentiality of participants' information. Researchers kept the participants' confidential information related to the study strictly out of reach of all except the study team in separate lockable cabinets before submitting them for analysis. The participants were engaged in the study only after they voluntarily consented and were provided with all the necessary information about the benefits and risks of the study [20].

5.1. Consenting procedure during the face-to-face facility interviews

The RAs obtained written consent after the patient/client had been attended to by the health team in the Wards or outpatient department. The RAs explained the study and its associated procedures to the potential participants before conducting any study procedure verbally in English or Kiswahili using translated consent forms. The explanation provided included the study aims and procedures. Following the verbal explanation, the patient was provided with a written consent form to go through [21]. The patient/client was allowed to ask questions [20,22]. The patient/client was also educated on her rights as a participant in the study. If one agreed to be interviewed, she was acknowledged with a signature or a mark [22,23]. The research assistant signed as a witness. Respondents were provided with an information sheet with phone numbers to call if she may have any problems or questions.

5.2. Summary

In conclusion, the methodology session has outlined a rigorous approach to investigating the research questions through a quantitative research design. The careful selection of research design and data collection techniques has laid a strong foundation for robust and meaningful analysis of the study findings. The next session will present the results and findings of the study.

6. Results

6.1. Introduction

Post-abortion family planning (PAFP) plays a crucial role in preventing unintended pregnancies and improving the reproductive health outcomes of women who have undergone abortions. The scope of the assessment was centred on general facility infrastructure, services, client satisfaction with services, service providers self-evaluation on job satisfaction and performance, capacity of service providers, equipment, supplies, Health

Management Information system (HMIS), Service integration/referral and community engagement and availability of adolescent in youth friendly services. This scope was informed by the WHO Building blocks of health systems (selected components) and the Elements of PAC.

6.2. Facility infrastructural and assessment

A comprehensive investigation involving interviews, observations, and record reviews was conducted at six healthcare facilities in Nairobi. The data collected from all these sources was comprehensively analysed, ensuring accuracy and reliability, to derive insightful conclusions.

6.3. Infrastructure

6.3.1. Amenities: During the facility assessment, the researcher, in their role as an impartial observer, asked each facility's manager to share their observations and comments on the general appearance and amenities at their facility, both at the baseline and endline periods. The researcher also confirmed the facility manager's responses by observing various aspects of the facility.

The questions focused on several aspects, such as security, utilities, client waiting areas, and signage at each facility . The lighting, ventilation, and privacy (auditory and visual), specifically in the FP and PAC departments at all facilities, were confirmed to be adequate. However, functional referral systems and waste disposal in all facilities were identified as areas that needed improvement. Additionally, the general security and adequacy of waiting areas at the intervention facilities were also highlighted as areas for improvement.

Overall, the facilities reported consistently high satisfaction rates regarding their appearance, functional communication services, reliable electricity and backup services, and reliable, safe running water.

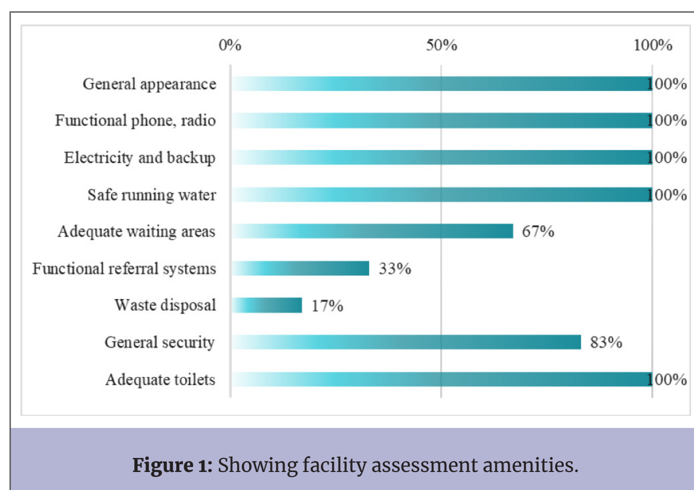

Figure 1: Showing facility assessment amenities.

6.3.2. Signage at the facilities

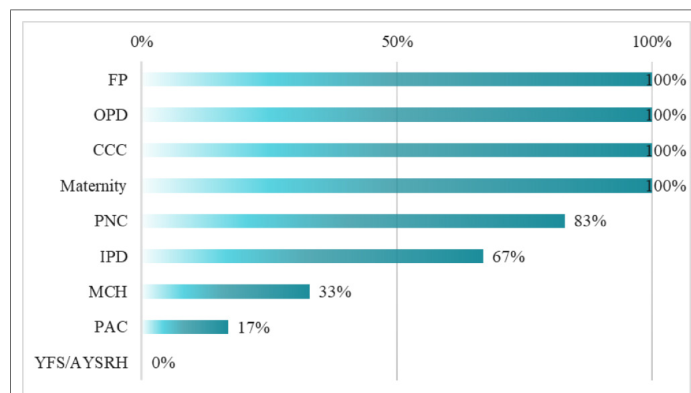

Figure 2: Showing facility assessment signage.

