

**REPUBLIC OF KENYA**



**MINISTRY OF HEALTH**

# **Post Abortion Care**

**A POCKET GUIDE FOR HEALTH CARE PROVIDERS**



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**February, 2019**

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Suggested citation:

Ministry of Health, Kenya. Post Abortion Care, A Pocket Guide for Health Care Providers. Nairobi, February 2019.

Published by:

Ministry of Health, Division of Family Health, P.O. Box 43319,  
GPO 00100 Nairobi, Kenya. <http://www.health.go.ke>



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## FOREWORD

Maternal mortality ratio (MMR) in Kenya has reduced from 488/100,000 (KDHS 2009) to 362/100,000 (KDHS 2014). However, this is still high in comparison to South Africa with a maternal mortality ratio of 138/100,000 (2015), and Ethiopia with a maternal mortality ratio of 353/100,000 (2015).

The health of women is a cornerstone to productivity, empowerment and economy of any nation. The Kenya maternal and newborn health model (National Road Map, 2010) recognizes Post abortion care (PAC) services as one of its six pillars and has identified it as one of the strategies to improve maternal and newborn survival. The other five pillars include pre-conceptual care, family planning; focused antenatal care; essential obstetric care; essential newborn care; and targeted post-natal care. Quality post abortion service provision requires skilled health care workers, enabling environment and supportive health care systems. A supportive healthcare system involves functional referral systems, management, procurement, training, supervision, health management information system, community action, partnerships and male involvement. These elements of quality healthcare service provision need to be grounded on the principle of equity for all and respect for human rights.

The Post abortion Care (PAC): A pocket guide for health care providers is borne out of the need to equip reproductive health service providers with the necessary knowledge and skills to provide timely quality PAC services to reduce morbidity and mortality associated with the complications of abortion, towards achievement of SDGs and Vision 2030.

Development of this PAC pocket guide was guided by current

scientific evidence and need for service providers to access knowledge and skills when needed. It will act as a reference for the many service providers who would wish to provide the much needed PAC services but lack, or are limited in knowledge and skills.

This PAC pocket guide is a complementary document to the PAC reference manual, PAC curriculum and other training packages and approaches offered by the Ministry of Health. The pocket guide should act as a quick reference at the service area and does not, in any way, promote abortion outside the law.

To develop this PAC pocket guide, the MOH-RHMSU consulted widely with expertise in reproductive health.

It is envisioned that the use of this pocket guide will contribute to the universal health coverage and, by extension, Vision 2030 through improvement of maternal and newborn health in Kenya.



**Dr. Kioko Jackson K., OGW, MBS**

Director of Medical Services

Ministry of Health.

## ACKNOWLEDGEMENTS

The Post abortion Care (PAC) pocket guide for health care providers is the result of collaborated efforts of various individuals, institutions and stakeholders in reproductive health that contributed to its development through a series of meetings and workshops coordinated by the Reproductive and Maternal Health Services Unit (RMHSU) under the leadership of the Ministry of Health. The process of developing this PAC pocket guide for health care providers has benefitted from inputs made in several meetings and workshops attended by reproductive health experts, managers, trainers and implementers from various institutions.

The Ministry of Health wishes to thank members of the post abortion care task force meeting in Naivasha and the stakeholders validation meeting in Nairobi for technical expertise and input to this document in various stages of its development. In particular, RMHSU wishes to express its gratitude to all those who participated in one way or the other in the development of this PAC pocket guide.

A special word of thanks goes to individuals who tirelessly devoted their time and effort to the production of the final version of the PAC pocket guide for health care providers. In particular, special recognition and gratitude is given to the PAC task force - the technical team that has guided the process of developing this PAC pocket guide through various consultative forums and review of draft versions.

Special recognition goes to all institutions and organizations represented in the task force. These include the RMHSU–Ministry of Health, Dr. John Nyamu (consultant, RCOG), University of Nairobi, KOGS, CNS-Kenya, K-MET, FHOK, MKU, RCOG, Ipas,

Marie Stopes-Kenya, Reproductive Health Services (RHS), Planned Parenthood Global (PPG), KELIN, CRR, TICHA, FOHA, Women Spaces Africa, Reproductive and Maternal Health Consortium-Kenya, and Reproductive Health Network-Kenya (RHN-K).

The Post abortion Care taskforce was led by Dr. Wangui Muthigani-manager, Maternal and Newborn Health, Reproductive and Maternal Health Services Unit (MOH).

The Ministry wishes to thank the following consultants who reviewed this PAC pocket guide for health care providers: Dr. Jean Kagia, consultant obstetrician and gynaecologist; Dr. Anthony Karanja Wanyoro (Kenyatta University); Dr. Benjamin Elly Odongo, chairman, KOGS; Dr. Daisy Ruto, JHPIEGO; Dr. Solomon Marsden, FHI 360 and Dr. Alice Kaaria, consultant obstetrician and gynaecologist.

The development of this PAC pocket guide for health care providers would not have been possible without the generous financial support of the Royal College of Obstetricians & Gynaecologists of the United Kingdom (RCOG), Ipas Africa Alliance and Marie Stopes-Kenya.



**Dr. Gond J. O.**

Head, Reproductive and Maternal Health Services Unit  
Ministry of Health.

## ABBREVIATIONS AND ACRONYMS

<b>CNS</b>	- Clinical Nursing Society
<b>CRR</b>	- Center for Reproductive Rights
<b>EVA</b>	- Electric Vacuum Aspiration
<b>FHOK</b>	- Family Health Options- Kenya
<b>FIGO</b>	- International Federation of Gynecologists and Obstetricians
<b>FOHA</b>	- Fortress of Hope Africa
<b>KELIN</b>	- Kenya Legal and Ethical Issues Network
<b>KMET</b>	- Kisumu Medical and Education Trust
<b>KOGS</b>	- Kenya Obstetrics and Gynecological Society
<b>MKU</b>	- Mount Kenya University
<b>MMR</b>	- Maternal Mortality Ratio
<b>MOH</b>	- Ministry of Health
<b>MSK</b>	- Marie Stopes Kenya
<b>MUE</b>	- Medical Uterine Evacuation
<b>MVA</b>	- Manual Vacuum Aspiration
<b>PAC</b>	- Post Abortion Care
<b>POC</b>	- Products of Conception
<b>PPG</b>	- Planned Parenthood Global
<b>RCOG</b>	- Royal College of Obstetricians and Gynaecologists
<b>RHN-K</b>	- Reproductive Health Network-Kenya
<b>RHS</b>	- Reproductive Health Services
<b>RMSHU</b>	- Reproductive and Maternal Health Services Unit
<b>SDGs</b>	- Sustainable Development Goals
<b>TICHA</b>	- Trust for Indigenous Culture and Health
<b>UON</b>	- University of Nairobi
<b>WHO</b>	- World Health Organization

## OPERATIONAL DEFINITION

**Abortion:** The loss of a pregnancy, whether spontaneously or by induction, before viability outside the mother's womb.

**Complete abortion:** Complete expulsion of all the products of conception.

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

**Incomplete abortion:** Abortion in which parts of the products of conception are retained in the uterus.

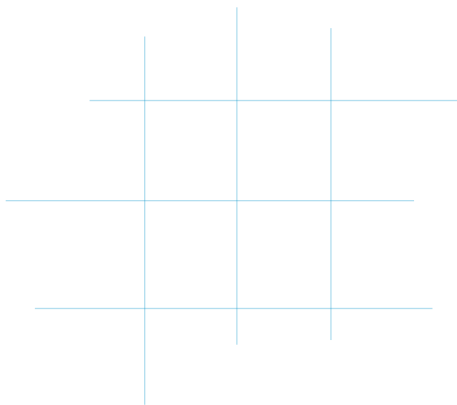
**Missed Abortion:** Is when the embryo or foetus has died inside the uterus but a miscarriage has not yet occurred.

