

REPUBLIC OF KENYA



MINISTRY OF MEDICAL SERVICES

STANDARDS & GUIDELINES

for reducing
morbidity & mortality
from unsafe abortion
in Kenya

September 2012

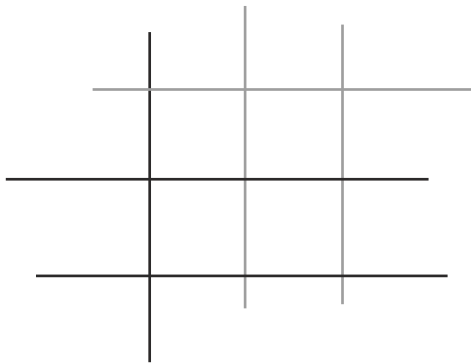
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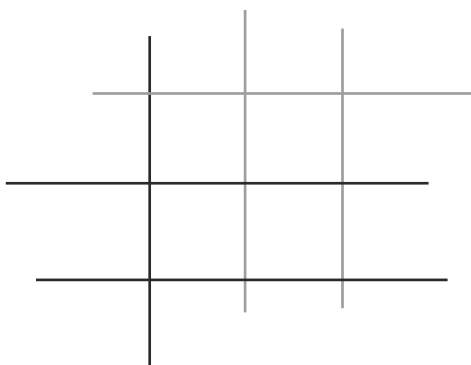


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LIST OF ABBREVIATIONS

COA	-	Clinical Officers Association
D&E	-	Dilatation and Evacuation
EVA	-	Electric Vacuum Aspiration
GBV	-	Gender Based Violence
HIV	-	Human Immunodeficiency Virus
ICPD	-	International Conference on Population and Development
KMA	-	Kenya Medical Association
K-MET	-	Kisumu Medical and Education Trust
KOGS	-	Kenya Obstetrical and Gynecological Society
MVA	-	Manual Vacuum Aspiration
MDGs	-	Millennium Development Goals
M&E	-	Monitoring and Evaluation
NACADA	-	National Agency for Campaign Against Drug Abuse
NNAK	-	National Nurses Association of Kenya
PAC	-	Post Abortion Care
RH	-	Reproductive Health
WHO	-	World Health Organization

ACKNOWLEDGMENTS

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- Kenya Medical Practitioners and Dentists Board
- Nursing Council of Kenya
- Clinical Officers Council
- Provincial Directors of Health
- Provincial Reproductive Health Coordinators
- Kenya National Commission on Human Rights
- World Health Organization (WHO)
- UNFPA
- Kenya Obstetrical and Gynecological Society
- National Nurses Association of Kenya
- Clinical Officers Association
- Ipas Africa Alliance
- Marie Stopes Kenya
- Family Health Options Kenya
- Family Care International
- Kisumu Medical and Educational Trust
- Family Health International 360
- Christian Medical and Dental Association
- Christian Health Association of Kenya (CHAK)
- Association of Muslim Medical Practitioners
- Institute of Family Medicine
- Forum of Christian Professionals
- Great Lakes University of Kisumu
- Kenya Medical Training College
- Egerton University
- University of Nairobi

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- | | | |
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FOREWORD

The Ministry of Medical Services is dedicated to coordinating all efforts aimed at reducing maternal mortality in Kenya. This coordination is especially key on the issue of unsafe abortion. While this cause of maternal mortality is preventable and there are many stakeholders working to tackle it, lack of cooperation among these partners has been rather disturbing and has not helped in improving the situation.

The Ministry believes that the problem of unsafe abortion is multifaceted – it has legal, religious, gender, rights and public health dimensions among others. As such, multi-sectorial involvement is important in solving it because each sector has something special to offer.

In the area of preventing unwanted pregnancies, the role of families, religious institutions, the school system, providers of contraceptives and the community as a whole must be appreciated. Once a woman has an unplanned, risky or unwanted pregnancy, professional non-judgmental counseling and provision of safe options including psychosocial support and adoption services must be provided to stop the woman from seeking unsafe abortion. For women having complications of abortion, a well-designed response system should be in place to prevent permanent disability and death.

The core role and guiding principle of this document is to bring together all the aspects of care in preventing unsafe abortion using the multi-sectorial approach. In all instances, proven scientific recommendations are adhered to. In addition, the recommendations stick to laws as set out in the Kenya Constitution, Acts of Parliament and other legal instruments. The Ministry hopes that each partner will find this document important in implementing their programs and that care will be standardized in the whole country to reduce morbidity and mortality from unsafe abortion.



DR. FRANCIS M. KIMANI

Director Of Medical Services

BACKGROUND

Maternal mortality is still worryingly high in Kenya and is estimated at 488 per 100,000 live births. Attempts to reduce this figure to meet national and global targets such as the Millennium Development Goals have not been successful. Maternal deaths result from five major causes—bleeding after delivery, infection, hypertensive diseases, unsafe abortion and obstructed labour.

In responding to one of these major causes of mortality - unsafe abortion, the Ministry responsible for health has put a lot of effort in preventing unwanted pregnancies through contraception and sexuality education. The Ministry has also promoted post-abortion care. Despite this, unsafe abortion remains a major cause of maternal mortality and morbidity. According to WHO (2007), while the world incidence rate of unsafe abortions is 14 per 1000 women aged 15 – 49 years, Eastern Africa leads in the whole world with a rate of 39 per 1000 women aged 15 – 49 years. Eastern Africa also leads in the proportion of maternal deaths caused by unsafe abortion.

One missing link in reducing maternal mortality has been the absence of technical and policy guidelines for preventing and managing unsafe abortions to the extent allowed by the Kenyan law. Standards and guidelines are meant to regulate quality of care across health facilities as well as guide quality of services to be provided by different cadres of health workers. The Ministry therefore sees this document as crucial because the safety of patients depends on how much health workers follow the standards and guidelines that it sets. It also sets a guideline on the implementation, monitoring and evaluation on how the health professionals utilize it.

Defining Standards and Guidelines

The Royal College of Obstetricians and Gynaecologists describes standards and guidelines as systematically developed statements which assist clinicians and patients in making decisions about appropriate treatment for specific conditions.