6.3.3. Signage: During the facility assessment, the researcher asked the manager of each facility and confirmed through observation, the availability of signage for different health services .The FP, OPD, CCC, and Maternity signage were visible in 100% of the facilities. However, none of the facilities had any signage depicting YFS/AYSRH services. The signage for PAC services was also significantly low at 17%. The lack of this signage is a concern as it may lead to confusion and difficulty for individuals in accessing the necessary services they require.

6.3.4. Supplies: The researcher assessed the availability of supplies in the FP and PAC departments across the six facilities, specifically querying the availability of FP commodities and three primary IP (Infection Prevention) items: soap, chlorine, and gloves. The FP and PAC departments across all six facilities were noted to have FP commodities available. Additionally, the study found that in the FP department, most of facilities had all three IP items available. In the PAC department, all six facilities had all three IP items available (Soap, Chlorine, and Gloves)

6.3.4. Equipment: The researcher inspected the functional items at FP, PAC and Maternity service delivery points. It was noted that some equipment was shared across these three departments. The items inspected included examination lights, couches, blood pressure (BP) machines, autoclaves, vaginal examination sets, MVA kits, and implant insertion/removal kits. During the inspection, it was found that examination lights, couches, BP machines, vaginal examination sets and implant insertion/removal kits were available at all six facilities. Four (67%) facilities had an autoclave.

6.3.5. Staffing: Almost 50% of all technical staff offering the PAC and FP service were Nurses .The Clinical officers and doctors constituted 26% of the service providers.

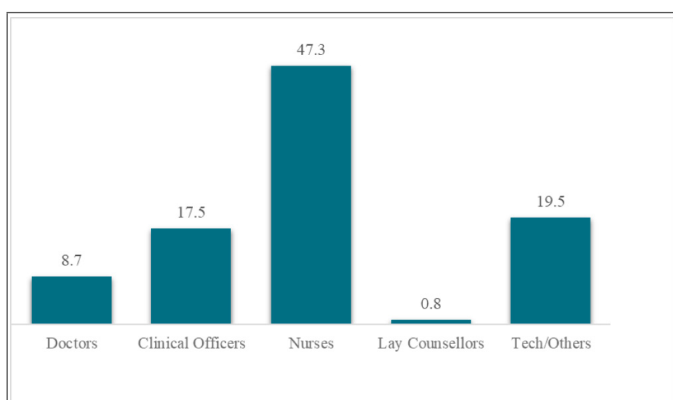

Figure 3: Showing facility assessment availability of service providers.

6.3.6. Staff training: This section of the study comprised a set of questions directed towards the facility in charge. These questions related to the continuous medical education (CME) being provided at the facility, whether the facility conducts any CMEs on FP or PAC and whether any staff is undergoing on-the-job training (OJT) on FP or PAC. These questions aimed to identify gaps in the training and education at these facilities.

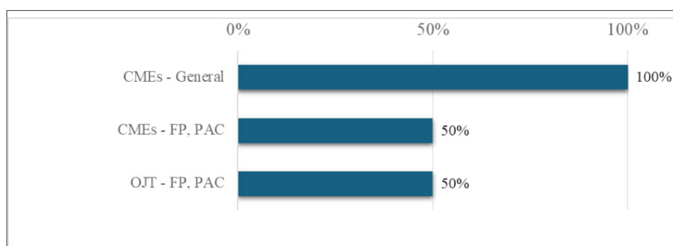

Figure 4: showing availability of CMEs during facility assessment.

The results indicated that all the facilities had established CMEs. Half of the facilities conducted CME programs and underwent OJTs on FP or PAC.

6.3.7 Staff trained in reproductive health: The study also examined the number of staff trained in reproductive health. The Table 3 below illustrates that the facilities had little to no staff who were specifically trained on the various reproductive health components. Nevertheless, with the knowledge and skills acquired during their basic qualification training they were competent to offer the required services.

The results indicated that all the facilities had established CMEs. Half of the facilities conducted CME programs and underwent OJTs on FP or PAC.

6.3.7 Staff trained in reproductive health: The study also examined the number of staff trained in reproductive health. The Table 3 below illustrates that the facilities had little to no staff who were specifically trained on the various reproductive health components. Nevertheless, with the knowledge and skills acquired during their basic qualification training they were competent to offer the required services.

