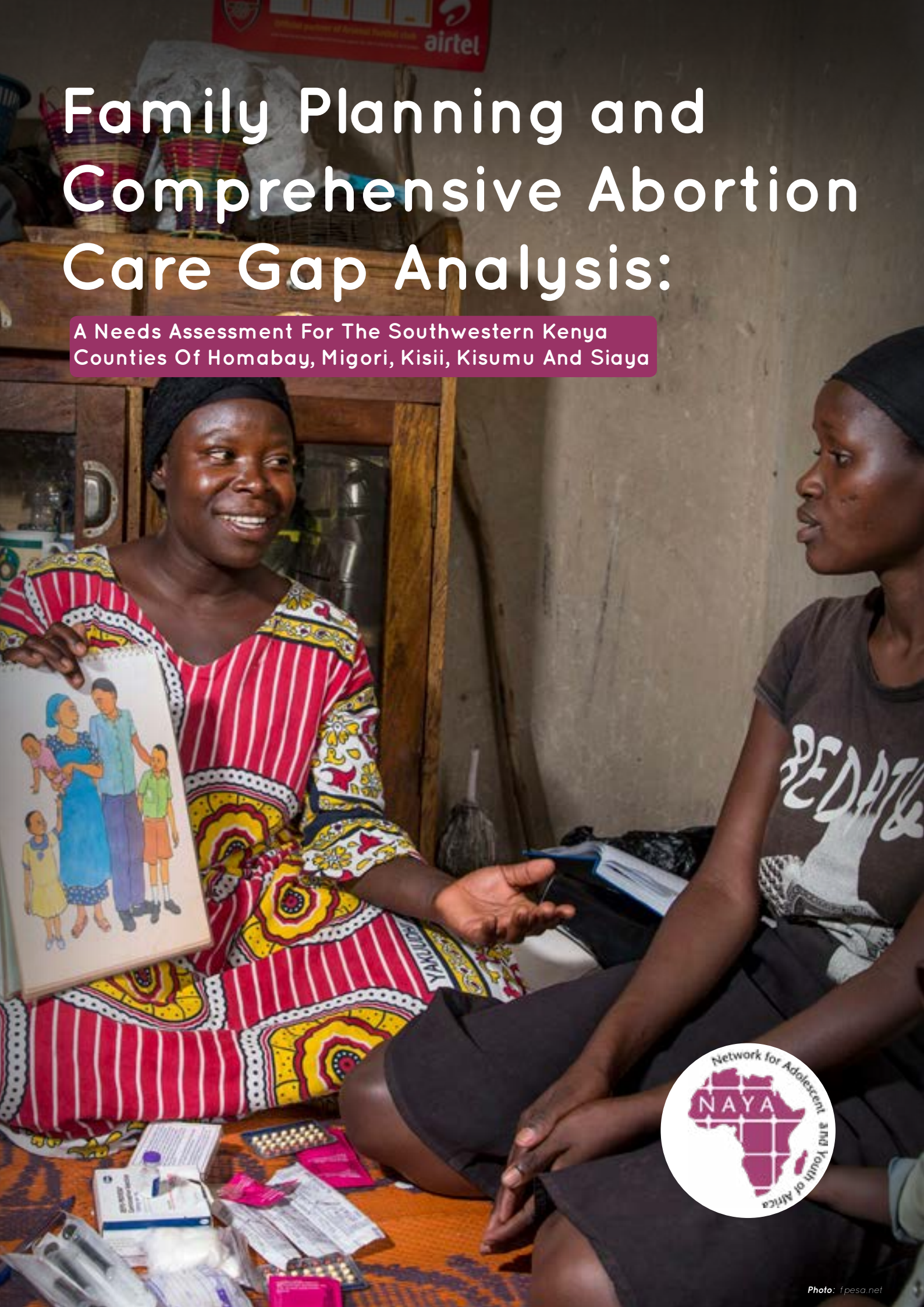
Family Planning and Comprehensive Abortion Care Gap Analysis:

A Needs Assessment For The Southwestern Kenya Counties Of Homabay, Migori, Kisii, Kisumu And Siaya