Standards are the bare minimum of requirements that each health facility and service provider must meet. Standards are normally not negotiable. If a health facility or a provider lacks the standards, they should not be allowed to operate. Standards together with protocols that are derived from them are used during supervision. Courts sometimes use set standards to determine cases of negligence. Standards adhere to strict scientific evidence and for abortion related services, must also be to the extent allowed by the law, neither violating, nor failing to meet what has been set by the law.

Practice guidelines, on the other hand, are intended to assist healthcare providers in clinical decision making by describing a range of generally acceptable approaches for the diagnosis, management, and prevention of specific diseases or conditions. They are the different approaches that can be used either singly or in combination to achieve the standards. They are more flexible and some may not be derived from hard and fast science.

Sections of the Standards and Guidelines Document

The problem of unsafe abortion is multifaceted and needs a variety of approaches. Preventing unplanned pregnancy is important in this. If a woman already has a pregnancy that is unintended, or unplanned, they should be counseled and various options provided such as psychosocial support,

adoption or fostering. For risky pregnancy, medical management, including termination of pregnancy should be considered. Post abortion care should be provided to those who have had miscarriages or abortion. This document is therefore arranged in four parts as follows:

Part I: Prevention of unintended, risky and unplanned pregnancies

Part II: Management of unintended, risky and unplanned pregnancies

Part III: Post-abortion care

Part IV: Standards for audit, monitoring and evaluation

Each of the standards in this book is derived from a policy statement that has been coined from policies and laws guiding the Ministry of Health in providing services. For each standard, there are guidelines developed for its achievement.

Target Audience for the Standards and Guidelines

This document is to be used by frontline health workers involved in the care of women seeking reproductive health services. It is to be used in making decisions for patient care. Policy makers may also find it important in planning for and monitoring services.

Responsibility for implementing Standards and Guidelines

It is the responsibility of the Ministry in charge of health through its regulatory organs and through inter-ministerial and inter-sectorial collaboration to ensure that standards set forth in this book are implemented. The Division of Reproductive Health takes responsibility on behalf of the Ministry in charge of health in ensuring a coordinated response in the implementation process.

Cross Cutting Issues

To the extent that it improves access to safe care, male involvement should be part of programs for reducing morbidity and mortality from unsafe abortion. Care should however be taken not to compromise privacy, confidentiality and autonomy of patients in the pretext of male involvement.

Efforts should be made to make services for reducing morbidity and mortality from unsafe abortion youth friendly. In all circumstances, the best interest of the youth should be taken into account in the provision of these services.

Revision of Standards and Guidelines

The Division of Reproductive Health will oversee periodic reviews of the standards and guidelines. The reviews will be undertaken after five or more years of implementation.

PART 1: PREVENTION OF UNINTENDED, RISKY AND UNPLANNED PREGNANCIES

Introduction

The first level of care in managing unsafe abortion is the prevention of unintended, risky and unplanned pregnancies. This section details policies, standards and guidelines to help achieve this. It has six subsections that if implemented will significantly reduce unintended, risky and unplanned pregnancies in Kenya.

Policy statement: *The overall policy statement for this section is as follows:*

All couples and individuals have the basic right to decide freely and responsibly the timing, number and spacing of their children and equitable access to reproductive health information, education and services in order to ensure informed decision-making and optimal health (Constitution of Kenya 2010, Article 43 (1) (a); RH policy pp 3 and 9).

Subsection 1: Adolescent/Youth Sexual and Reproductive Health

Policy statement: *Empowering adolescents/youth with education and skills on sexuality improves decision making on sexuality and reduces the risk of unintended pregnancy and unsafe abortion*

Standard 1: All adolescents and youth should have access to comprehensive sexual and reproductive health information and services

Guidelines:

- i) Education in pregnancy prevention should be part of the school curriculum and should be tailored to the age or level of the child
- ii) Sexuality education in schools should incorporate the role of teachers and parents/guardians.
- iii) Ensure accessible, acceptable, appropriate and quality reproductive health programs and services for adolescents and youth in and out of school.

Standard 2: Providers of sexual and reproductive health should ensure availability of youth friendly services that enable adolescents and youth to make informed decisions free of coercion.

Guidelines:

- i) Ensure adequate non-judgmental counseling for the adolescents and youth for them to make informed choices
- ii) Adolescents and youth should participate in the design and provision of services they get
- iii) Strengthen linkages between community programs and facility-based youth friendly services
- iv) Services should be in the interest of the adolescents and youth and the need for consent should not breach autonomy, privacy and confidentiality requirements (Constitution of Kenya 2010 Article 53 (2))
- v) Providers should be adequately trained in youth friendly services
- vi) All centres providing sexual and reproductive health services should be youth friendly.

Subsection 2: Family Planning and Contraception

Policy Statement: *A holistic approach to family planning and contraception is beneficial to socio-economic development of the country by reducing unintended, risky and unplanned pregnancies, unsafe abortion and related morbidity and mortality.*

Standard 1: Community and facility-based family planning and contraceptive services should be linked.

Guidelines:

- i) Engage stakeholders such as religious groups, media, opinion leaders, civil society and educational and relevant line ministries to promote use of FP
- ii) Ensure that communities are linked to the facility FP services using the Community Strategy
- iii) Ensure cross-referral between community and facility-based family planning and contraceptive services
- iv) The national and county governments should ensure adequate provision of community-based family planning and contraceptive services
- v) Services should be decentralized to the lowest level possible to meet the needs of all those who need them
- vi) Where necessary mobile and outreach services should be provided

Standard 2: All providers of family planning and contraceptive services should be adequately trained and supervised

Guidelines:

- i) Training should be according to the level of service provision and should take care of knowledge, skills and attitude to ensure quality of care
- ii) Training should include counseling and effective communication
- iii) Training should include respect for clients' rights in the provision of services
- iv) Routine supportive supervision should be carried out to all providers of FP.

