Expanding access to medical abortion services among adolescent and young women using task sharing approach: Case study of Private Public Partnership in Kenya

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Short Abstract (200/200)

Maternal mortality and morbidity from unsafe abortion constitutes a serious challenge even though unsafe abortion is preventable**.** This is further exacerbated among adolescents and young women. This study that was conducted in four counties in Kenya, explored enabling factors and barriers to accessing sexual and reproductive health (SRH) services, specifically medical abortion (MA), among adolescent girls and young women in private pharmacies within the context of task sharing. Data was collected through in-depth interviews with AGYW, key informant interviews with providers and health management teams, and focus group discussions with community health promoters and youth peer providers. Study findings indicated that strategic partnerships with private pharmacies and public health facilities, coupled with referral pathways facilitated by community health promoters and youth peer educators, significantly enhanced service coverage and accessibility. Increased number of facilities, subsidized SRH commodities, capacity building initiatives for healthcare providers further improved service quality and affordability and. However, financial constraints, a restrictive legal environment, negative societal perceptions, staff turnover, referral difficulties and concerns about documentation hindered access to MA services. Addressing these challenges through comprehensive integrated interventions is crucial to ensure equitable and accessible SRH services including MA for adolescent girls and young women.

Extended Abstract (4/4 pages maximum)

Background

Adolescents aged 10 to 19 years consists of the greater percentage of women who suffer from complications emanating from unsafe abortion [1] because of their high risk of unintended pregnancies and limited availability of safe abortion services [2, 3]. A big number of unplanned pregnancies among this age group is influenced by their restricted ability to negotiate safe sexual practices and contraception use, along with adequate access to sexual and reproductive health resources and information [4, 5] as well as their unmet need for contraception [6]. Most African nations including Kenya have legal/safe abortion restrictions and maintain cultural and religious stigma surrounding abortion, which frequently creates hurdles to safe abortion availability and leads to women having an unsafe abortion [1]. In such situations, many women, particularly young women in need of pregnancy termination, resort to unsafe abortion methods [2] and/or postpone the choice to seek an abortion, resulting in late-term abortions, which are linked with severe risks, including death [3]. Additionally, in cases where the legal environment permits induced abortion under certain conditions, significant barriers and social stigma make safe abortion sites inaccessible, including requiring parental consent for adolescents, a lack of information on safe abortion providers, and delays in timely care that may exacerbate abortion-related health complications[3, 4]. This is frequently owing to stringent laws that prohibit abortion; but, even when abortion is allowed, other hurdles, such as cost, distance, and regulatory restrictions, can limit access to services[5]. In Kenya, the 2010 constitution of Kenya permits abortion when the life or health of the woman is in danger. Yet broad uncertainty remains about the interpretation of the law. Unsafe abortion remains a leading cause of maternal morbidity and mortality in Kenya. A 2012 study estimated that in one year more than 465,000 unsafe abortions occurred of which 120,000 women sought medical care in health facilities for complications from incomplete or unsafe abortion. Further, three-quarters of these complications were moderate or severe. Complications were especially severe among young women, 45% of whom experienced severe complications.[6] Globally, pharmacies are increasingly recognized as important settings for accessing abortion services due to their accessibility and anonymity.[7-9] In Kenya, pharmacies can play a crucial role in informing clients about available options, providing referrals, and safely dispensing medical abortion (MA) products when presented with a prescription.[9] While previous studies have explored pharmacy provision of sexual and reproductive health services, limited research exists on the provision of MA services across the country. This study aims to identify factors that facilitate or hinder the expansion of adolescent sexual and reproductive health (ASRH) services, including abortion and post-abortion care, in pharmacies. The focus of this study is on young women aged 10 to 24, within the context of task-sharing initiatives. The findings from this study will be instrumental in informing service delivery practices that enhance accessibility, minimize barriers to medical abortion services, and maintain high-quality care.

Methods

Study design

This qualitative study was conducted in 4 counties in Kenya with a high burden of adolescent pregnancy and maternal mortality rates. The data from this study was collected as part of a project aimed to increase access to comprehensive ASRHR services specifically for AGYW. This intervention model encompasses the private and public sector where private providers would offer medical abortion (MA) services and refer clients of higher gestation age or need of other termination methods such as manual vacuum aspiration to public sites. The intervention includes capacity building of health care providers in both public and private sector on provision of MA services, community awareness and sensitization by CHPS/YPPS and community-based organizations, strengthening of data, commodity supply, and advocacy for an enabling environment.

The goal of this study was to identify facilitators and barriers to this task-sharing model. A total of 282 interviews were conducted with a diverse range of study participants, including in-depth interviews with 102 AGYWs; key

informant interviews with 72 providers and 17 county health management teams; and 8 focus group discussions with community health promoters, youth peer providers, and community influencers.

Analysis

Qualitative data was collected in English, Swahili, or local languages. Audio-recordings were transcribed, translated, and back-translated to ensure accuracy. Data was securely transferred weekly for quality control, cleaning, and analysis. Transcripts were reviewed by multiple analysts for coding and theme generation. Findings were also coded deductively and inductively to ensure all emergent insights were drawn from the data. A final codebook was established through collaborative review and discussion. Multiple coders reviewed categories and agreed on a final matrix of codes. Dedoose software facilitated data management and analysis.

Ethics statement

All study procedures were reviewed and approved by AMREF Research Ethics Board and by the National Council for Science and Technology (NACOSTI). All eligible participants provided verbal informed consent which was documented by enumerators prior to engaging in study procedures.