**Post Abortion Care:** Is the medical, social, psychological, spiritual care and support given to a person after an abortion. For PAC, the cervix should be open plus or minus POCs.

**Reproductive health:** 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.

**Septic abortion:** Abortion associated with infection of the products of conception and endometrial lining of the uterus, leading to a generalized infection.

**Unsafe abortion:** A procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with minimal medical standards, or both.





## CHAPTER 1

### COMPREHENSIVE COUNSELING SERVICES DURING POST ABORTION CARE

The guiding principle for comprehensive counseling is to achieve a woman centered — including rights based — approach for an informed choice and decision making.

Trained health professionals need to have knowledge, skills and attitude for counseling as an important cornerstone for successful provision of post abortion care.

Trained health professionals attending to women presenting for post abortion care need to identify and respond to the women's emotional and physical health needs; address the immediate abortion related needs and institute preventive strategies to avert their recurrence.

#### **A. Considerations during Post Abortion Care (PAC) counseling**

1. Address the clients emotional and psychological needs.
2. Ensure confidentiality, privacy and dignity of the client while addressing her feelings.
3. Consider their sexual and reproductive health issues.
4. Use the two-way communication; Active listening and effective questioning.
5. Ask open-ended questions using simple language and visual aids.
6. Use effective communication techniques eg. **GATHER** which stands for: (**G**reet **A**sk **T**ell **H**elp **E**xplain **R**eturn visit/Referral), **REDI** (**R**apport building, **E**xploration, **D**ecision making, **I**mplementing the decision).
7. Use the nonverbal communication skills; **SOLER** (**S**it squarely, **O**pen posture, **L**ean forward, **E**ye contact, **R**elax).
8. Use verbal communication skills **CLEAR** (**C**larity, **L**isten, **E**ncourage, **A**cknowledge, **R**epet and reflect).

## B. PAC Counseling process

- ⊙ In emergency situations provide treatment but ensure counseling is provided prior to discharge.
- ⊙ Assess client's ability/capacity to give or receive information.
- ⊙ Explore client's needs and feelings.
- ⊙ Examine values and life plans/reproductive health needs.

The counseling process involves the following:

### 1. Initial welcoming of the client

- Approach the client in a friendly manner, greet and call her by name.
- Re-assure her that she is in good hands and the treatment will be fine.
- Reassure her of privacy and confidentiality.
- Give her moral and psychological support.
- Do not be judgmental.
- Find out if she has been referred or came in on her own.

### 2. Counseling before the treatment / pre-procedure

- There is need to perform quick assessment before counseling.
- The patient might need resuscitation first.

Table 1.1: Pre-treatment Counselling.

Patient obligations	Health Professional Obligations.
Give correct information (be truthful)	Be gentle and non-judgmental
Seek clarifications (ask questions on grey areas)	Ensure confidentiality and privacy
Be cooperative during the service	All women being treated for abortion complications have a right to information about their condition, including: <ul style="list-style-type: none"><li>• Overall physical condition</li><li>• Results of physical and pelvic examinations and lab tests</li><li>• Obtain consent from the patient before treatment</li><li>• Need for referral; first aid provided prior to referral and access transport to another facility</li></ul>
Communicate her feelings throughout the process.	Be attentive to verbal and nonverbal communication relayed by the patient
Follow instructions	Explore with the client on the possible FP method of choice.

### **3. Counselling during the treatment**

- a. The health care provider to explain the procedure to the client.
- b. Verbal support (Verbocaine)
- c. Give continuing emotional support by providing positive, empathetic, verbal and non-verbal communication

### **4. Counseling after the treatment (Post-treatment counselling).**

- a. Explore patient's feelings, questions, and concerns and provide encouragement and support.
- b. Remind patient of possible side effects, risks, and warning signs; patient should return when warning signs occur;
- c. Tell client how to take care of herself at home by giving written post-procedure information consisting of;
  - Sexual activity resumption after the bleeding has stopped and when comfortable,
  - Avoid strenuous activity,
  - Warning signs,
  - Bleeding and cramping similar to a normal period for up to one week,
  - Fatigue,
  - Depression or sadness (for several days),
  - Complications requiring coming back or going to the nearest health facility e.g. Continuous bleeding (more than 1 week), foul smelling discharge, low abdominal pains, dizziness, fever.
- d. Remind client of the importance of follow-up; return to fertility in 10 days.
- e. Advice on nutrition and iron supplements.
- f. Discuss available contraceptive methods as appropriate.
- g. Discuss Reproductive Tract Infections/Sexually Transmitted Infections including HIV.
- h. Assess the need for additional counseling and/or referral for other reproductive health needs or non-medical issues or linkages to post rape care services including Trauma counseling.

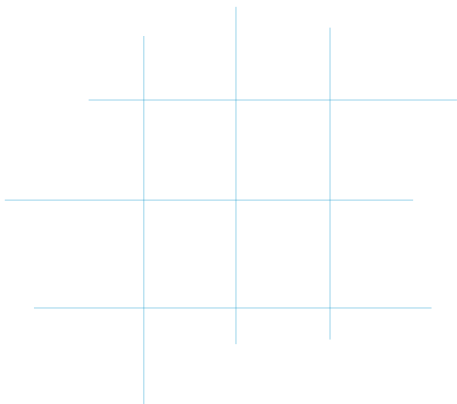
## 5. New approaches to counseling

The Balanced Counseling Strategy Plus (BCS+): A toolkit for Family Planning Service Providers working in High HIV/STI Prevalence Settings (Third Edition) includes five new counseling cards that address adolescent counseling and post abortion care, among others.

The updated cards include instructions for service providers, guiding them through supplementary counseling and services that Family Planning clients may need.

### **To remind clients of the follow-up**

The use of phone follow-up and self review of progress and recovery is a promising strategy for client follow-up.



## CHAPTER 2

# MANAGEMENT OF INCOMPLETE ABORTION AND THE COMPLICATIONS

### The Legislative Framework guiding Post Abortion Care in Kenya

Post abortion care, as recognized in the National Guidelines for Quality Obstetrics and Perinatal Care (MOH, 2012), constitutes emergency treatment of complications from spontaneous or induced abortion.

Article 43(2) of the Constitution, 2010, recognizes that no person shall be denied emergency medical treatment. As defined in the Health Act, 2017, emergency medical treatment refers to necessary immediate health care that must be administered to prevent death or worsening of a medical situation.

In accordance with Section 7(3) of the Health Act, health providers who fail to provide emergency treatment commit an offence. Whereas the right to exercise one's religion and beliefs is safeguarded in the Constitution, Section 12(2) of the Health Act mandates providers to offer emergency medical treatment. Conscientious objections therefore cannot be exercised in emergency situations.

Women presenting with incomplete abortion and/or complications of incomplete abortion should be managed as a matter of emergency to reduce associated morbidity and mortality.

## I. MANAGEMENT OF INCOMPLETE ABORTION

### A. Client assessment

Inform patient/client what you are going to do.

The purpose of the initial assessment is to assess for immediate life-threatening complications such as shock, severe vaginal bleeding, infection/sepsis or intra-abdominal injury. Address these complications immediately if present.