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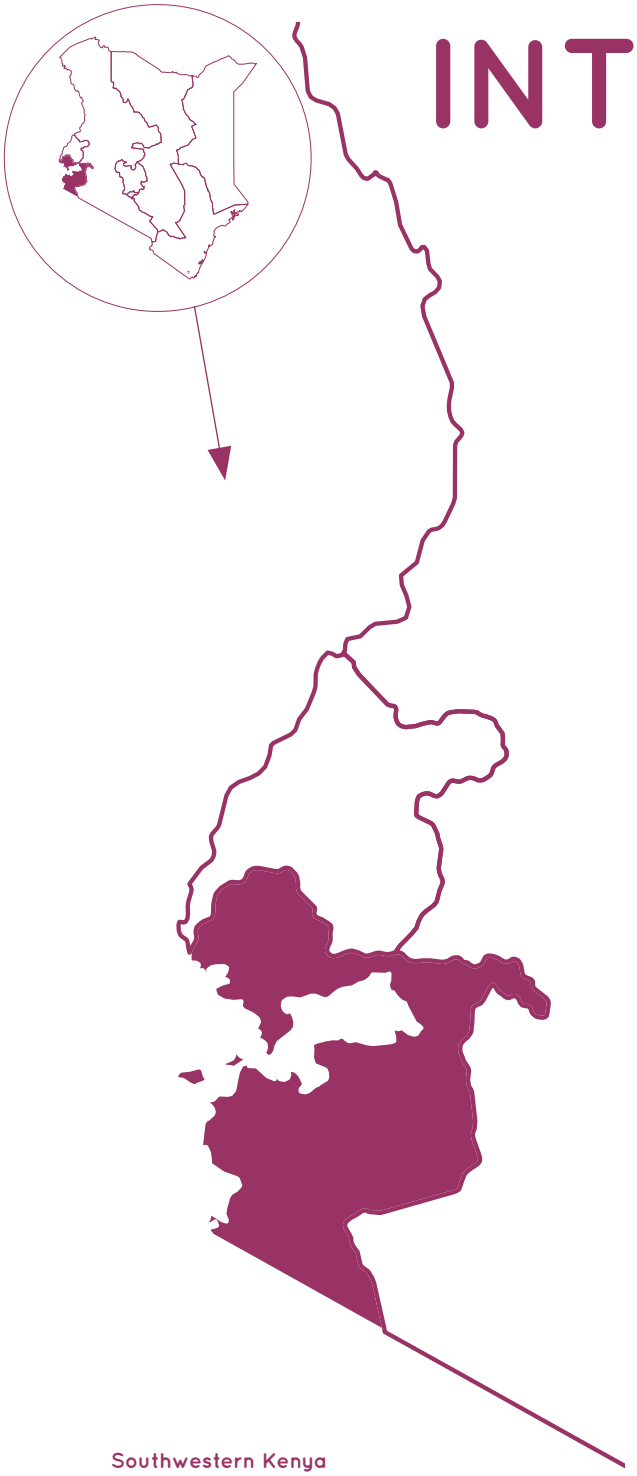
1.0 INTRODUCTION



Southwestern Kenya

There's a growing concern on the low uptake of family planning services coupled with high incidents of unsafe abortion in Southwestern Kenya (Migori, Kisii, Homabay, Siaya, Kisumu). The region has demonstrated deteriorating reproductive health indicators in the country.

Migori and Homabay are among the counties with the lowest median age at first marriage for women. The whole sub region has the earliest sexual debut among women recorded at 16 years. This needs assessment report highlights some of the existing gaps in the provision and uptake of quality family planning and comprehensive abortion care services with a view to project actions that should be taken both at policy and service delivery levels to ensure quality reproductive health information and services are provided for the wellbeing of mothers, youth children and the general population. This would go along way in preventing maternal, child morbidity and mortality in the five counties.