Standard 3: All women, men and young people should be provided with family planning and contraceptive services of their choice without provider bias as long as they meet medical eligibility criteria

Guidelines:

- i) The provider, county and national governments should ensure a broad method mix of contraceptives to allow for choice
- ii) The choice of the client prevails as long as they meet the medical eligibility criteria for FP.
- iii) The provider, county and national governments should ensure commodity security
- iv) Promote male involvement in FP and contraception

Standard 4: Appropriate infrastructure for the level of care should be in place to ensure quality family planning and contraceptive services

Guidelines:

- i) Physical facilities should ensure audio and visual privacy
- ii) Physical structures should be accessible to all people including those with disabilities
- iii) Physical infrastructure should ensure reasonable comfort to the client.

Subsection 3: Community Education, Sensitization and Advocacy for Prevention of Unintended, Risky and Unplanned Pregnancies

Policy statement: *The government and all stakeholders regardless of religion, belief and opinion should play their role in preventing unintended, risky and unplanned pregnancies.*

Standard 1: The government should integrate education sensitization and advocacy in the existing administrative structures such as DHMT, county health committees, technical working groups among others for the prevention of unintended, risky and unplanned pregnancies

Guidelines:

- i) The government through the Media Council should ensure that the print and electronic media promote national values
- ii) Strategies should incorporate needs of vulnerable people and those with disabilities (Constitution Art. 7 (3)(b))

Standard 2: Community health workers and community health extension workers should be trained to provide pregnancy prevention information and services

Guidelines:

- i) Community health workers and community health extension workers should be trained in counseling for abstinence, safe sex and contraception
- ii) Community distribution of family planning commodities should be strengthened
- iii) Cross-referral between health facilities and community health workers should be functional

Standard 3: The media should be sensitized on unsafe abortion and supported to provide accurate community education and news reporting.

Standard 4: Champions should be identified and trained to provide information and advocate for pregnancy prevention services

Guidelines:

- i) Positive peer influence should be encouraged in use of champions
- ii) Role modeling should be encouraged as a strategy for advocacy by champions
- iii) All media should be used to support champions to reach a wide audience
- iv) Champions should come from all sectors including civil society, religious institutions, education sector among others

Subsection 4: Relationship Counseling to Prevent Unwanted Pregnancy

Policy statement: *Counseling is important in preventing unwanted pregnancies among people in relationships.*

Standard: Relationship counseling should be provided by trained counselors

Guidelines:

- i) Relationship counseling should be integral part of counseling curriculum
- ii) Counselors can be affiliated to the medical or religious institutions
- iii) Cross-referral between clinicians and counselors should be encouraged to meet the needs of the client
- iv) Counseling should adhere to ethical principles of confidentiality, privacy and autonomy

Subsection 5: Rape, Defilement, Incest and Other Forms of Sexual and Gender Based Violence

Policy statement: *Access to prevention and quality treatment for rape, defilement, incest and other forms of sexual and gender based violence reduces harm to the survivor including unplanned pregnancy, unsafe abortion and associated morbidity and mortality.*

Standard 1: Community and facility based sexual and reproductive health services should include information and services on prevention and management of sexual and gender based violence

Guidelines:

- i) Enforce laws against sexual and gender based violence including child protection laws
- ii) Create awareness about health risks associated with sexual and gender based violence through media, community participation and other existing structures

Standard 2: Facilities providing sexual and reproductive health services should have protocols for providing services to survivors of sexual violence

Guidelines:

- i) Build capacity of all providers and institutions involved in handling survivors of sexual abuse and gender based violence
- ii) Ensure provision of the basic package for emergency care for survivors of sexual violence according to National Guidelines on Management of Rape and Sexual Violence in Kenya
- iii) Strengthen and operationalize the referral system through formalized agreements with stakeholders

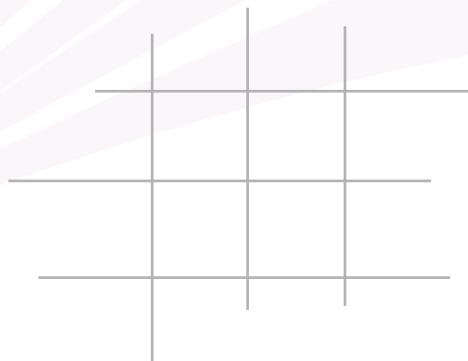
Subsection 6: Use and Abuse of Alcohol, and other Drugs and Substances of Addiction

Policy statement: *Limiting the use of alcohol and eradicating abuse of drugs and substances of addiction reduces morbidity and mortality arising from unintended and unplanned pregnancies.*

Standard: The county and national governments should enforce a multi-faceted approach to preventing and managing consequences of alcohol, other drugs and substance addiction

Guidelines:

- i) Collaborate with statutory bodies such as NACADA and other stakeholders to provide information, education and communication for preventing abuse of alcohol and other drugs and substances of addiction
- ii) Create awareness on the dangers of abuse of alcohol and other drugs and substances of addiction in the community
- iii) Provide information on safe sex and condoms in social outlets
- iv) Provide counseling and rehabilitation for addicts of alcohol and other drugs and substances of abuse



PART II: MANAGEMENT OF UNINTENDED RISKY AND UNPLANNED PREGNANCIES

Introduction

Management of unintended, risky and unplanned pregnancies is multifaceted and includes psychosocial support and having the woman carry the pregnancy to term if she chooses, adoption services where needed and safe termination of pregnancy to the full extent of the law. This section outlines the laws and policies that guide these services as well as standards to be adhered to. Each standard is supported by guidelines for implementation.

Subsection 1: Implementation Guide for Psycho-Social and Economic Support and Adoption Services

(a) Psychosocial and economic support

Policy Statement: *Provision of psychosocial support for women and girls with unintended, risky and unplanned pregnancies reduces maternal mortality and morbidity attributed to unsafe abortion.*

Standard 1: The State shall provide appropriate social security to persons who are unable to support themselves and their dependents. This applies to women and girls with unplanned and/or unintended pregnancies who may need to be provided with shelter and or other economic empowerment. (See Article 43 (3) of the Constitution).

Women and girls with unplanned and unintended pregnancies may also be supported by families, communities and support groups.

Standard 2: Families, communities, faith based organizations and support groups should be encouraged to provide psychosocial and economic support to women and girls with unplanned and/or unwanted pregnancies.