Results

Findings of this evaluation indicated that the following were the key **enablers** for facilitating young women's (ages 10-24) safe access to medical abortion and other SRH services.

The **strategic partnerships with private pharmacies and public health facilities** (for referrals of complicated cases) have significantly enhanced access to SRH services for adolescent girls and young women. Combining public and private healthcare has increased the number of facilities that offer MA services especially in underserved areas and provided a more discreet environment for seeking care. Furthermore, the partnership resulted in an established a referral pathway involving community health promoters and youth peer educators who have been instrumental in providing information and referrals within their communities, facilitating seamless access to necessary services, including between public and private facilities.

Secondly, a **consistent supply of subsidized sexual and reproductive health (SRH) commodities, including medical abortion drugs and MVA kits**, facilitated increased access to services. This reduced costs for providers, making MA services more affordable for adolescent girls and young women. Providers actively collaborated with suppliers to ensure a steady supply of commodities. The provision of subsidized commodities enhanced accessibility for adolescents who might otherwise be unable to afford services, ultimately leading to more affordable care.

Thirdly, **capacity building initiatives provided to healthcare providers** on MA, legal frameworks, values clarification, attitude transformation, youth-friendly services, and contraceptives were instrumental in enabling the delivery of high-quality services. The presence of trained providers facilitated access to SRH services for adolescent girls and young women.

Several barriers were identified to limit access to MA services at pharmacies.

Despite the subsidized rates offered by the pharmacies, **financial constraints** especially among adolescents were a hindrance to uptake of service. Most adolescents sought services clandestinely hence were unable to afford the subsidized costs. Furthermore, long distances to pharmacies that offer the services exacerbated the problem, as the majority of AGYW could not afford transportation costs. These factors collectively contributed to limited access to SRH services within the study population.

The **legal environment surrounding abortion services creates fear** and uncertainty among providers, hindering service delivery. Providers frequently encountered legal and ethical complexities when delivering sexual and reproductive health (SRH) services, particularly to adolescent girls under the age of 18, especially on consenting which is required as per the National Reproductive Health Policy. Consequently, providers expressed concern about documenting all clients who sought MA services, fearing disciplinary action or negative labeling by management. This apprehension stems from the restrictive legal environment surrounding abortion services in the country.

Despite availability of MA services, **negative societal perceptions of teenage pregnancies and abortion** hindered access to SRH services for adolescent girls and young women. Negative perceptions of teenage pregnancies and medical abortions lead to stigma, isolation, and reluctance to seek help. Other notable barriers included a **lack of adequate supplies** in public facilities, while private facilities struggled with high staff **turnover** as trained workers sought better opportunities.

These barriers collectively contribute to the challenges faced by AGYW in accessing essential SRH services, highlighting the need for comprehensive interventions to address these issues.

Discussion

This study explored facilitators and barriers to expanding access to ASRHR services, including abortion and post-abortion care, in pharmacies among young women aged 10-24 in Kenya. Findings highlight the significance of strategic partnerships, subsidized commodities, and capacity building in facilitating access to these services. However, several barriers, including financial constraints, legal challenges, societal stigma, and provider concerns, continue to hinder the uptake of services.

Collaborations between private pharmacies and public health facilities have significantly expanded service coverage, especially in underserved areas. Referral pathways involving community health promoters and youth peer educators have facilitated seamless access to necessary services. Studies have shown that the private sector can play an important role in expanding access to sexual and reproductive health services, especially for adolescents and young women.[10]

Our findings revealed that the provision of subsidized SRH commodities, including medical abortion drugs and MVA kits, has significantly lowered costs for healthcare providers, making essential services more accessible to adolescent girls and young women. While these subsidies have undoubtedly improved affordability, financial barriers remain a substantial challenge for many, especially the younger women. Additionally, the distance to pharmacies and the associated transportation costs can further limit access, especially for those without reliable transportation options. These findings are supported by other research indicating that financial difficulties are a primary obstacle for adolescents seeking SRHR services.[11]

Our findings indicated that the restrictive legal framework surrounding abortion services creates fear and uncertainty among providers, hindering service delivery and potentially discouraging clients from seeking care. The Kenyan Constitution article 26(4) states that abortion is permitted when, in the opinion of a trained health professional, there is a need for emergency treatment, or if the life or health of the mother is in danger, or if permitted by any other written law. However, studies have shown that many women do not know whether and under what circumstances abortion is legal[3, 12]

The stigma associated with teenage pregnancies and medical abortions continues to marginalize young women, making them feel like outcasts and preventing them from accessing essential healthcare services. This fear of social isolation and discrimination further exacerbates the challenges they face.

To effectively address the barriers to accessing ASRHR services, several key interventions are necessary. First, legal frameworks must be reformed to decriminalize abortion and create a more supportive environment for providers and clients. Second, comprehensive social and behavioral change programs should be implemented to challenge negative attitudes and promote understanding of SRH issues. Third, financial support, such as vouchers, should be provided to adolescent girls and young women to help them afford services. Fourth, the availability of SRH services, particularly in underserved areas, should be expanded through increased numbers of pharmacies offering these services and ensuring a consistent supply of essential commodities. Fifth, healthcare providers should receive ongoing training and support to address legal and ethical challenges, improve counseling skills, and adopt a youth-friendly approach to service delivery. Finally, advocacy and policy change are essential to promote the expansion of ASRH services, including task-sharing initiatives and the integration of SRH into broader health systems.

This study makes an important contribution to understanding the role of the private sector in expanding access to ASRH services such as medical abortion. Our findings indicate that this is a model that can be scaled up as pharmacy workers have the potential to significantly expand access to MA and FP services.

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