The issues presented cut across the various five counties, given that they coexist within a similar cultural, historical and religious context defined by the same communal values, norms and lifestyles, and with an almost similar policy environment

2.0 METHODOLOGY

This report analysis report was compiled through a systematic desk top review of documents from implementation of CtG 2, activity reports, annual reports from the organizations, county governments and stakeholders working in Kisumu, Kisii, Homabay, Siaya and Migori. This is illustrated below

- Review existing documents
- Conduct quality assurance on chosen documentation

- Screening of documentation by a staff and youth advocate
- Check screening outcomes for discrepancies
- Resolve all discrepancies

- Review of each document/article used
- Determine if synergies of efficiencies are documented

3.0 REPORT FINDINGS

The review showed that despite the efforts that have been put in place, there are still remarkable gaps when it comes to FP and CAC service provision. These gaps range from policy implementation, lack of awareness by young people on the existing policies, cultural and religious factors, abortion stigma, under-budgeting for CAC and FP as discussed below

3.01 Legal and Policy Context

There is limited knowledge particularly among young people on the existence of county and national polices to support their SRH rights. Quite a number of young people and women from Siaya, Kisii, Kisumu, Homabay and Migori counties do not know that their reproductive health rights are anchored in the constitution and supported by a robust policy environment including international treaties like the Maputo protocol. The level of awareness among people in urban county of Kisumu is quite higher though, but most young people and women do not know how to go about claiming, demanding and upholding their rights. The provisions of the National Adolescent Sexual and Reproductive Health Policy and the National Guidelines on the Provision of Youth Friendly Services have not been fully disseminated to benefit women and young people who are in dire need of family planning and other reproductive health information and services.

Since the government withdrew the Standards and Guidelines on Reduction of Maternal Morbidity and Mortality from Unsafe Abortion, there has been confusion among healthcare providers on how to go about providing safe abortion services to those in need. The debate surrounding unsafe abortion is often clouded in controversy, with most people opting to take the moralist approach because of the cultural and religious orientation of Kenyans. In most urban centers in the five counties, unsafe abortion service points have sprung up, while in the more rural areas it is mostly performed in dingy places often by traditional herbalists using concoctions and other crude methods. Most health

facilities-particularly public ones-have avoided provision of safe abortion services even to those who need them in the meaning of article 26(4) of the constitution. Advocacy efforts should therefore target the reinstatement of these provisions and guidelines to reverse the ever-escalating trends of fatalities resulting from unsafe abortion practices.

Additionally, although Kenya is a signatory to the African Charter on Human and Peoples' Rights and on the Rights of Women in Africa (Maputo Protocol), which supplement the African Charter and provides broad protection for women's rights, most county governments still lag behind in providing basic right for women. Domestication of this international instrument would mean expanded access to safe abortion services to include exceptions, so as to preserve woman's health in cases of rape, incest and defilement and related infirmities.

The National Adolescent Sexual and Reproductive Health Policy aims at mainstreaming adolescent health concerns in the national development matrix, in order to improve the quality of life and the standards of living of young people and women in Kenya. Whereas the policy is specific on issues of adolescent youth friendly services and the need for the nation to constantly work towards raising the age of sexual debut to 18 years by 2025, it is conspicuously silent on the issue of abortion which continues to be a pertinent, ravaging problem among this age group.

3.02 Abortion Stigma

Little research has been conducted in relation to societal views on abortion within the Kenyan society at large, leave alone southwestern Kenya, yet it is common knowledge that negative values on abortion continue to influence and cripple legal and policy environment in Kenya. The debate is often around religion and culture with considerations on human rights, medical and legal discourses being given lip service. It is often about who is portrayed as a victim and who is to blame for the high incidences of unsafe abortion. While the mostly patriarchal society views reproductive health and particularly issues around pregnancy, childbirth or abortion as a sphere for women, a recent survey squarely blamed men for the high rates of abortion not only in the five counties but also in the country at large. The issue therefore shifted from the course and how to tackle it to who is to be blamed for it. This only propels the blame game between men and women. It is true that reproductive health issues must be approached on the basis of evidence and through a human rights perspective. And this goes back to the negative attitudes on services that prevent unwanted pregnancies which result into unsafe abortions.

3.03 The Place of Religion in widening the Gap for FP and CAC Provision

Most conservative religious institutions have taken a stand against the provision of family planning services, opting instead to preach for people to give birth and "fill the earth". Duty bearers and other stakeholders often take a moralist stand or choose not to publicly debate family planning and abortion issues even when they understand the problem. These are the contributing factors towards perpetuation of negative attitudes towards the provision of family planning and comprehensive abortion care services. Advocacy initiatives must therefore aim at bringing everybody on board, from the grassroots to duty bearers in a bid to create an enabling environment where reproductive health issues on abortion and family planning can be debated openly and inclusive solutions sought.