	Total Staff	PAC	FP Counselling	FP	YFS/ ASRH	LMIS
Doctors	8.7	0.2	0.2	1.2	0.0	0.0
Clinical Officers	17.5	1.3	0.8	1.5	0.0	0.0
Nurses	47.3	1.3	15.0	14.8	0.0	0.2
Lay Counsellors	0.8	0.0	0.0	0.0	0.0	0.0
Tech/Other	19.5	0.0	0.0	0.0	0.0	0.0

6.4. Family planning

6.4.1 Family planning services: During the study, the officer-in-charge of each facility was asked about the family planning options provided to patients. Six FP options - condoms, combined oral contraceptive pills (COC), injectables, intrauterine contraceptive devices (IUCD), implants, and tubal ligation (TL) - were enquired about being provided to FP clients in general and to PAC clients specifically. The graph below summarizes the findings. The table illustrates the number of FP options provided by the facilities.

Only one facility provided all six FP options in general. The two FP options offered to clients at all facilities were implants and injectables day of the week. To assess the level of PAFP integration, service providers were asked to indicate whether they stocked FP options for the post abortion patients specifically.

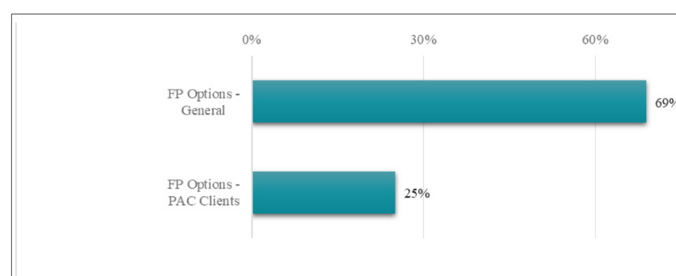

Figure 5: showing family planning options.

Only 25% of the facilities had this provision as per the Figure 5 above.

The Table 4 below shows the specific methods that were offered in the facility generally and the PAFP options. It is worth noting that only one of the facilities was offering Permanent methods (Tubal Ligation) with all the facilities providing injectables and implants as general FP. Surprisingly, these services were not available options for post abortion patients who options remained majorly injectables and pills provided in 50% of the facilities.

Table 4: showing FP methods availability in the facilities.

FP Options - General			FP Options - PAC Clients	
Condoms	4	67%	3	50%
COCs	4	67%	3	50%
Implants	6	100%	1	17%
Injectables	6	100%	1	17%
IUCDs	4	67%	1	17%
TL	1	17%	0	0%

While we noted that FP commodities were stocked in the facilities, more must be done to ensure that all options are provided at all facilities, both in general and specifically for PAC clients.

6.5. Post-abortion care

6.5.1. PAC services: The officer-in-charge of each facility was asked about the PAC services provided at their facilities. They were specifically asked about the following services:

- PAC emergency management services
- Uterine evacuation using Manual Vacuum Aspiration (MVA) or Dilatation and Curettage (D&C) procedure
- Medical uterine evacuation using PGs (Misoprostol)
- Pain management
- Counseling for Post-Abortion Care
- Post-evacuation counselling
- Family Planning counselling
- Integration of other services such as Reproductive Health (RH), Sexually Transmitted Infections (STI), Human Immunodeficiency Virus (HIV), and Cervical Cancer screening
- Community advocacy, education, and sensitization on prevention and availability of PAC services

6.5.2 Community involvement: The officers in charge of each of the facilities were asked about community involvement and participation in relation to PAC and FP services. None of the facilities were found to be doing anything to create awareness for FP or the availability of PAC services through mediums such as outreach services, community mobilization, community-based IEC campaigns, peer education, media, or community mentors. No messaging on components such as, prevention of unplanned pregnancies, the effects of abortion and its complications, the availability of emergency post-abortion care services, or the availability of PAFP, by any of the facilities during their community IEC events.

6.6. Documentation and reporting

6.6.1. Health records: The researcher checked the records of the FP and PAC departments for daily activity registers, reporting forms, client cards, and referral forms at all six facilities. The findings have been summarized in the graph.

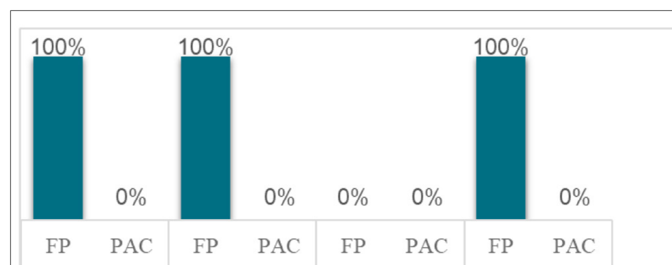

Figure 6: Showing PAC documentation and referral tools at the facility level

The results show that client cards were largely unavailable at the FP and PAC departments. However, all facilities had daily activity registers, reporting forms and referral forms at the FP department, while none of facilities kept these records for the PAC care and the patients were recorded in various other registers as either OPD patient, Maternity or gynecological registers. Some facilities had improvised documentation record books that were not consistently used. This implies a general lack of formalized documentation and record-keeping for PAC services, which is a huge area of improvement needed, as clear records can be used to track progress, identify areas for improvement, and ensure accountability. Additionally, well-maintained records can be used as evidence to support decisions and actions taken, improving transparency and trust with stakeholders.