Guidelines:

- i). Trained health professionals should provide information on available psychosocial support services e.g. rescue homes, pregnancy crises centres etc.
- ii). Trained health professionals may provide linkages to economic empowerment services.

(b) Adoption

Policy Statement: *Provision of adoption services as an option for women with unplanned and unintended pregnancies reduces maternal morbidity and mortality from unsafe abortion.*

Standard 1: The Government shall facilitate the adoption process in accordance with the law.

Guidelines:

- i). The Government shall develop simplified guidelines on adoption law and the process
- ii). The trained health professionals should familiarize themselves with the relevant adoption laws and procedures.
- iii). The trained health professionals should provide linkages to registered adoption societies.
- iv). The Government should promote adoption through the relevant ministry

Summary of Adoption Law

The Kenyan legislative framework has provided for matters related to or incidental to adoption through the Children's Act, Act No. 8 of 2001.

The powers of making adoption orders are placed with the high court of Kenya. A child who is resident in Kenya whether citizen or not is eligible for adoption.

Any parent or guardian, who is unable to take care of any child, may offer to place the child at the disposal of a registered adoption society for purposes of adoption.

For a child to be adopted, the child must be at least six weeks old and must have been declared free for adoption by a registered adoption society in accordance with the prescribed rules. The child must have been in continuous care and control of the applicant for a consecutive period of three months preceding the application. And the applicant must meet the conditions outlined in the Children's Act. (See S. 156, 157 and 158 of the Children's Act):

- Has attained the age of twenty-five years and is at least twenty-one years older than the child but has not attained the age of sixty-five years; is a relative of the child; or the mother or father of the child.

The adoption order shall not be made in favour of the following persons: unless the court is satisfied that there are special circumstances that justify the making of an adoption order:

- A sole male applicant in respect of a female child;
- A sole female applicant in respect of a male child;
- An applicant or joint applicants who has or both have attained the age of sixty-five years;
- A sole foreign male or female applicant.

An adoption order shall not be made if the applicant or, in the case of joint applicants, both or any of them:

- Is not of sound mind within the meaning of the Mental Health Act;
- Has been charged and convicted by a court of competent jurisdiction for or any of the offences set out in the Third Schedule of this Act or similar offences;
- Is a homosexual;
- In the case of joint applicants, if they are not married to each other;

Provided that the court may refuse to make an adoption order in respect of any person or persons if it is satisfied for any reason that it would not be in the best interests of the welfare of the child to do so.

Health workers involved in managing women with unintended, risky and unwanted pregnancies should be familiar with adoption laws and should provide it as an option.

Subsection 2: The Law and Implementation Guides for Termination of Pregnancy

(a) The Law

This section is incorporated in the guideline with the aim of enabling all trained health professionals involved in the provision of abortion care, to be well informed of the law. Knowledge of the law is

essential to enable health providers to inform and educate counsel those who seek their services.

The Kenyan legislative framework on the termination of pregnancy is defined by the Constitution of Kenya 2010 in Article 26. The Constitution repealed the former legislation that governed termination of pregnancy thus Sections 158-160 and 240 of the Penal Code.

The Constitution of Kenya Article 26 provides thus:

- (1) Every person has the right to life.
- (2) The life of a person begins at conception.
- (3) A person shall not be deprived of life intentionally, except to the extent authorized by this Constitution or other written law.
- (4) Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.

Reproductive Health

The Constitution further provides for economic, social and cultural rights and provides in article 43 (1) (a) and (2) thus:

Every person has the right to attainable standard of health, which includes the right to health care services including reproductive health care

and that:

A person shall not be denied emergency medical treatment.

The World Health Organization defines health thus:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Further the International Conference on Population and Development (ICPD) in Cairo in 1994 defines reproductive health as:

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services to will enable women to go safely through pregnancy and childbirth and provide couples with best chance of having a healthy infant

Further WHO defines mental health as a part of overall health. Mental health includes:

“Subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one's intellectual and emotional potential”

Limitations of Termination of Pregnancy

The Constitution does not allow abortion on demand or request.

According to the constitution, an abortion in Kenya can be performed under the following circumstances:

- i. Where there is need for emergency treatment to preserve the life of the pregnant woman and/or the fetus;
- ii. Where the pregnancy constitutes danger to the life of the pregnant woman
- iii. Where the pregnancy constitutes a danger to the health of the pregnant woman
- iv. Where it is permitted by any other written law.

(b) The Implementation Guides for Termination of Pregnancy

The following guide has been developed to help providers apply the requirements of the Constitution. Providers should make appropriate consultations in making decisions on and providing pregnancy termination.

- i) Implementation Guide on Place for termination of pregnancy
In order to reduce complications arising from unsafe abortion, termination of pregnancy services will be provided in facilities that meet minimum standards.
- ii) Implementation guide for Article 26 (1) Protection of life
The health professional must bear in mind that the Constitution is premised on the principle that life begins at conception and must be protected except as outlined in Article 26 (3) and (4)
Termination of pregnancy is lawful, provided it is performed by a trained and skilled health professional within the confines of the law.
It is presumed that providers are acting in "Good faith" and within the tenets of medical ethics of preventing harm.
- lii) Implementation guide for persons allowed to provide termination of pregnancy
A trained health professional is a registered medical practitioner, registered clinical officer, registered nurse and registered midwife who has acquired the relevant skills for decision making and provision of the service.
- iv) Implementation guide for situations where pregnancy poses danger to the life of the pregnant woman (Article 26 (4))
The trained health professional must perform or recommend termination of pregnancy where he/she forms the opinion that the continuance of the pregnancy poses danger to the life of the pregnant woman greater than if the pregnancy were terminated.
The trained health professional should, in all good faith, follow the knowledge of standard medical indications that necessitate termination of pregnancy to preserve the life of the pregnant woman.
- v) Implementation guide for danger to health of the pregnant woman Art. 26(4)
The trained health professional should counsel and provide his/her opinion made in good faith to the woman whose health is endangered and who has made an informed decision to

terminate the pregnancy. The trained health professional should perform or refer the patient for termination of pregnancy.