3.04 Unsafe Provision

Whilst desk reviews have yielded little recent evidence to show who the providers of unsafe abortion are in Kenya, this study finds out that wealthier women are more likely to obtain abortion from providers considered relatively safe by them; including doctors, midwives and nurses. However, young people and women from lower economic classes e.g. informal settlements, rural areas have less access to health professionals and are more often turning to traditional healers, other lay practitioners and pharmacists for abortion services, which they consider accessible and affordable.

Quacks from urban areas are thought to use hormonal drugs or rubber catheters, and many in rural areas on the contrary turn to herbs and sharp objects. Unsafe procedures, including oral or intra-vaginal introduction of herbs, caustic substances, drugs, and/or sharp objects, result in complications that can be quite severe and even result in permanent damage to the body. Nowadays the use of misoprostol has influenced the means and complications of unsafe abortion in Kenya.

3.05 Long Acting and Reversible Contraception

Because of low levels of information on contraception among women particularly those in rural areas and among the urban poor, most women who would want to delay child bearing even by two years still opt for short term methods of family planning. They believe that long acting and reversible methods are irreversible. As such, many would not opt for long acting methods because of this fear. Family planning services must therefore go hand in hand with the provision of quality information and education if women are to reap the benefits of such services. While a majority of women in the five counties have knowledge of the existence of modern contraceptive options, their understanding is limited to just that, with little deeper knowledge on how such contraception work. This is reflected a lot in the Total Fertility Rate for the region standing at 4.3, quite higher than the national average of 3.9. It was evident from the 2014 Kenya Demographic and Health Survey that quite a number of women would want to be in charge of their future reproductive behavior assuming that the required family planning services are available, affordable and accessible to allow them choose their fertility preferences.

A majority of women would also want to space their births by delaying the next birth with two years or

more. Southwestern Kenya counties have the second highest number of currently married women who would want more children. At least 2 in 3 of currently married women who have children would not want the next child. This is only possible if the unmet need for family planning services is bridged.

3.06 Costed-Family Planning Implementation Plans

Homabay and Migori counties have adopted costed-family planning implementation plans in the past two years while Siaya county is underway. Although their budgetary allocation towards contraception is relatively low taking into account the high unmet needs for family planning in those counties, it is a step in the right direction and their implementation must be closely monitored through robust advocacy initiatives. Advocacy targeted at development of costed-family planning implementation plans can be carried out in Kisii and Kisumu. The onus is on these governments to forecast their need for contraceptive commodities so that the overreliance on international donors, foreign governments and the private sector can be reversed. Also, having costed-implementation plans at the county level provides a basis for the counties to be held to account when it comes to the provision of family planning services.

3.07 Capacity of County Assemblies to legislate on FP and CAC Issues

Quite often, most members of county assemblies do not understand their role in budget making processes and aspects of health, as such reproductive health in general and family planning in particular are often not given the attention they deserve. In particular, most of them may not understand that majority of laws supporting human rights are efforts towards domesticating international commitments that Kenya has ratified. There is therefore need to build their capacity in county legislation and policy development so that robust legislation and policies supporting family planning can be developed at the county level. MCAs also need to be capacity built on the place of safe abortion in the Kenyan legal context so that the debate for the provision of safe abortion services can shift to those who bear the greatest responsibility in the provision of primary healthcare. Because governments change after every five years, there needs to be a sustainable way of ensuring the knowledge gained by MCAs in one government is carried on to the next one so that advocacy organizations must not always be there at the turn of each government to support MCAs on this.

3.08 Male Involvement in Family Planning

Evidence has proved that there is need for male involvement in family planning initiatives if at all the interventions have to succeed. However southwestern Kenya is one of the regions in the country with high acceptance of contraception among men with only 16.1% of married men having the feeling that family planning is women's business. Advocacy initiatives at the grassroots need to tap into this and target men in order to build on this acceptance and support for family planning initiatives. Targeted male forums have proved to be an effective way of engaging men in family planning but have not been fully utilized by most grassroots advocacy initiatives. Also, most service providers assume the impact of engaging men in discussions surrounding contraception. There is need therefore to also advocate for the sensitization among reproductive health providers to equally involve both women and men in contraception drives.