6.6.2. PAC documentation: The researcher observed the PAC service delivery points to check for three important documentation and reporting tools: the PAFP referral form for referral/linkage, job aids for PAC, and IEC materials for PAC. The Table 5 below shows that, almost no documentation was present. However, there is still room for improvement in all facilities regarding the availability of IEC materials for PAC.

Table 5: Showing PAFP Referrals and IEC Materials availability.

	n	%
PAFP referral forms	0	0%
PAC job aids	1	17%
PAC IEC materials	0	0%

6.6.3. PAFP referral system: At the beginning of the study, none of the six facilities confirmed having a functional referral system in place for PAFP.

A client exit interview was conducted to evaluate RH clients' overall satisfaction with the healthcare services at 6 selected sites. The interview was designed to gather general overall feedback from clients regarding their experience with the Reproductive Healthcare services, including quality of care, level of satisfaction with services provided, and feedback on the service providers at the healthcare facilities visited. The input gathered from the general client exit interviews of FP, Maternity and PAC clients was analysed to identify trends and patterns as presented in the Table 6 below;

Table 6: Baseline and post-intervention client satisfaction with health services.

	Yes	No	No Comment
This facility is easily accessible	36	0	0
You were treated with respect	32	4	0
Waiting times were reasonable	26	9	1
You had enough privacy during the entire consultation visit	20	0	16
You had enough time with the service provider(s) to share your concerns and have your questions satisfactorily answered	15	11	10
You have enough information about your care	29	7	0
Procedures were sufficiently explained	17	10	9
Appropriate arrangements were made for follow-up visits if necessary	17	19	0
All your needs were met to your expectations	30	2	4
Service providers in this facility are friendly	29	3	4
You have been referred for some services in outside facilities	17	19	0
Would you return to this facility or recommend it to somebody else?	31	0	5

7. RH Client Satisfaction with Reproductive Health (RH) services (PERCEPTIONS)

7.1. Client exit interviews

The graph showcases the feedback of the patients interviewed who visited a health facility and their experience .To assess service delivery, the patients were asked to provide feedback in five areas: meeting their expectations, friendliness of service providers, being treated with respect, having the procedures adequately explained, and having enough privacy during the consultation visit. Eighty three percent (83%)of patients reported that all their needs were met to their expectations. Similarly, the percentage of patients who reported that service providers in the facility were friendly increased were 81%. Regarding being treated with respect, 89% of patients reported that they were treated with respect. A total number of 17 patients(47%) believed that procedures were sufficiently explained .Finally, the percentage of patients who reported having enough privacy during the consultation visit were slightly above half (56%).

7.1.1. Follow-up arrangements post-intervention

The client exit interview enquired about the clients experience with the services related to appropriate arrangements for follow-up visits and referrals for services in outside facilities.

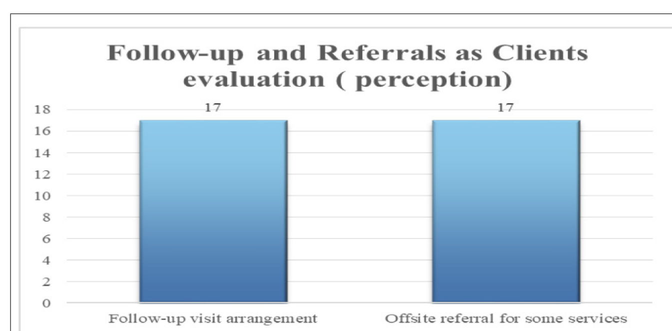

Figure 7: Showing clients Follow up and referral experiences and perceptions.

The data presented in the graph indicates the number of individuals who felt that appropriate arrangements

they had ample time with the service providers to share their concerns and questions.

8. Service Provider Performance Self-Evaluation Interviews

The researcher interviewed service providers to obtain their perceptions of job satisfaction, competency and administration support. The providers were interviewed from the following service delivery points: MCH, FP, PAC and Maternity.

Table 7: Service provider performance self-evaluation results (n=20).

	n	%
Are you well supervised and managed?	18	90%
Do you have enough supplies, equipment and space to work?	6	30%
Do you receive adequate feedback about your performance?	17	85%
Are you motivated?	15	75%
Are your clients satisfied with your services?	18	90%
Are you performing to your satisfaction?	18	900%
Are you well-informed and trained to perform your duties?	18	900%
Are you aware of what is expected of you?	18	900%
FP clients	17	85%
PAC clients	5	25%
PAFP	15	75%
Linking patients to services within this facility	13	65%
Referring patients to other external facilities	14	70%

were made for follow-up visits. Only 47% of individuals responded positively. The number of respondents referred for services in outside facilities were 47%.