## Medical History:

History	What to ask for
History of presenting symptoms	Vaginal bleeding, passing of clots, lower abdominal pains
Reason for seeking medical care	Circumstances of pregnancy loss, including pregnancy symptoms or possible complications, such as vaginal bleeding.
Obstetric history	Details of previous pregnancies and their outcomes, including ectopic pregnancies, miscarriages or abortions, fetal deaths, live births and mode of delivery.
Gynecological history	<ul style="list-style-type: none"> <li>• Estimated Gestational Age(GA), taken to the number of weeks from the first day of client's Last Menstrual Period (LMP) to the present time.</li> <li>• Menstrual cycle pattern and whether the last period was normal.</li> <li>• Gynecological issues, including previous uterine surgery, caesarian section, myomectomy, or surgery for reproductive organ tumors.</li> <li>• History of female genital mutilation/physical abnormalities/ other conditions.</li> <li>• Contraceptive history- current use and methods used in the past and experience with these methods.</li> </ul>
Sexual history	<ul style="list-style-type: none"> <li>• Current partner(s) and whether current partner(s) may have other partner(s).</li> <li>• History of correct and consistent use of condom(s)</li> <li>• History of symptoms of any STIs (e.g. chronic pelvic pain, genital ulcers, abnormal vaginal discharge) and HIV/AIDS.</li> </ul>
Medical and Surgical history	<ul style="list-style-type: none"> <li>• Chronic diseases, such as hypertension, seizure disorder, blood clotting disorders, liver diseases, heart diseases, diabetes, sickle cell anemia, asthma, cancer and psychiatric diseases.</li> <li>• Details of admissions to hospital</li> <li>• Details of past surgical operations.</li> </ul>
Current medical treatment and allergies	<ul style="list-style-type: none"> <li>• Allergies to medication</li> <li>• Daily medications; use of recent medications or herbal remedies, including any medications and the details of their use(dose, route, timing) or if self-abortion was attempted.</li> </ul>
Social history	<ul style="list-style-type: none"> <li>• Marital or partner status and family environment</li> <li>• Gender based violence or coercion by partner or family</li> <li>• History and current alcohol and illicit drug use.</li> <li>• Tobacco consumption</li> </ul>

## Physical examination:

Assessment needed	What to check for
General health assessment	Observe general appearance (signs of weakness, lethargy, anemia or malnourishment and state of mind e.g. agitated, depressed and clothes soaked in blood). Observe vital signs: BP, pulse rate, respiratory rate and temperature Carry out general physical examination as indicated
Abdominal examination	Inspect abdomen for appearance of scarring, tenderness, distention and abnormal masses on the abdomen. Palpate the abdomen for areas of tenderness or masses and to estimate size of uterus.
Pelvic examination <ul style="list-style-type: none"><li>• Visual examination of genitalia</li></ul>	Inspect external genitalia for bleeding, injuries, instruments or signs of infection, abnormal or signs of disease (ulcers, warts, swelling such as Bartholin's gland abscess, and inguinal swelling).
<ul style="list-style-type: none"><li>• Speculum examination</li></ul>	Check for bleeding, cervica dilation, tears or lacerations, any visible POCs and any intra-peritoneal contents such as gut.
<ul style="list-style-type: none"><li>• Bimanual pelvic examination.</li></ul>	Check the status of the cervix (open and soft) and presence of POCs and cervical motion tenderness/ excitation to exclude sepsis. Assess the size of the uterus and feel for any foreign bodies in case of self-termination of pregnancy.

## Laboratory Tests and Ultrasound

Pregnancy test is not necessary as we are dealing with incomplete abortion.

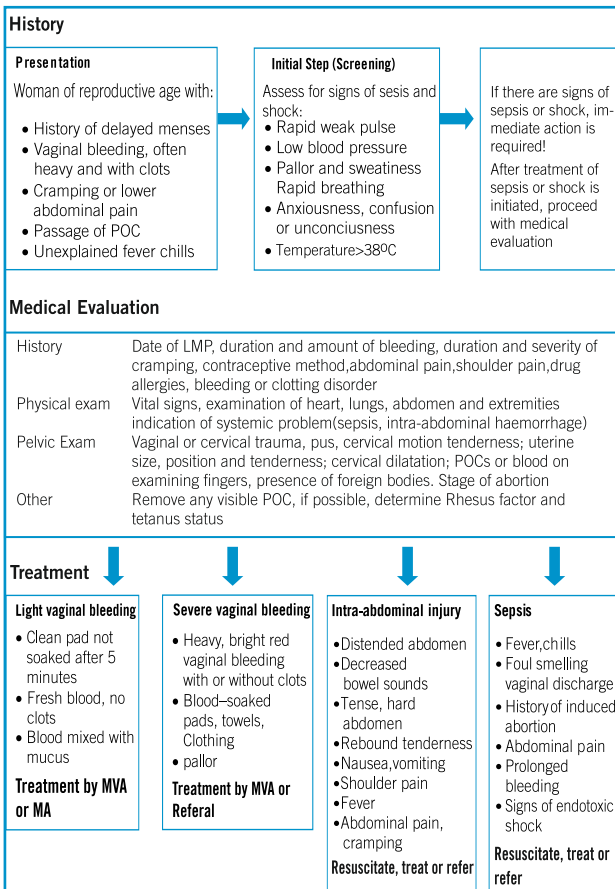
Blood group and Rhesus factor may be done and anti-D immunoglobulin — dose 250 IU (50µg) for first trimester — should be given to Rhesus negative women who have not actively formed their own anti-D.

Grouping and cross-matching is not necessary unless there is need for blood transfusion.

Haemoglobin / Haematocrit may be done if anaemia is suspected.

Ultrasound is not mandatory to confirm the diagnosis of incomplete abortion. Clinical diagnosis is adequate.

## Summary of Key Steps in Evaluating and Treating Clients with Incomplete Abortion (Adapted from WHO)





## B. Methods of Uterine Evacuation

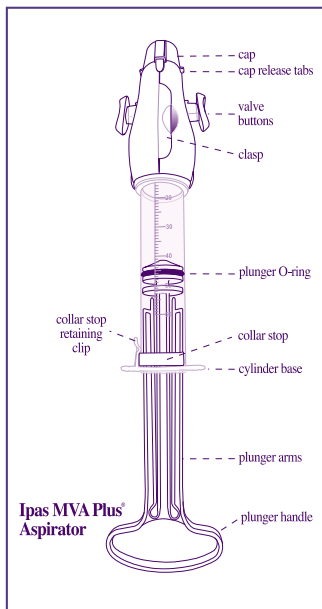
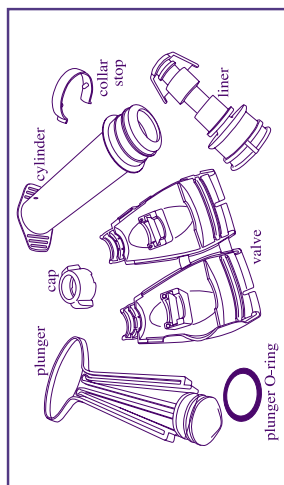
Uterine evacuation is a primary component of emergency management of incomplete abortion to minimize the risk of complications. This can be achieved by use of surgical and/or medical methods.

### 1. First Trimester Uterine Evacuation ( $\leq 12$ weeks)

#### a. Surgical Methods of Uterine Evacuation (1st trimester)

##### Manual Vacuum Aspiration (MVA)

- ⊙ Prepare tools and supplies for doing MVA



- ⊙ Procedure for doing MVA

- Give the client a general analgesic intramuscular (e.g. Diclofenac 75mg).