3.09 Acceptability of Services

Due to unclarified values among providers, women have been turned away from family planning services because the provider thinks that they are too young to access them. Healthcare providers indicate that even when they know that sexual debut is often at 15 years of age, they feel quite uncomfortable providing an unmarried 18-year-old with an effective contraception method. They note that they have been brought up to believe that it is a sin to have sex at a young age, more so if someone is unmarried, such a client would therefore be turned away from an effective service. Clinics such as those in education institutions do not provide contraception services because they believe the students are interested only in study. Sexually active students have no option than to turn to nearby low quality facilities for contraceptive methods, and are liable to have unplanned pregnancies. In fact in urban Kisumu, most chemists often report stock outs of emergency contraception during or around weekends- a clear evidence of unsafe sex practices mostly resulting from inadequate family planning education and services. There are also women who confess to have aborted more than once in their lifetime. Most of them suffer complications as result and blame the lack of youth friendly services in most clinics for the practice.

Stigma and discrimination experienced by pregnant adolescents' impact on their rights to health and education. Pregnant young women –particularly those who are unmarried –
are subject to violence by family members and may be sent away from their homes, are expelled from school, and receive "rude, abusive and threatening treatment" from healthcare workers when they attempt to seek pregnancy-related care. This stigma and discrimination push some young women to procure unsafe abortions, risking their health and lives.

3.10 Monitoring The Right to Health

A gap exists in monitoring the right to health. Sexually active young people are often denied access to contraceptive information and services. This is discrimination on the basis of age. Also, most health facilities only offer post abortion care. This is an assumption that unsafe abortion can be carried out elsewhere so that the health facilities only come in to clear the mess. If health facilities were to freely offer safe abortion services on demand, then such scenarios wouldn't exist. The tragedy also is that after a high court ruling that sentenced a health practitioner in Nyeri for a botched abortion, most health facilities now shy away from offering post abortion care fearing that they would be blamed for procuring the abortion should anything go wrong in the process of treating a patient for complications of unsafe abortion. Yet a Ministry of Health report early this year put the burden of treating complications arising out of incomplete abortion to be at 533 million shillings annually, an amount that can comfortably procure at least two cancer treatment machines.

Alternatively, this is twice the amount that can provide family planning services to over 100,000 women all year round and prevent instances of unwanted/mistimed pregnancies. To save lives therefore, most women must be able to access post-abortion treatment for incomplete abortions. They must also be able to access post abortion family planning counseling and services. There is need therefore to build the capacity of community reproductive health champions in monitoring the right to health and providing oversight so that no one should be denied the right to access reproductive health services including family planning and comprehensive abortion care.

3.11 Community Engagement on the focus on Family Planning

Most communities living in these counties don't understand why the focus is on family planning and comprehensive abortion care. To them, family planning is about controlling population. While women from such counties are faced with high unmet needs for family planning and are silently procuring abortion, often through unsafe ways, quite often they shy away from these discussions when the problem is presented at the societal level. They also view such initiatives that empower the community as donor-generated and far fetched from them. Communities must own such initiatives and their buy-in is important if any tangible progress is to be made in involving them in family planning and comprehensive abortion care programmes. Also, an understanding must be built around why the focus is on family planning and comprehensive abortion care. Dissemination forums are important so that latest findings and presentation of case studies so that situations within the communities are presented as they are. Partnership with young people is important here so that when they tell their story, they own such programmers.

3.12 Health Infrastructure for Family Planning and Comprehensive Abortion Care

Most health facilities still lack the essential infrastructure for the provision of diverse family planning services. Some family planning methods require simple surgical procedures that must be carried out with essential equipment and commodities. Availing an array of services also means women and men are able to make their own choices after being given the requisite information to empower them make such choices. Provision of high quality services must therefore be grounded on improved health facility infrastructure, procurement of high quality equipment and medicines as well as other vital essentials.

4.00 Conclusion

These gaps that exist in the five counties hinder effective provision of FP and CAC advocacy and service delivery efforts. They however provide a viable opportunity for advocacy in those areas mentioned.

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