Upon analysing the data, it is evident that 42% of the patients interviewed responded positively, stating that

The researcher interviewed service providers to obtain their perceptions of job satisfaction, competency and administration support. The providers were interviewed from the following service delivery points: MCH, FP, PAC and Maternity.

Administrative Support

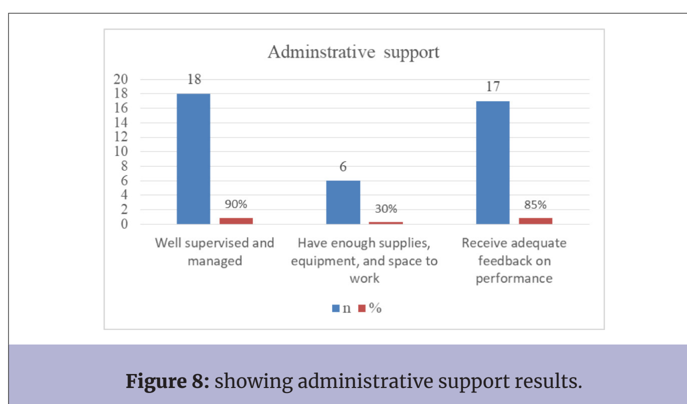

Figure 8: showing administrative support results.

Almost all the service providers interviewed reported being well-supervised and managed(90%) with 85% reporting to receive feedback about their performance. However, only 30% of service providers reported having enough supplies, equipment, and space to work low.

8.1. Job satisfaction

Almost all (90%) of the service providers perceived that their clients are satisfied with their services and that they too

were performing their jobs to their satisfaction. However, a few reported to be motivated to work.

Almost all the service providers interviewed reported being well-supervised and managed(90%) with 85% reporting to receive feedback about their performance. However, only 30% of service providers reported having enough supplies, equipment, and space to work low.

8.1. Job satisfaction

Almost all (90%) of the service providers perceived that their clients are satisfied with their services and that they too were performing their jobs to their satisfaction. However, a few reported to be motivated to work.

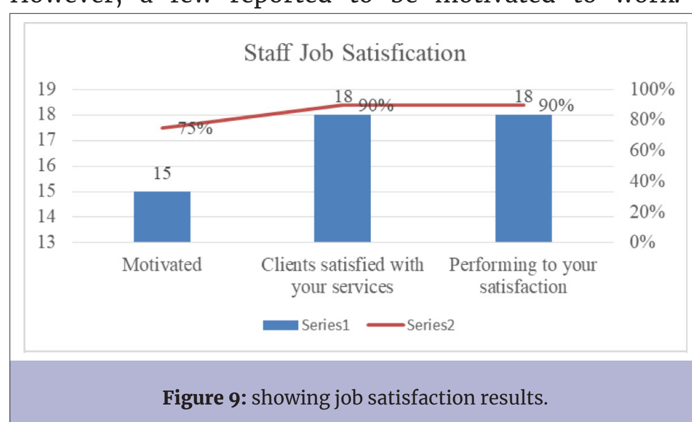

Figure 9: showing job satisfaction results.

Job Performance and competencies

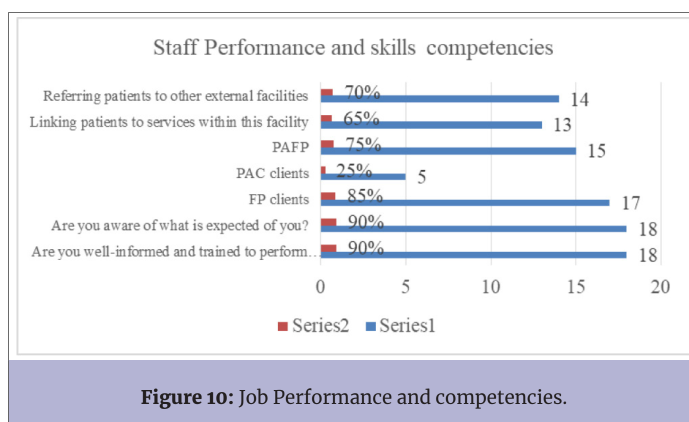

Figure 10: Job Performance and competencies.

Performance and Competence self-evaluation results. The results show that the healthcare providers felt well-informed (90%) and trained to perform their duties and were generally aware of expectations regarding their roles (90%).However majority demonstrated reduced competency in handling PAC patients(25%) compared to general FP patients(85%).

9. Post Abortion Patients Records Review Findings

Data abstraction from the clients record for the 6 Months from the 6 facility was conducted (n=385). The focus was on selected biodata indicators (age, Marital status); Service uptake and records availability and completeness in each of the sampled facility. This data was disaggregated as per the table below.

Table 8: PAC client Biodata per facility.