- ii. Give local analgesic; use 1% or 2% lignocaine to provide local anaesthesia (paracervical block).

While holding the speculum with one hand, gently grasp the cervix with the tenaculum forceps at the 12 o'clock position.

While gently pulling on the cervix, pass a size 5 cannula through the cervical os and progressively increase the cannula size until you reach the appropriate size of the MVA cannula for the gestational age and depending on the dilation of the cervix.

Once you have the appropriate cannula in place, attach the charged syringe to the cannula.

Note: do not push the syringe to the cannula, but fix the syringe to the cannula by pulling the cannula to the syringe to avoid risk of perforation.

Reach uterine fundus with cannula and release the valve, hold the barrel and start aspiration of uterine content, withdraw slightly by rotating the MVA set 180 degrees to cover all surface of the uterine cavity.

When the syringe is  $\frac{3}{4}$  full, pull the cannula tip down to the internal os, close the valve, detach the syringe, open the valve and empty the contents into a strainer/kidney dish.

- iii. Repeat the three steps above until you find signs of completeness, which include:

- appearance of red foam with air bubble in the syringe/cannula,
- a 'gritty' sound or feel, and
- sense of gripping of the cannula by the uterus.

When you are confident that the evacuation is complete, remove the cannula, clean the vaginal canal and make sure there is no major on-going bleeding.

# Steps for Performing Manual Vacuum Aspiration (MVA) Using the Ipas MVA Plus® and Ipas EasyGrip® Cannulae

## Step One: Prepare the Aspirator

- Position the plunger all the way inside the cylinder.
- Have collar stop in place with tabs in the cylinder holes.
- Push valve buttons down and forward until they lock (1).
- Pull plunger back until arms snap outward and catch on cylinder base (2).



## Step Two: Prepare the Patient

- Administer pain medication to have maximum effect when procedure begins.
- Give prophylactic antibiotics to all women, and therapeutic antibiotics if indicated.
- Ask the woman to empty her bladder.
- Conduct a bimanual exam to confirm uterine size and position.
- Insert speculum and observe for signs of infection, bleeding or incomplete abortion.



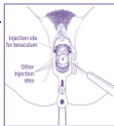
## Step Three: Perform Cervical Antiseptic Prep

- Use antiseptic-soaked sponge to clean cervical os. Start at os and spiral outward without retracing areas. Continue until os has been completely covered by antiseptic.



## Step Four: Perform Paracervical Block

- Paracervical block is recommended when mechanical dilatation is required with MVA.
- Perform paracervical block with 1% lidocaine, 20cc. Inject 2cc into the cervix at the tenaculum site. Inject the remaining 18cc in equal doses at the cervicovaginal junction at 2, 4, 8 and 10 o'clock. *Always* aspirate before injecting to prevent intravascular injection of lidocaine.

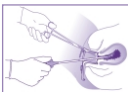


## Step Five: Dilate Cervix

- Observe no-touch technique when dilating the cervix and during aspiration. Instruments that enter the uterine cavity should not touch your gloved hands, the patient's skin, the woman's vaginal walls, or unsterile parts of the instrument tray before entering the cervix.
- Use mechanical dilators or progressively larger cannulae to gently dilate the cervix to the right size

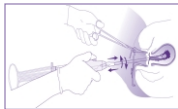
## Step Six: Insert Cannula

- While applying traction to tenaculum, insert cannula through the cervix, just past the os and into the uterine cavity until it touches the fundus, and then withdraw it slightly.
- Do not insert the cannula forcefully.



## Step Seven: Suction Uterine Contents

- Attach the prepared aspirator to the cannula if the cannula and aspirator were not previously attached.
- Release the vacuum by pressing the buttons.
- Evacuate the contents of the uterus by gently and slowly rotating the cannula 180° in each direction, using an in-and-out motion.
- When the procedure is finished, depress the buttons and disconnect the cannula from the aspirator. Alternatively, withdraw the cannula and aspirator without depressing the buttons.



## Signs that indicate the uterus is empty:

- Red or pink foam without tissue is seen passing through the cannula.
- A gritty sensation is felt as the cannula passes over the surface of the evacuated uterus.
- The uterus contracts around or grips the cannula.
- The patient complains of cramping or pain, indicating that the uterus is contracting.

## Step Eight: Inspect Tissue

- Empty the contents of the aspirator into a container.
- Strain material, float in water or vinegar and view with a light from beneath.
- Inspect tissue for products of conception, complete evacuation and molar pregnancy.
- If inspection is inconclusive, reaspiration or other evaluation may be necessary.



## Step Nine: Perform Any Concurrent Procedures

- When procedure is complete, proceed with contraception or other procedures, such as IUD insertion or cervical tear repair.

## Step Ten: Process Instruments

- Immediately process or discard all instruments, according to local protocols.

## b. Medical Methods of uterine evacuation

Medical uterine evacuation (MUE) is managed by the use of Misoprostol either orally or sublingually.

Medical treatment of incomplete abortion is an outpatient procedure if the bleeding is minimal, and follow-up is recommended after 7 days.

In case of excessive bleeding, admit the client or ask her to go to the nearest health facility for emergency treatment if this happens at home.

### *Misoprostol Dosage for PAC by Route of Administration (adopted from FIGO)*

Gestation	Dosage	Route of Administration	Timing	Efficacy
Less than 12 weeks uterine size	600µg	Oral	Stat	91-99%
	400µg	Sublingual	Place the tablets under the tongue for 30 minutes, then swallow the remaining drug- if any- after the 30 minutes are over.	95%

## 2. Second Trimester Uterine Evacuation (13-20 weeks)

- Second trimester PAC services are preferably managed in a hospital setup, especially one with a dedicated space for such services.
- If a client presents in an outpatient facility, resuscitate and refer to a well equipped facility to handle second trimester abortion, with well trained personnel and blood transfusion facilities.

### a. Surgical Methods of Uterine Evacuation (2nd Trimester)

- The clients should be admitted and evacuation of POCs done in theatre under sedation or general anaesthesia.
- If it is not possible to manage the case, refer to a more equipped facility to manage 2nd trimester abortion cases.

## **b. Medical Methods of Uterine Evacuation (2nd Trimester)**

Admit the client and induce the remains of the pregnancy using misoprostal 400mcg sublingually, 3-hourly till expulsion of the POCs, or use other uterotonics such as oxytocin to expel the retained POCs.

After the expulsion of the POCs, there might be a need to evacuate the uterus using MVA kit.

## **II. MANAGING COMPLICATIONS OF INCOMPLETE ABORTION**

### **General principles of emergency abortion care**

- stabilization and referral
- IV fluids replacement
- blood transfusion
- antibiotics
- pain control
- maintaining emergency tray

### **1. Haemorrhage**

- ⊙ Causes of heavy bleeding include uterine atony, retained products of conception, cervical or vaginal laceration and uterine rupture or perforation.
- ⊙ Management of the cause of bleeding is required after diagnosis is confirmed.
- ⊙ Therapies for post abortion:

Treatment	Dose
Ergometrine	0.2 mg/ml. (1)ml
Misoprostal	800 mcg S/L or rectally
Tamponade	Balloon or condom catheter, sterile packing

**Note:** DIC occasionally occurs after a second trimester abortion and should be considered if bleeding cannot be controlled, particularly in women with an intra-uterine fetal death as a cause of the abortion. Blood products need to be administered to stop bleeding from DIC.