Danger to the physical health means any such danger of a physical nature that would befall the woman whether actual or reasonably foreseeable. It is up to the trained health professional to ascertain upon taking a history, performing a physical examination and/or laboratory investigations on the pregnant woman.

Danger to mental health means any such danger to the pregnant woman premised upon psychological reasons taking into consideration the definition of mental health.

vi) Implementation guide for conscientious objection

The Ministry responsible for health services respects the right of trained health professionals to conscientious objection in participating in termination of pregnancy. However the client's right to information and access to health care services including reproductive health must be respected. (See Art. 35(1) (b), Art. 43(1)(a) and 26(4) of the Constitution).

Though individuals have freedom of conscience, religion, belief and opinion, this should not hinder access to care for others needing the service. (See Art. 32(1) of the Constitution). If a trained health professional has a moral or religious objection to abortion, he/she must respectfully refer the client who is eligible for termination of pregnancy to a colleague who is willing to provide the service without delay.

No trained health professional has the right to conscientious objection in an emergency situation (See Art.43 (2)).

Conscientious objection applies only to individual trained health professionals and not to groups or an institution. Likewise, it does not apply to support personnel or complementary services.

Subsection 3: Policies, Standards and Guidelines for Care in Termination of Pregnancy

a) Who Can Provide Termination of Pregnancy Services

Policy statement: *Termination of pregnancy is a safe procedure when performed by a trained and skilled health professional.*

Standard 1: According to the Article 26 (4) of the Constitution, pregnancy termination must be performed by health professionals who are trained and skilled in the provision of termination of pregnancy.

Guidelines:

- i) With appropriate training Doctors, Nurses, Midwives and Clinical Officers can provide first trimester termination of pregnancy.
- ii) Termination of pregnancy in the second trimester should be performed by a skilled medical officer in consultation with a gynaecologist or a gynecologist

Standard 2: All health professionals performing termination of pregnancy must receive appropriate training.

Guidelines:

Training should be competency based for decision making and skills for providing services

b) Where Termination of Pregnancy can be Performed

Policy statement: *Termination of pregnancy should be carried out in a facility that meets the minimum standards to maternal morbidity and mortality.*

Standard 1: All terminations of pregnancy should be carried in a health facility with appropriate equipment

Guidelines:

- i). The health facility should be operating legally
- ii). The method used to provide termination of pregnancy should determine the level of health facility where the termination of pregnancy is carried out
- iii). Second trimester terminations should be done in facilities with adequate supportive care, e.g. blood transfusion, theatre
- iv). If a woman who is considered for lawful pregnancy termination in a health facility cannot undergo the procedure there she must be duly informed and referred.
- v). Appropriate referrals should be available for patients who cannot be cared for in a particular facility.
- vi). Public health facilities are legally obligated to provide abortion related services.

Standard 2: The period of gestation determines the level of health facility where termination of pregnancy is performed.

Guidelines:

- i) Termination of pregnancy of up to 12 weeks gestation may be performed as an outpatient procedure.
- ii) Termination of pregnancy above 12 weeks gestation should be performed in a health facility with appropriate equipment.
- iii) Where the pregnancy endangers woman's health and termination of pregnancy is carried out in advanced pregnancy, the procedure should be performed in a facility with a new-born intensive care unit

Standard 3: The presence of associated medical conditions in the pregnant woman determine the level of health facility where termination of pregnancy is performed

Guideline:

Termination of pregnancy in women with associated pathology should be performed in a health facility with appropriate capacity to manage the pathology

c) Counseling, Informed Choice and Consent

Policy statement: *Access to correct and accurate information on abortion-related services helps a woman to make an informed decision on termination of pregnancy to reduce the risk of unsafe abortion.*

Standard 1: All women undergoing termination of pregnancy must give informed consent before the procedure.

Guidelines:

- i) Informed consent should include the patient's affirmation that she understands the procedure and its alternatives, potential risks, benefits and complications.
- ii) In case of pregnancies in an under-18 year old or in women with no capacity to consent, the parent's or guardian's approval to terminate pregnancy must be sought and documented. However, the best interest of the child shall be of paramount importance in every matter concerning them. (See Article 53 (2) of the Constitution and Section 4 of the Children's Act 2001).

Standard 2: Accurate information on the risks and benefits of abortion must be given to all women undergoing termination of pregnancy to enable them make an informed choice.

Guidelines:

- i) All trained health professionals offering information must be non-judgmental, and responsive to the emotional state of the woman.
- ii) Information on alternatives and support for options to termination of pregnancy must be given to the woman
- iii) Information must be provided in a language that the client understands and may be accompanied by written information where available
- iv) All reasonable precautions must be taken to ensure the woman's privacy and confidentiality
- v) Counseling should not be hurried and adequate time should be allowed for decision-making

Standard 3: Family planning and contraceptive counseling and methods should be offered to all women undergoing termination of pregnancy.

Guidelines:

- i) All women who have undergone termination of pregnancy must be counseled for contraception and offered a method of their choice
- ii) Where methods chosen are not available, women should be referred
- iii) A temporary method should be provided for women referred for a method of their choice
- iv) Accepting a contraceptive method should never be a prerequisite for providing her necessary abortion care

d) Pre-Procedure Care

Policy Statement: *Appropriate clinical assessment of a woman undergoing termination of pregnancy is prerequisite to a successful performance and outcome of the procedure*

Standard 1: Gestational age must be established and documented

Guidelines

- i) Appropriate assessment includes history and physical examination which should include bimanual exam
- ii) Ultrasound can be used in inconclusive cases requiring confirmation of gestational age
- iii) Confirmation of pregnancy and documentation must be undertaken.

- iv) Where ectopic pregnancy is suspected, appropriate evaluation should be performed.

Standard 2: Efforts should be made to prevent Rhesus iso-immunization in abortion care

Guidelines:

- i) It is important to know the blood group and Rhesus factor of the woman before termination of pregnancies of over 12 weeks gestation.
- ii) Where anti-D is indicated, it must be given within 72 hours

e) Uterine Evacuation Procedures

Policy statement: *Uterine evacuation using appropriate methods reduces complications from termination of pregnancy procedures*

Standard 1: Termination of pregnancy within the first 12 weeks gestation should be by either vacuum aspiration or medical methods.