	Facility 1A	Facility 2A	Facility 3A	Facility 4A	Facility 5A	Facility 6A	Total	%
15-19 years (1-Yes; 0-No)	6	2	16	12	3	2	41	11%
20-24 years (1-Yeas; 0-No)	19	10	51	46	11	11	148	40%
25-29 years (1-Yes;0-No	7	9	43	34	5	6	104	28%
30-34 years (1-Yes;0-No	4	6	25	7	3	2	47	13%
35 years & Above (1-Yes;0-No)	5	5	10	4	1	1	26	7%
TOTAL	41	32	145	103	23	22	366	99%
Married (1-Yes; 0-No)	34	26	98	70	19	17	264	72%
Other	7	6	47	33	4	5	102	28%
PAFP Information Counselling (1-Yes; 0-No)	8	4	66	53	8	3	142	39%
PAFP Accepted (1-Yes; 0-No)	4	5	12	9	4	3	37	10%
Referred (1-Yes; 0-No.)	3	4	12	8	2	1	30	8%
PAC Register Available (1-Yes; 0-No.)	0	0	0	0	0	0	0	0%
Records complete (1-Yes; 0-No)	0	0	0	0	0	0	0	0%

Table 9: Summary Biodata.

	Pretest Percentage
15-19 years	11%
20-24 years	40%
25-29 years	28%
30-34 years	13%
35 years & Above	7%
TOTAL	99%

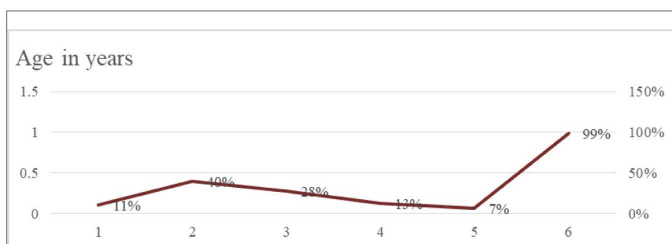

Figure 11: Age in years.

Further the biodata (age in years) was summarized in as Figure 11 given below. This showed that more than 50% of all the patients were adolescent and youth (24-years and below) with only a few aged 35 and above years (7%).

9.1. Marital status

The table below gives a summary of the patients married status where most of the patients were reported to be married.

Table 10: Marital status summary.

	Percentage
Married (1-Yes; 0-No)	72%
Other	28%

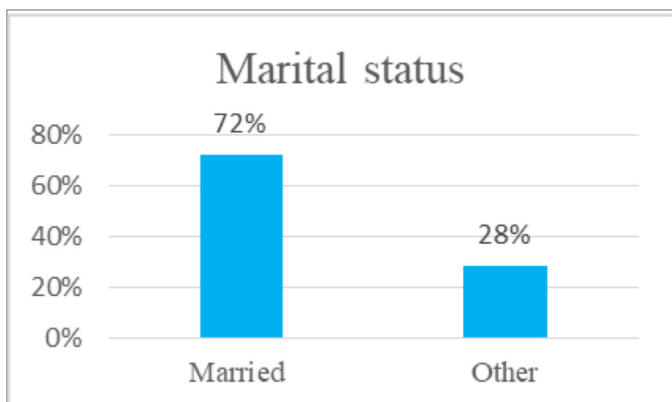

Figure 12: Patients Marital status.

Post Abortion Family Planning (PAFP) service uptake and referral tools availability.

From the Records review, the uptake of PAFP was reported to be below average with only 10 % acceptance rate and 39% of the records at indicated that patients had been counselled for contraceptive choices. None of these records had been maintained in a formal MOH PAC registers and it was observed that 100% of all the patients' records were incomplete .This his summarized as per the Table 11 below.

Table 11: PAFP services and availability of the Referral tools.

	Percentage
PAFP Information Counselling	39%
PAFP Accepted	10%
Referred	8%
PAC Register Available	0%
Records complete	0%

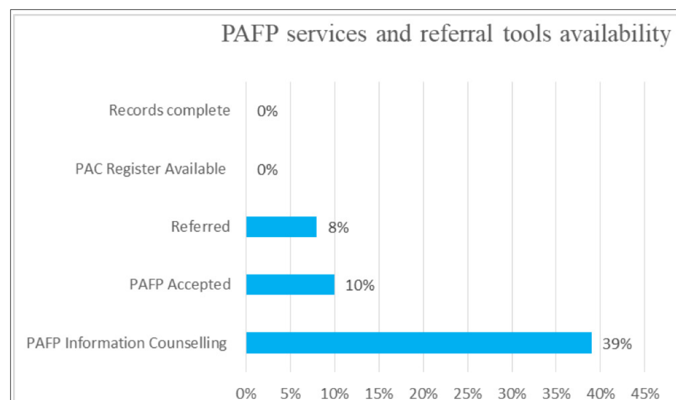

Figure 13: PAFP services and availability of the Referral tools.