## 2. Retained Products of Conception (POCs)

- ⊙ Women present with increased pain, moderate to heavy bleeding and/or signs of infection.
- ⊙ Retained POCs are typically placental tissue.
- ⊙ If infection is present, start antibiotics and do aspiration without delay, taking care not to perforate the uterus.

## 3. Infection and Sepsis.

- ⊙ Infection may present at any time after the abortion and may be localized to the uterus or generalized, eg. sepsis.

In all cases, immediate treatment is required.

- ⊙ Signs and symptoms of infection include fever, foul-smelling discharge, lower abdominal pains, distended abdomen, guarding and rebound tenderness, general malaise and prolonged bleeding.

a. Initial stabilization measures (give IV antibiotics and IV fluids) is followed promptly by definitive treatment of the source of infection.

b. Evacuate the uterus and if DIC is suspected, transfuse with fresh whole blood or plasma and give heparin 5,000-10,000 units IV every six hours, or refer the patient to a tertiary center.

c. Principles of Infection Prevention and Control:

### i. Hand hygiene

Wash hands before and after performing any procedure.

Use soap and clean running water according to local hand-washing protocol.

If no running water, use bucket with a tap, or a jug to pour water over the hands with help from an assistant.

### ii. Personal Protective Equipment (PPE)

Personal protective equipment (PPE) reduces, but does not completely eliminate, the risk of acquiring or transmitting infection. PPE includes gloves, aprons, capes, masks, goggles, gowns, closed shoes or boots, etc.

### iii. Gloves

Gloves should be used in addition to hand washing. They should only be worn when there is risk of contact with blood or body fluids.

Use sterile gloves when performing MVA.

### iv. Processing Instruments for Re-use

The basic infection prevention steps that are recommended for reducing disease transmission from soiled instruments and other reusable items are decontamination, cleaning, high level disinfection and sterilization.

#### 1). Decontamination

After use, instruments should be soaked in 0.5% chlorine solution for 10 minutes. This inactivates most organisms including HBV and HIV. After 10 minutes remove the instruments and immediately rinse them with water to remove residual chlorine.

#### 2). Cleaning

Clean all instruments and equipments to remove organic materials or chemical residue after decontamination. Ensure all surfaces of instruments and equipment are cleaned.

Cleaning with liquid soap or enzymatic detergent and water removes up to 80% microbes.

After cleaning, rinse in clean water, dry the instrument by using a clean, lint-free cloth.

#### 3). High level disinfection

High level disinfection (HLD) is recommended in the absence of sterilization or incase of heat-sensitive instruments that cannot be sterilized. HLD is achieved by boiling or submerging the instruments in chemical (Cidex or Steranios) for 20 minutes .

#### 4). Sterilization

Sterilization is the destruction of all micro organisms (bacteria, viruses, fungi and parasites) including bacterial endospores from instruments and other items. Sterilization is achieved by high pressure steam (Autoclaving) or dry heat (oven) and submerging the items overnight (24 hours) in chemical (Cidex or Steranios).

### 5). Storage

Store the cannula, MVA Kit and other equipment dry after processing.

#### d. Cleaning of the Procedure Room

Clean the procedure room including the couch, floor, walls, rubber draw-sheets, toilets and other areas with detergents and hot water; If soaked with blood or body fluid, use a 0.5% Chlorine solution.

#### e. Segregation of Waste

Segregate the waste into sharps, soiled waste, blood, pocs, used gowns, masks, equipment and instruments and place them in different receptors for processing.

#### f. Waste Disposal

##### i. On-site

- Placenta pit
- Incineration
- Pouring into a safe sewage system

##### ii. Disposal elsewhere

- Arrangements can be done for a contract with a supplier to collect the wastes and take them for incineration or other disposal methods.

## **4. Shock**

### ⊙ Shock may occur following haemorrhage or sepsis.

Signs of shock include rapid, weak pulse ( $\geq 110$  b/min), low blood pressure (diastolic  $<60$  mmHg, systolic  $<90$  mmHg), pallor, rapid breathing ( $\geq 30$  b/min), anxiety, confused or unconscious mental state.

- The management requires initial treatment to increase blood pressure and circulatory volume. This includes: ensuring airway is open; administer oxygen through a mask or nasal cannulae (6-8 l/m), administer 1L of IV fluids (Ringer's lactate or isotonic solution) over 15-20 minutes through a large-bore needle (16-18 gauge).
- Start blood transfusion if there is evidence of severe blood loss.



- c. Give antibiotics by IV route, if sepsis or intra-abdominal injury is present.
- d. In case of renal failure, refer to a tertiary care center.

## 5. Severe vaginal bleeding

- a. *Initial treatment:* Ensure airway is open; Check vital signs; Elevate feet; Check HB; General health status; Abdominal exam; Give oxygen (6-8 litres/ min.); Start IV fluids (NIL by mouth); Give IV antibiotics.

Draw blood for grouping and cross-match.

- b. *Definitive treatment:* Treat the cause of bleeding and replace lost blood (transfuse).

Check for uterine perforation or injury to genital tract and repair.

- c. Refer after stabilizing the client.

## 6. Intra-abdominal injury

- a. *Initial treatment:* Ensure airway is open and check vital signs. Give oxygen (6-8 litres/ min.); Give IV fluids -NIL by mouth- (Ringer's lactate or normal saline); Transfuse if HB<5g/dl.

Immediately begin antibiotics.

Draw blood for grouping and cross-match.

- b. *Definitive treatment:* Repair the gut or bladder, with the assistance of a surgeon, if necessary. Repair uterine perforation after evacuating the uterus.

## 7. Genital injury

- a. After initial assessment and stabilization measures, repair the vaginal, cervical or uterine injuries under general anaesthesia. Vulval injuries, if any, may be repaired under local anaesthesia.
- b. Refer, if not possible to repair the injuries.

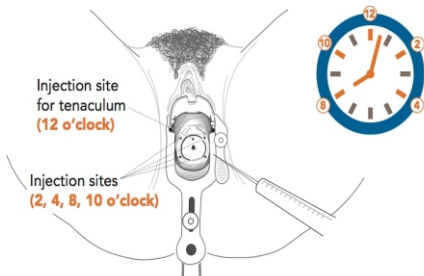
## 8. Pain

- ⊙ Management of pain will follow the evaluation of the situation and cause of the pain.
- ⊙ Severe pain can be due to unrecognized perforation/ injury to the uterus, hematometria, infection and retained POCs or all of the above.