Guidelines:

- i) For aspiration methods use manual vacuum aspiration (MVA) or electric vacuum aspiration (EVA)
- ii) For medical methods use misoprostol only or in combination with mifepristone

Standard 2: Patient's dignity, privacy and comfort during the procedure must be ensured

Guidelines:

- i) The procedure should be performed in a quiet, private environment.
- ii) Adequate analgesia and other comfort measures should be offered.

Standard 3: All instruments entering the uterine cavity must be sterile or high-level disinfected.

Standard 4: All patients should receive prophylactic antibiotics prior to uterine evacuation where possible. Where prophylactic antibiotics are not available, uterine aspiration can still be performed.

Standard 5: Successful uterine evacuation should be verified clinically or by ultrasound if necessary.

Guidelines:

- i) A good history and physical exam should be used to determine completion
- ii) Ultrasound confirmation may be used in non-conclusive cases.

Standard 6: Uterine evacuation in the second trimester should be done using appropriate methods

Guidelines:

- i) Dilatation and Evacuation (D&E) may be done for pregnancies 13 to 16 weeks
- ii) Medical methods and D&E can be used for the whole of second trimester

PART III: POST ABORTION CARE (PAC)

Introduction

This section focuses on strategies, policies, standards and guidelines to increase equitable access to PAC health services, by enhancing quality, efficiency and effectiveness of service delivery at all levels through improving responsiveness to client needs.

PAC is the service provided by a trained and skilled health professional in the management of incomplete abortion and related complications.

Incomplete abortion is a condition presenting clinically with per vaginal bleeding, an open cervix and incomplete passage of products of conception.

Components of PAC

1. Counseling
2. Evacuation of the uterus
3. Management of complications
4. Post abortion family Planning and contraception
5. Infection Prevention
6. Community Involvement

Subsection 1: Legal Basis for PAC

The following are the relevant laws that guide PAC services:

Constitution Art 26(1) *Every person has the right to life*

PAC is crucial in saving the life of the woman having incomplete abortion.

Constitution Art 43(1) *Every person has a right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care;*

PAC is a reproductive health service.

Constitution Art 43(2) *A person shall not be denied emergency medical treatment.*

PAC is an emergency medical service.

Constitution Art 35(1) (b) *Every citizen has the right of access to information held by another person and required for the exercise or protection of any right or fundamental freedom.*

Providing information is important in PAC services.

Constitution Art 46(1) *Consumers have the right:*

- a) *To goods and services of reasonable quality*
- b) *To the information necessary for them to gain full benefit from goods and services; and*
- c) *To the protection of their health, safety and economic interests.*

PAC must be of good quality to protect the health and safety of patients.

Subsection 2: Policies, Standards and Guidelines for PAC

I) Who Should Provide PAC?

Policy statement: *In order to reduce morbidity and mortality from complications of abortion, PAC services should be provided by trained and skilled health professional.*

Standard 1: PAC should be provided by registered, trained and skilled health professionals.

Guidelines:

- i) The trained and skilled professionals include registered medical practitioners, registered clinical officers, registered nurses and midwives.
- ii) The trained and skilled professionals should be able to provide emergency evacuation of the uterus.
- iii) The trained and skilled professionals should refer patients with anticipated or actual complications.

II) Where PAC Should Be Provided

Policy statement: *PAC services should be provided in a health facility that meets minimum standards to reduce maternal morbidity and mortality.*

Standard 1: PAC services should be provided in private and public health facilities that meet minimum standards

Guidelines:

- i) Facilities lacking equipment for surgical evacuation may provide medical evacuation
- ii) Facilities with equipment for surgical evacuation should also provide medical evacuation.
- iii) There must be clear referral protocols in place.
- iv) Dilatation and curettage are not procedures used in PAC

Standard 2: Procedure rooms for providing PAC services must meet the minimum health standards

Guidelines:

- i) Infrastructure should have adequate space, light, privacy and running water
- ii) There should be appropriate equipment and supplies
- iii) Infection prevention and control guidelines should strictly be adhered to
- iv) There should be a provision for post-procedure observation and recovery room

Standard 3: All procedures within PAC services should be fully documented

III) Referral System

Policy statement: *An appropriate and functional referral system mitigates delays and enhances survival of patients with complications*

Standard: All facilities providing PAC services must have strong referral linkages

Guidelines:

- i) Communities should be trained to recognize and refer abortion cases

- ii) There should be an ambulance and/or appropriate means of transport for referring patients from one facility to another
- iii) Facilities should have functional communication system
- iv) Security and safety of health workers should be ensured during the referral process
- v) Elements of PAC

Policy statement: *Quality PAC services with all elements lead to better outcomes in patient care thereby reducing morbidity and mortality*

(a) PAC Emergency Care Treatment

Standard 1: All patients who present with abortion related complications should have a pertinent medical history taken, physical examination and laboratory findings documented.

Guidelines:

- i) Assessment must be prompt to determine the clinical stability of the patient
- ii) All patients with a life threatening condition should have resuscitative measures instituted immediately.
- iii) Physical examination should include a pelvic examination.
- iv) Appropriate laboratory specimens should be taken but should not delay initiation of treatment.

Standard 2: All patients should receive timely care.

Guidelines:

- i) The time of registration, attendance and intervention should be recorded
- ii) Triage should be done all the time
- iii) There should be proper documentation of PAC services

Standard 3: All patients should be counseled on the methods of uterine evacuation

Guidelines:

- i) Counseling should be provided on treatment plan, including pain management
- ii) Options of uterine evacuation may be surgical (MVA or EVA) or medical.
- iii) Lifesaving procedures should not be delayed by counseling as this can be done later.

Standard 4: An informed written consent should be obtained from all patients undergoing uterine evacuation.

Guideline:

A written signed consent is mandatory for any patient undergoing uterine evacuation.

Standard 5: Prompt referral after stabilization of the patient is essential in the absence of minimum standards of PAC services at the health facility.