The above Figure 13 summarized the PAFP service uptake status with highlights that though PAFP counselling was leading among the PAFP services, it was still way below 50% recorded in most of the clients records. Referrals were not indicated in the available records except for the 8% of the case.

9.2 Conclusion

Facility assessment revealed variations in the availability of trained staff, infrastructure, and equipment necessary for the provision of PAFP services. Record reviews indicated that only a small proportion of post-abortion patients received PAFP counseling, highlighting the underutilization of these services. Patient interviews identified generalized satisfaction with the services and service provider interviews identified generalized job satisfaction, positive perception of administrative support and they appraised themselves as highly competent in their skills providers providing a stable ground for model introduction of the PAFP linkage

and referral model towards improved access to PAFP services. Moving forward, we shall discuss the findings draw conclusions and recommendations of the study in the last section. This study is poised to offer a nuanced and holistic perspective that can inform future research and practice Reproductive Health particularly on Post abortion care to include post abortion family planning access.

10. Discussion, Conclusions and Recommendations

Post-abortion family planning (PAFP) is a set of interventions to help women delay the next pregnancy [24,25]. It can be described as the deliberate action of providing family planning information and services to women at their first contact point with the healthcare system after having an induced or spontaneous abortion [26]. Working under the assumption that women who have an induced or spontaneous abortion are clearly at risk of an unintended pregnancy. The assessment highlighted the existing gaps in PAFP services uptake, including limited PAFP counseling, low Post abortion contraceptive uptake, and various barriers faced by patients and service providers [27,28,29,30,31]. Adolescent and youth formed the highest proportion of patients and those 35 years and above were the least. Patients maintained a positive attitude towards their experiences with the facilities, service providers the services they received. Accordingly, the providers appraised their work as satisfactory and contentment with their working environment except inadequate supplies and commodities to facilitate their work. For effective service delivery generally, it is essential for facilities offering post abortion family planning services to have appropriate physical infrastructure according to the WHO which was a positive finding of the study [24,32,33,34].

10.1. Limitations: The findings could reflect over-estimation service provider performance resulting from Hawthorne effect since self-evaluated themselves [35,36]. Moreover, missing and incomplete could have affected the study findings.

10.2. Conclusion: The assessment of PAFP services uptake identified best practices, barriers and gaps that need to be addressed to improve PAFP access.

10.3. Recommendation: Future research should focus on designing an effective strategic approach that could optimize access to PAFP services and contribute to reducing unintended pregnancies and improving women's reproductive health outcomes.

11. References

1. Making abortion safe. (2022).
2. Melenia M, Cowles C, Mwachiro M. (2020) The Quality of Post Abortion Care Package Offered to Women Presenting to Two Referral Hospitals in Bomet County. Kabarak J Res Innovation. 10(2): 33-58.
3. Ojuok R, Nyamongo DD, Mutai DJ. (2022) Determinants of unintended pregnancy among women attending antenatal clinic at Kenyatta National Hospital. F1000Research. 11.
4. WHO, UNICEF, UNFPA, T. W. Bank. (2007) Maternal Mortality in 2005: estimates developed by WHO, UNICEF, UNFPA and The World Bank. Bull World Health Organ.
5. Kim CR, Tunçalp Ö, Ganatra B, et al. (2016) WHO multi-country survey on abortion-related morbidity and mortality in health facilities: Study protocol. BMJ Glob Health. 1(3): e000113.
6. WHO. (2011) International statistical classification of diseases and related health problems - 10th revision. World Health Organisation.
7. Say L, Chou D, Gemmill A, et al. (2014) Global causes of maternal death: A WHO systematic analysis. The Lancet Global Health. 2(6): 323-333.
8. Ministry of Health (MOH) [Kenya]. (2013). Incidence and Compliations of Unfsafe Abortion in Kenya: Key findings of a national study. Nairobi, Kenya: Ministry of Health. August.
9. Quine L, Steadman L. (2014) Pregnancy and childbirth. In Cambridge Handbook of Psychology, Health and Medicine, Second Edition.
10. Marlow HM, Wamugi S, Yegon E, Fetters T, Wanaswa L, Msipa-Ndebele S. (2014) Women's perceptions about abortion in their communities: Perspectives from western Kenya. Reproductive Health Matters. 22(43): 149-158.
11. Hussain R. (2012) Abortion and unintended pregnancy in Kenya. Issues in Brief (Alan Guttmacher Institute).
12. Jayaweera RT, Ngui FM, Hall KS, Gerdts C. (2018a) Women's experiences with unplanned pregnancy and abortion in Kenya: A qualitative study. PLoS ONE. 13(1): 0191412.
13. Kabiru CW, Ushie BA, Mutua MM, Izugbara CO. (2016a) Previous induced abortion among young women seeking abortion-related care in Kenya: A cross-sectional analysis. BMC Pregnancy and Childbirth. 16(1): 104.
14. Ziraba KK, Izugbara C, Levandowski BA, et al. (2015) Unsafe abortion in Kenya: A cross-sectional study of abortion complication severity and associated factors. BMC Pregnancy and Childbirth. 15(1): 34.
15. Kabiru CW, Ushie, BA, Mutua MM, Izugbara CO. (2016b) Previous induced abortion among young women seeking abortion-related care in Kenya: A cross-sectional analysis. BMC Pregnancy and Childbirth, 16(1): 104.