## a. Pain control during uterine evacuation

Type of intervention	Examples	Possible adverse effects, complication and management	Notes
Analgesic	<ul style="list-style-type: none"> <li>Ibuprofen 400-800mg</li> <li>Diclofenac injection 75mg or 100mg suppository</li> <li>Ponstan 500mg</li> </ul>	<ul style="list-style-type: none"> <li>Possible gastrointestinal upset with non-steroidal anti-inflammatory drugs (NSAIDs)</li> </ul>	<ul style="list-style-type: none"> <li>Administer 30-60mins before performing the procedure</li> <li>Duration of effect of 3-6 hours</li> </ul>
Anxiolytic/ Sedative	<ul style="list-style-type: none"> <li>Diazepam 5-10 mg orally</li> <li>(Pethidine injection should be avoided)</li> </ul>	<ul style="list-style-type: none"> <li><b>Dizziness:</b> after the procedure, the patient should be accompanied at all times until the symptoms wears off and refrain from using stairs, driving, handling machinery, walking long distances</li> </ul>	<ul style="list-style-type: none"> <li>Administer 30-60mins before performing the procedure</li> <li>Muscle relaxation and reduced anxiety</li> <li>Effective for 2 hours</li> </ul>
Local anaesthesia: Paracervical block using lignocaine	<ul style="list-style-type: none"> <li>The provider must be trained to administer paracervical block</li> <li>Ensure there is no allergy to local anaesthesia</li> <li>Lignocaine 1% without epinephrine, limited to 3.5mg/kg body weight. Maximum dose of 20mls</li> <li>Aspirate before injecting</li> <li>Lignocaine 2% can be used. Max. dose 10mls.</li> </ul>	<ul style="list-style-type: none"> <li><b>Toxic reactions</b> (rare): avoid by using the smallest effective dose, aspirate before each injection</li> <li><b>Mild reaction:</b> (numbness of the tongue and lips, metallic taste in the mouth, dizziness or light headedness, ringing in the ears, difficulties in focusing eyes). Wait and support verbally.</li> <li><b>Severe reaction</b> (sleepiness slurred speech,</li> </ul>	<ul style="list-style-type: none"> <li>Wait 4-5mins for it to take effect</li> <li>Duration of effect 60-90 minutes</li> </ul>
General Anaesthesia, Regional Anaesthesia and Ketamine	<ul style="list-style-type: none"> <li>When necessary, administered by a person with anaesthetic skills.</li> </ul>	Expected anaesthetic complications managed appropriately.	Carries higher risks of complications including hypotension, hypoxia, cardiac arrest.

## b. Paracervical block



- 1 Prepare lidocaine syringe.**
  - Use 20mL of 1% lidocaine OR 10mL of 2% lidocaine.
  - Do not exceed the lidocaine maximum dose of 4.5mg/kg or 200mg total.
- 2 Attach needle to the syringe.**
  - A needle 3cm (1in) in length is recommended to facilitate deep injection.
- 3 Place the speculum and perform cervical antiseptic prep.**
- 4 Inject small amount of lidocaine superficially into the anterior lip of the cervix at the site where the tenaculum will be placed (12 o'clock).**
  - Inject 2mL if using 20mL of 1% lidocaine.
  - Inject 1mL if using 10mL of 2% lidocaine.
- 5 Grasp cervix with the tenaculum at 12 o'clock.**
- 6 Inject remaining lidocaine in equal amounts at the cervicovaginal junction, at 2, 4, 8 and 10 o'clock.**
  - Injections should be 3cm (1in) deep.
  - Aspirate before injecting to prevent intravascular injection.

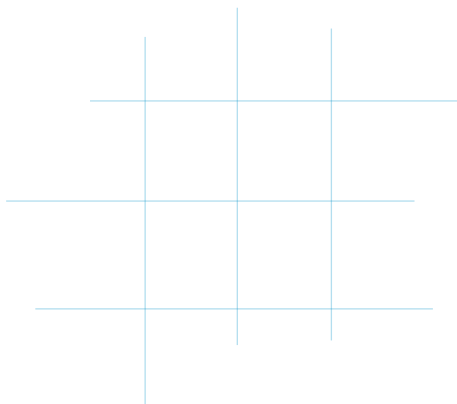
### PRACTICE TIPS

- Deep injection of lidocaine (3cm or 1in) provides more effective pain relief than superficial (1.5cm) injection.
- Possible side effects seen with intravascular injection include peri-oral tingling, tinnitus, metallic taste, dizziness or irregular/slow pulse.
- Midlevel providers trained to provide paracervical block demonstrate similar safety and efficacy rates as physicians.
- Serious adverse events related to paracervical block are rare.

For more information, visit [www.ipas.org/clinicalupdates](http://www.ipas.org/clinicalupdates).

### III. PREVENTION OF INCOMPLETE ABORTION/UNSAFE ABORTION.

- a). Effective post abortion counseling to break the cycle of unintended pregnancy
- b). Social Protection to support those who wish to carry the pregnancy to term
- c). Economic gender empowerment e.g. encourage them to initiate income generating activities such as table banking, merry go round, chamas and small business
- d). Provide care to the pregnant woman to avoid unsafe abortion.
- e). Implement evidence-based interventions to prevent unsafe abortion
- f). Re-integration of women with unplanned pregnancy into the society to reduce stigma and discrimination.
- g). Prevention of unintended pregnancy which might lead women to seek unsafe abortion.
- h). There is need to establish rescue centres for those in crisis pregnancy when, and if, necessary.



## CHAPTER 3

### POST ABORTION CONTRACEPTION AND FAMILY PLANNING SERVICES.

Fertility resumes almost immediately after abortion or miscarriage; the Post abortion care client and her partner should be offered counselling and information on family planning, including contraception options. During Family Planning or contraception counseling, clients must be informed of the fact that ovulation and fertility may resume within 2 weeks after emergency treatment.

Where a desired Family Planning method is not available, an alternative method may be offered and appropriate information on referral provided

The World Health Organization's (WHO) 2015 Medical Eligibility Criteria for Contraceptive Use classifies all contraceptive methods as category one, or safe for immediate use, following first-trimester uncomplicated aspiration abortion.

#### **A. Family planning following Post abortion Care**

1. Assess the client's suitability for each method using the WHO Medical Eligibility Criteria Wheel.
2. All hormonal methods may be used following postabortion care. IUCD can also be given after confirmation of complete uterine evacuation and in the absence of infection.
3. Fertility awareness methods: Standard days method, cervical mucus method, symptothermal method, etc.— Use with caution after recent abortion.
4. Standard Days Method (SDM) can be used if the monthly cycle is between 26 days and 32 days and then day 8 – day 19 are considered fertile. The Cycle Beads method is a perfect way to implement the Standard Days method and its Application can be

downloaded from Appstore (IcycleBeads) or Playstore (CycleBeads) for easy use.

5. The diaphragm and cervical cap are unsuitable until six weeks after abortion. Condoms may be used after 1–2 weeks following MVA and MUE respectively.
6. Post-abortion voluntary female sterilization and male sterilization should only be provided after uncomplicated abortion, patients have completed desired family size and only after appropriate and adequate counselling for informed and voluntary consent.

## B. Post-abortion medical eligibility for contraceptive use

Summary table of post-abortion medical eligibility recommendations for hormonal contraceptives, intrauterine devices, barrier contraceptive method and others.

### 1. Post-surgical uterine evacuation (MVA)- Quick start

Post-abortion condition	COC	CIC	Patch & vaginal ring	POP	DMPA, NET-EN	LNG/ETG implants	Copper-bearing IUD	LNG-releasing IUD	Condom	Spermicide	Diaphragm
First trimester	1	1	1	1	1	1	1	1	1	1	1
Second trimester	1	1	1	1	1	1	2	2	1	1	1
Immediate post-septic abortion	1	1	1	1	1	1	4	4	1	1	1

### 2. Post-medical uterine evacuation (MUE)- Quick start

Post-abortion condition	COC	CIC	Patch	Vaginal ring	POP	DMPA, NET-EN	LNG/ETG implants	Copper-bearing IUD	LNG-releasing IUD	Condom	Spermicide	Diaphragm
First trimester	1	1	1	4	1	1	1	4	4	4	4	4
Second trimester	1	1	1	4	1	1	1	4	4	4	4	4

*N.B. - Quick start: Starting FP/Contraception on same day of the PAC.*

*- Interval: Starting FP/Contraception after one week, or later, of the PAC.*

CIC, combined injectable contraceptive; COC, combined oral contraceptive; DMPA/NET-EN, progestogen-only injectables: depot medroxyprogesterone acetate/norethisterone enanthate; IUD, intrauterine device; LNG/ETG, progestogen-only implants: levonorgestrel/etonorgestrel; POP, progesterone-only pill.