Guidelines:

- i) All patients requiring referral should first be stabilized.
- ii) Laid down referral protocols should be adhered to.

(b) Uterine Evacuation Procedures

Policy statement: *Prompt evacuation of the uterus using methods that are appropriate for gestation reduces morbidity and mortality*

Standard 1: The preferred method of uterine evacuation for up to 12 weeks gestation is either vacuum aspiration or medical methods.

Guidelines:

- i) Any patient with up to 12 weeks of gestation who require surgical uterine evacuation should be offered MVA/EVA services
- ii) Misoprostol can be used for medical evacuation of the uterus.
- iii) Infection prevention and control is paramount

Standard 2: For gestations from 13 to 27 weeks, appropriate management should be instituted

Guidelines:

- i) Evacuation of the uterus during the 2nd trimester should be performed in a facility with access to theatre and blood transfusion services.
- ii) Evacuation of the uterus during the 2nd trimester should be managed by a gynaecologist or a trained and experienced medical officer in consultation with a gynaecologist.
- iii) In case of anticipated or actual complications, timely referral is mandatory

Standard 3: Ensure patient's comfort during and after uterine evacuation

Guidelines:

- i) Medications for pain management must be provided during and after evacuation
- ii) Procedures must be done gently
- iii) Patient must be treated with compassion, respect and dignity
- iv) General anesthesia and heavy sedation should only be used when indicated

Standard 4: Completion of the procedure must be documented.

Standard 5: Routine prophylactic use of antibiotics is essential in uterine evacuation.

Guidelines:

- i) Where antibiotics are not available the procedure can still be done but the patient should be counseled and given a prescription.
- ii) National protocols should be used for the choice of specific antibiotics.

(c) Management of Complications

Policy statement: *Prompt recognition and institution of optimal management of abortion related complications reduces morbidity and mortality*

Standard 1: Functioning equipment and appropriate supplies must be available on site to handle emergencies.

Guidelines:

- i) The facility should have emergency equipment and supplies including oxygen and essential medications.
- ii) Emergency drill protocols should be in place to ensure emergency preparedness.

Standard 2: Every facility should be able to provide services to stabilize and treat or refer any woman with complications as quickly as possible.

Management of Hemorrhage

Policy statement: *Timely and optimal management of excessive blood loss is critical in reducing morbidity and mortality*

Standard 1: Prompt recognition, diagnosis and early intervention in patients with hemorrhage should be undertaken.

Guidelines:

- i) Blood loss should be assessed by history and physical examination including pulse rate, blood pressure and urine output.
- ii) Resuscitation and correction of hypovolaemia should be undertaken immediately
- iii) The cause of hemorrhage should be established and managed accordingly.
- iv) If blood is needed, the transfusion should be done safely.

Management of Septic Abortion

Policy Statement: *Prompt treatment of sepsis, with broad spectrum antibiotics and evacuation of the uterus reduces morbidity and mortality from septic abortion*

Standard 1: All patients should be assessed and managed appropriately for sepsis.

Guidelines:

- i) There should be high index of suspicion for retained products of conception, uterine perforation, injury to abdominal organs, septic shock, disseminated intravascular coagulopathy and renal failure and protocols should be in place to manage them accordingly
- ii) Assessment should be comprehensive
- iii) Treat the sepsis with appropriate antibiotics and non-steroidal anti-inflammatory analgesics according to the appropriate protocols.
- iv) Evacuation of the uterus should be done once the patient is stabilized and antibiotics started
- v) If unable to manage as above, refer the patient appropriately

Management of toxic and chemical reactions

Policy statement: *Patients who present with symptoms of poisoning secondary to substances used to procure abortion will require prompt and specialized management instituted*

Standard 1: For all cases of poisoning and toxicity, appropriate action should be undertaken to establish the causative substance and appropriate management instituted.

Guidelines:

- i) Relevant history, physical examination and appropriate laboratory investigations should be done to establish possible substance used
- ii) Provide resuscitation and supportive care, and where possible administer appropriate antidote
- iii) Patients who present with poisoning and/or toxicity may need specialised or intensive care and so should be referred to facilities where these services are available
- iv) Multi-disciplinary care is highly encouraged

(d) Post Abortion Family Planning and Contraception

Policy statement: *Post Abortion Family Planning and Contraceptive counseling and provision of a method prevent repeat abortions and hence reduce maternal morbidity and mortality*

Standard 1: Family planning counseling and services should be available to all women receiving PAC services.

Guidelines:

- i) Counseling should be tailored to the individual patient's needs.
- ii) All facilities providing PAC services should be able to provide method mix of contraceptives according to the level of care and provider skills.
- iii) Patients should be referred appropriately to the next level of care if the chosen method is not available and meanwhile interim method should be provided.
- iv) Almost all methods can be given to women after an abortion provided they meet the medical eligibility criteria.

Standard 2: Every provider must document the method of contraception offered to all women who received PAC services.

Guideline:

Information on the chosen method and follow up should be documented and communicated to the patient to ensure correct and continued use

(e) Linkages to other Reproductive Health/GBV Services

Policy Statement: *Provision of other reproductive health services as integrated package to patients who have received PAC services reduces morbidity and mortality*

Standard 1: All women receiving PAC services should be provided with integrated RH/HIV/GBV services or referred where these services are not available.

Guidelines:

- i) Provide screening for STIs/HIV, breast and reproductive tract cancers especially cancer of the

cervix.

- ii) Provide or refer for psychosocial counseling and support in cases of rape, defilement or incest.
- iii) Women who had spontaneous abortion and desire to have a child should be managed or referred to a specialist.
- iv) All women receiving PAC services must have follow up instructions according to protocols.

(f) Other Issues Related to PAC Procedures

Confirmation of fetal tissue

Policy Statement: *Identification of products of conception helps confirm diagnosis of uterine pregnancy and rules out ectopic and/or molar pregnancy*

Standard 1: All evacuated uterine tissues must be examined.