16. Maina BW, Mutua MM, Sidze EM. (2015) Factors associated with repeat induced abortion in Kenya Global health. BMC Public Health. 15(1): 1048.

17. Izugbara C, Wekesah FM, Sebany M, Echoka E, Amo-Adjei J, Muga W. (2020) Availability, accessibility and utilization of post-abortion care in Sub-Saharan Africa: A systematic review. In Health Care for Women International. 41(7): 732-760.

18. Penfold S, Wendot S, Nafula I, Footman K. (2018) A qualitative study of safe abortion and post-abortion family planning service experiences of women attending private facilities in Kenya. Reproductive Health. 15(1).

19. Roshaidai S, Arifin M. (2018) Ethical Considerations in Qualitative Study. In International J Care Scholars. 1(2).

20. Yip C, Han NLR, Sng BL. (2016a) Legal and ethical issues in research. Indian Journal of Anaesthesia. 60(9): 684-688.

21. Corrigan O. (2003) Empty ethics: the problem with informed consent. In Sociology of Health & Illness. Sociol Health Illn. 25(7): 768-792.

22. Izydorczak K, Grzyb T, Dolinski D. (2022) Ascent of Humans: Investigating Methodological and Ethical Concerns About the Measurement. Collabra: Psychology. 8(1). 33927.

23. Waligora M, Dranseika V, Piasecki J. (2014) Child's assent in research: Age threshold or personalisation? BMC Medical Ethics. 15(1): 44.

24. Muchie A, Getahun FA, Bekele YA, Samual T, Shibabaw, T. (2021) Magnitudes of post-abortion family planning utilization and associated factors among women who seek abortion service in Bahir Dar Town health facilities, Northwest Ethiopia, facility-based cross-sectional study. PLoS ONE. 16(1): 0244808.

25. Tekle Lencha T, Alemayehu Gube A, Mesele Gessese M, Tsegay Abadi M. (2022) Post-abortion family planning utilization and associated factors in health facilities of Wolaita Zone, Southern Ethiopia: Mixed study. PloS One. 17(6): e0267545.

26. Majok SA, Makunyi EG. (2022) Uptake of modern family planning methods among women receiving spontaneous post abortion care at Kuajok hospital, South Sudan: a cross-sectional study. Int J Com Med Pub Health. 9(8): 3090.

27. Baynes C, Kahwa J, Lusiola G, et al. (2019) What contraception do women use after experiencing complications from abortion? an analysis of cohort records of 18,688 postabortion care clients in Tanzania. BMC Women's Health. 19(1): 22.

28. Mbehero F, Momanyi R, Hesel K. (2021) Facilitating Uptake of Post-abortion Contraception for Young People in Kenya. Frontiers in Global Women's Health. 2.

29. Quality of Post-Abortion Care in Kenya Findings from a national survey. (2020).

30. Tavrow P, Withers M, McMullen K. (2012) Age matters: Differential impact of service quality on contraceptive uptake among post-abortion clients in Kenya. Culture, Health and Sexuality, 14(8).

31. Wendot S, Scott RH, Nafula I, Theuri I, Ikiugu E, Footman K. (2018) Evaluating the impact of a quality management intervention on post-abortion contraceptive uptake in private sector clinics in western Kenya: A pre- and post-intervention study. Reproductive Health. 15(1): 10.

32. Evens E, Otieno-Masaba R, Eichleay M, et al. (2014) Post-abortion care services for youth and adult clients in Kenya: A comparison of services, client satisfaction and provider attitudes. J Biosocial Sci. 46(1).

33. Muga W, Juma K, Athero S, Kimemia G, Bangha M, Ouedraogo R. (2024) Barriers to post-abortion care service provision: A cross-sectional analysis in Burkina Faso, Kenya and Nigeria. PLOS Global Public Health, 4(3): e0001862.

34. Mutua MM, Achia TNO, Manderson L, Musenge E. (2019) Spatial and socio-economic correlates of effective contraception among women seeking post-abortion care in healthcare facilities in Kenya. PLoS ONE. 14(3).

35. McCambridge J, Witton J, Elbourne DR. (2014a) Systematic review of the Hawthorne effect: New concepts are needed to study research participation effects. In J Clin Epidemiol. 67(3): 267-277.