### Definition of categories

- 1: a condition for which there is no restriction for the use of the contraceptive method.
- 2: a condition where the advantages of using the method generally outweigh the theoretical or proven risks.
- 3: a condition where the theoretical or proven risks usually outweigh the advantages of using the method.
- 4: a condition which represents an unacceptable health risk if the contraceptive method is used.

## **C. Role of Counseling and Contraception Immediately after Post Abortion Care**

### **1. Counseling**

Use BCS+ counseling strategy to assist the woman choose the method of her choice.

### **2. Post Abortion Contraception**

It is recommended to provide a contraceptive immediately after PAC.

This is done according to medical eligibility criteria for contraceptive use.

Where possible, provide long term and reversible methods of contraception (LARC). These have been found to be more effective and more reliable in preventing a repeat unintended pregnancy. Such methods include implants and intra-uterine devices.

## CHAPTER 4

### INTEGRATION AND MANAGEMENT OF OTHER REPRODUCTIVE HEALTH CONDITIONS DURING POST ABORTION CARE.

Patients who present with PAC also present with other pre-existing reproductive health conditions. Such conditions should be managed as per the existing manuals and guidelines. In addition, during counseling, screening for some of these conditions should be offered to the client and if found, the patient must be taken care of and referred appropriately for completeness of care.

Such conditions include but are not limited to:

1. Genital tract infections including bacterial vaginosis, sexually transmitted infections, endometritis, pelvic inflammatory disease and pelvic abscess. This may be difficult to differentiate from post abortion sepsis.
2. Human Immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).
3. Cervical lesions, both benign and malignant.
4. Pelvic pathology including ovarian cysts and uterine fibroids.
5. Urinary tract infections.
6. Breast lesions, both benign and malignant.
7. Vaginal lesions such as cystoceles, rectoceles, fistulae and prolapses.
8. Gestational trophoblastic disease.
9. Infertility/Childlessness.
10. Recurrent loss of pregnancy .
11. Extra-uterine pregnancy.
12. Female genital Mutilation/cut.
13. Sexual and Gender Based Violence.

Note: Integration of any other services — including legal referral — required by the patient must be taken care of, for completeness of care.



## CHAPTER 5

### ESTABLISHING POST ABORTION CARE SERVICES

Post abortion care is emergency care, and that should be accessed at primary health care facilities. Where actual services cannot be directly offered, proper referral mechanisms should be established.

The following components should be considered in setting up comprehensive Post abortion Care services:

#### **A. Site set-up for Post abortion Care**

While setting up Post abortion Care services it is important to consider:

1. Space available and existing infrastructure for site set up.
2. Integration of Post abortion Care services with existing maternal health services- (Cervical cancer screening, family planning, HIV counseling and Testing).
3. Cadre and number of personnel available to provide Post abortion Care.
4. Where possible, Post abortion Care services should be offered in the outpatient department.
5. The Post abortion care rooms or centres should be called Reproductive Health (RH) rooms, or Reproductive Health (RH) centres.
6. Where possible, the RH room or RH centre should be separate from the delivery room.

##### **a. Infrastructure:**

Each facility should have a Reproductive Health (RH) room or RH centre.

The RH room or the RH Centre :

- Should be established with adequate space to facilitate service delivery

The Post abortion Care service set-up should have the following;

- A reception area
- A patient waiting area
- Consultation and counseling room
- Well -equipped procedure room
- Sterilization and instrument processing area
- Patient recovery room
- Washrooms/ Lavatories for patients where possible
- The RH room or centre should have Audio and Visual Privacy in all the areas of patient counseling and care.
- The RH room or the RH Centre should have hand washing facilities

#### **b. Personnel**

- i. The RH room or RH centre should be headed by a health care provider trained to provide and manage Post abortion care services.
- ii. All staff working in the RH center and RH room should be value clarified.
- iii. Health care providers providing Post abortion care services should be trained on surgical uterine evacuation (MVA and EVA where applicable) and Medical uterine evacuation.

These procedures should be performed by trained health professionals (doctors, clinical officers and nurses).

- iv. All Staff in the RH unit should be trained and retained in the Unit to ensure continuity of PAC services and enhance on job training.

#### **c. Equipment and supplies:**

- I. The RH center/ RH room should be a one stop shop for provision of Post abortion care services and related linkage services.

- ii. The RH room or RH centre should contain the equipment and supplies as shown on the table below:

Equipment	Supplies*	Job Aids
<ol style="list-style-type: none"> <li>1. Blood pressure machine</li> <li>2. Thermometer</li> <li>3. Stethoscope</li> <li>4. Vaginal speculum (Various sizes)</li> <li>5. Non-traumatic tenaculum</li> <li>6. Gynecological / Procedure Table with stirrups</li> <li>7. Angle poise Lamp</li> <li>8. Cover for perineum/ Green towels</li> <li>9. MVA Kits and Cannulae of various sizes</li> <li>10. Autoclave machine/ Boiler</li> <li>11. Waste Segregation bins and liners.</li> <li>12. Instrument trolley with at least two trays</li> <li>13. Instrument storage</li> <li>14. Clear Glass or Plastic Bowl</li> <li>15. Strainers</li> </ol>	<ol style="list-style-type: none"> <li>1. Pain medication- Non Steroidal Anti Inflammatory drugs</li> <li>2. Misoprostol</li> <li>3. Local Anesthesia- Lignocaine.</li> <li>4. All Contraceptive methods available (Pills, Injectables, Condoms, IUD and Implants),</li> <li>5. HIV test kits for integrated services.</li> <li>6. Antibiotics- (Where Possible)</li> <li>7. Uterotonics (eg. ergometrine and syntocinon).</li> <li>8. IV fluid and giving Set</li> <li>9. IP supplies- Sterilization chemicals, disinfectants</li> <li>10. Personal protective barriers (Gloves, face masks, boots etc).</li> <li>11. Non alcohol based antiseptic solution- povidone iodine, etc.</li> </ol>	<ol style="list-style-type: none"> <li>1. Relevant Information and educational materials (for adult and younger women)- refer to Job aids here)</li> <li>2. Client Record and Referral forms</li> <li>3. PAC procedure Register</li> <li>4. Informed Consent forms</li> <li>5. Counselling job aids (Mention)</li> <li>6. Contraceptive methods board/ apron (with samples of all contraceptives</li> <li>7. Clinical Handbook</li> <li>8. Balanced counselling scorecard table/ wall chart.</li> <li>9. Complete Referral Map.</li> </ol>
<p><i>*A DDA cabinet must be within the PAC center and should contain all necessary medicine and supplies for post abortion care (MVA and MA)</i></p>		

- iii. Emergency tray: A well stocked emergency tray with names of required drugs is mandatory.
- iv. Oxygen: This is required, with the necessary equipment to administer it, during resuscitation and emergency care.