Guidelines:

- i) When insufficient tissues are obtained the patient must be re-evaluated, including pregnancy test and ultrasound scan as necessary.
- ii) If no products are obtained ectopic pregnancy should be ruled out.
- iii) Formal histopathology examination may be required when there are copious amounts and grape-like products of conception to rule out molar pregnancy.
- iv) If the diagnosis of either ectopic and/or molar pregnancy is confirmed it should be managed appropriately

Fetal tissue disposals

Standard 1: Fetal tissue must be considered a biohazard and must be disposed off in accordance with infection prevention and control guidelines.

Guidelines:

- i) Procedures on disposal of tissue should be followed according to National protocols.
- ii) Universal precautions must be observed by all personnel handling fetal tissues.
- iii) Fetuses born dead may be incinerated/buried or otherwise disposed off according to the wishes of the parent/s

Standard 2: A fetus aborted alive should be resuscitated and efforts should be made to preserve its life.

PART IV: STANDARDS FOR AUDIT, MONITORING AND EVALUATION

Subsection 1: Monitoring and Evaluating Pregnancy Prevention Services

For Part I of this document, it is the responsibility of the agencies involved to monitor and evaluate implementation as follows:

- i) Adolescent youth/sexual and reproductive health – Division of Reproductive Health, in partnership with Ministry of Education
- ii) Family Planning and contraception – Division of Reproductive Health
- iii) Community education, sensitization and advocacy for prevention of unintended, risky and unwanted pregnancies – Division of Reproductive Health
- iv) Relationship counseling to prevent unwanted pregnancy – Division of Reproductive Health
- v) Rape, defilement, incest and gender based violence – Division of Reproductive
- vi) Use and abuse of alcohol, other drugs and substances – NACADA

National policies, guidelines and M&E frameworks exist for all the areas covered in this section and should be implemented appropriately.

Subsection 2: Monitoring and Evaluating Termination of Pregnancy and PAC Services

Introduction

A system should be created and implemented to audit, monitor and evaluate services in accordance with these standards and guidelines. Monitoring and evaluating (M&E) can be achieved using three approaches; Routine service statistics, periodic evaluation (internal & external) and patient information. This can be done at all levels – district, county and national levels.

Routine Monitoring:

- Regular monitoring and evaluation at the facility level are key to maintaining and improving the quality of services delivered. Facility managers /staff supervisors are needed to provide supportive supervision in routine monitoring and give appropriate recommendations to improve quality of care. This can be achieved through:
 - Analysis of patterns or problems in services using service statistics
 - Observation of counseling and clinical services to assess quality of interaction with the woman throughout the process, to correct any shortfalls in adherence to technical standards, or other practices that jeopardize quality of care (e.g. judgmental attitudes, imposition of “informal charges”.
 - Functioning of logistics system to ensure regular supply of equipment and consumables.
 - Regular aggregation of data from facility level upwards.
 - Utilization of aggregated data by the facility for service improvement.
 - Assessment of progress to remedy problems identified in routine monitoring.

- Engaging staff in a participatory process to implement recommendations for service delivery improvement

Periodic evaluation:

These could be client based and performed through exit interviews, observations and questionnaires. Information collected could include the following among others:

- Total number of clients seen, their demographic information
- A record of abortions provided, methods used, pain management provided
- Women seen but not provided with services,

Provider based surveys could also be done looking at, among others:-

- Skills of providers
- Perception
- Application of theory to practice
- Supportive systems in the delivery of the health services
- Facility level: case reviews, registers, observation, checklists, facility surveys and maternal death audits.

Policy Statement: *Monitoring and evaluation ensure high standards of quality of care*

Standard 1: All abortion procedures must be documented

Guideline:

Records should be accurate, complete and well organized

Standard 2: All levels of care must conduct regular audit of the care they provide

Guidelines:

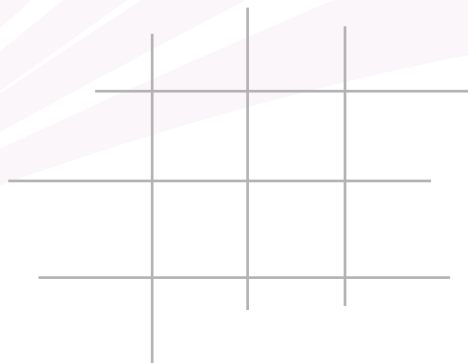
- Audit should assess case notes of women undergoing abortion and PAC to determine percentages performed as in-patient
- Audit the extent to which accurate and unbiased information is provided regarding abortions performed on medical grounds
- Assess proportion of clients being given antibiotic prophylaxis
- Assess proportion of patients having documented evidence of being screened for other medical conditions
- Case note review could be conducted to see which drugs are being used in termination of pregnancies.
- Audit percentage of women offered and accepting local anesthesia could be reviewed
- Assess proportion of providers offering services who have been formally trained
- Assess percentage of women receiving information on danger signs after the procedures
- Audit number of women who end up with complications following termination of pregnancy.

Standard 3: Any deaths resulting from termination of pregnancy and PAC must be reviewed according to nationally accepted maternal death review protocols

Standard 4: Managers must ensure inventory control and maintenance of equipment

Guidelines:

- i) In planning, inventory control and maintenance system; include:
 - a. The quantity and types of equipment and supplies to be kept in stock
 - b. Adequate storage facilities
 - c. Monitor of stock levels
 - d. Re-ordering of stock
 - e. Security of stock
 - f. Procedure for re-supply
 - g. Routine maintenance and repair of equipment
- ii) There should be protocols for routine maintenance of equipment.



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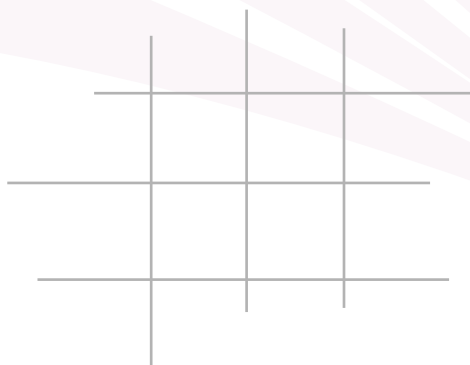
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PARTICIPANTS LIST

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NOTES:



& STANDARDS GUIDELINES

for reducing
morbidity & mortality
from unsafe abortion
in Kenya

September 2012