- d. Access to services
  - i. Post abortion care services must be available as an emergency in all health care facilities.
  - ii. Proper referral pathways must be established in all health care facilities where service provision is not possible.
  - iii. Integrate post abortion care with other existing RH services including HIV counselling, Cervical cancer screening and other RH services.
  - iv. On job training should be carried out in the RH room/ RH centre for service continuation.
- e. Information Provision
  - i. Avail information for post abortion care services in a language that the woman understands, and that is sensitive to persons with special needs.
  - ii. Provide counseling and decision-making support for post abortion care to the woman
  - iii. Informed consent should be obtained.
- f. Arrangement and preparation for the procedure
  - i. The procedure room and equipment set up should be ready at all times (see site set -up checklist in relevant sections of this document).
  - ii. Accurate and complete patient and service documentation should be done in the relevant tools
  - iii. Ensure the privacy, respect and dignity of the patient at all points of the post abortion counseling and procedure.
- g. Sustainability
  - i. Incorporate post abortion care in the Linda Mama program at your facility.
  - ii. Health facilities should ensure availability of resources to replenish post abortion care equipment and supplies.

- iii. The hospital management should be engaged and sensitized on post abortion care services to support resource allocation for service continuity.
- h. Quality Improvement:
  - ⦿ A post abortion care program audit shall be carried out for the purposes of improving service delivery and training
  - ⦿ A quality improvement team will be set up at facility level to ensure post abortion care program quality assurance.

## **B. Community Engagement and Networking**

### **1. Goal**

The goal is to increase awareness on Post abortion Care (PAC) and services in the community, which include facility linkages, referral and subsequent re-integration into the community, to reduce maternal mortality and morbidity due to unsafe abortion.

### **2. Community Entry**

- ⦿ Carry out a needs assessment.
- ⦿ Mapping the community
- ⦿ Plan of Action (POA) involving all community members

### **3. Implementation of the Plan of Action.**

### **4. Community sensitization and Education on PAC services**

### **5. Advocacy on unsafe abortion.**

- ⦿ Increase community knowledge on the dangers of abortion-related complications.
- ⦿ Inform about legality of providing PAC services and where to get the services.
- ⦿ Break the silence on unsafe abortion and reduce stigma.
- ⦿ Collect and use, data relevant case studies and stories to engage communities
- ⦿ Plan to involve SCHMT and CMVs.

6. Creating linkages and networking with partners.
  - ⊙ RMNCH facilities
  - ⊙ Youth Friendly clinics
  - ⊙ SGBV Care and management.
  - ⊙ Schools and colleges
  - ⊙ Faith Based Organizations (FBOs)
  - ⊙ Media
  - ⊙ Civil Society Organizations (CSOs)
  - ⊙ Community Based Organizations (CBOs)
7. Role of Community Health Workers (CHWs) and Community Health Volunteers (CHVs).
  - ⊙ To be trained in PAC Values Clarification and Attitude Transformation (VCAT) and PAC services for them to have knowledge on PAC provision and referrals.
  - ⊙ To communicate to the community that PAC services are legal and are available in all public and private health facilities.
8. Follow-up
  - ⊙ Conduct monthly consultative meetings and report writing during dialogue and open days
  - ⊙ Use the data obtained to improve community PAC strategies.

## **C. Sustainability of Post abortion Care Services**

- ⊙ This is the ability of health institutions to equip (forecast, finance and procure).
- ⊙ SDPs are provided with commodities from government stores.
- ⊙ Private clinics can get support from donors but will need to give data, or purchase from local distributors.
- ⊙ Government facilities can also get donations from donors.
- ⊙ Sustainability also involves offering quality services, training of providers (CME) and good financial management.
- ⊙ Incorporating PAC services into national government programs including NHIF and LINDA MAMA or any other health programs is also useful for sustainability.

## CHAPTER 6

### MONITORING, EVALUATION AND LEARNING

Monitoring, Evaluation and Learning is a continuous management function to assess if progress is made in achieving expected results, to spot bottle-necks in implementation and to highlight whether there are any unintended effects (positive or negative) from a programme or project and its activities.

#### A. Monitoring

##### 1. Post Abortion Care (PAC) data management

- ⦿ Post abortion care registers will be used to document service data accurately and consistently.
- ⦿ Post abortion care registers and all relevant reporting tools should be availed in all the health facility offering post abortion care services.
- ⦿ The data should be uploaded onto the District Health Information System (DHIS).

##### 2. Documentation and Research

###### a. Documentation

- Proper and accurate documentation should be adhered to.
- Serious adverse events should be documented and monitored.

###### b. Research

- Relevant research should be done whenever the need arises, after going through the necessary processes of approval including the ethical board's clearance.
- All findings from the research should be properly documented and shared with RMHSU for its records and reference.

### 3. Support supervision

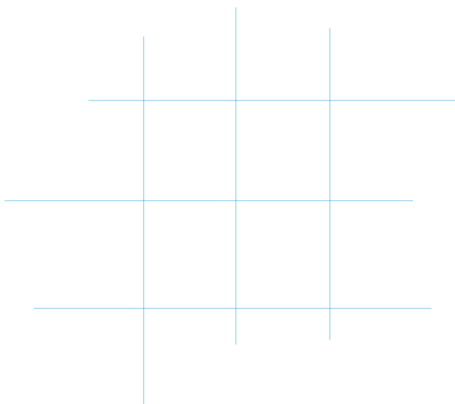
- ⦿ Support supervision must be conducted to evaluate the program and provide support to continuous improvement strategies.
- ⦿ Post abortion care support supervision should be part of the integrated support supervision process.

## B. Evaluation

An effective evaluation pathway includes planning for the evaluation, managing the evaluation, high quality performance evaluation, rigorous impact evaluation and follow-up on evaluation.

## C. Learning

Unless we learn effectively, we may continue repeating our mistakes.





## APPENDIX

### i). Patient Information Form for Post abortion Care

<b>Facility Name</b>			<b>MFL Code</b>
Date/Time DD:MM:YYYY		HH:MM	
<b>Patient Name</b>			<b>OP/IP Number</b>
First	Middle	Surname	
Date of Birth DD:MM:YYYY		Referred Yes <input type="checkbox"/> No <input type="checkbox"/>	
Address		Phone No	
<b>Medical and Obstetric History</b>			
Parity	LNMP	Gestation age	
Per vaginal bleeding Yes <input type="checkbox"/> No <input type="checkbox"/> Duration _____ Pelvic pain or cramping Yes <input type="checkbox"/> No <input type="checkbox"/> Passed tissue Yes <input type="checkbox"/> No <input type="checkbox"/> Using a contraceptive method when conceived? Yes <input type="checkbox"/> No <input type="checkbox"/> Type _____ Current medication _____ Drug or food allergy Yes <input type="checkbox"/> No <input type="checkbox"/> History of medical condition _____ History of surgery _____			
<b>Physical Examination</b>			
Vital signs: Temperature _____ BP _____ Pulse _____ Respiration Rate _____ Pallor: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Uterus: Size: _____ Tenderness: _____			
Speculum Examination: External Genitalia _____ Vagina _____ Cervix: Os open <input type="checkbox"/> Blood: (describe) _____ Discharge (describe) _____ Other signs: (products of conception, injuries, foreign objects, etc) _____ Cervical motion tenderness Yes <input type="checkbox"/> No <input type="checkbox"/> Adnexa: Tenderness Yes <input type="checkbox"/> No <input type="checkbox"/> Mass Yes <input type="checkbox"/> No <input type="checkbox"/>			

<b>Diagnosis</b>
<input type="checkbox"/> Incomplete abortion – uncomplicated <input type="checkbox"/> Incomplete abortion – complicated (specify) _____ <input type="checkbox"/> Complete abortion <input type="checkbox"/> Other Reproductive tract condition (specify) _____
<b>Treatment</b>
<input type="checkbox"/> Misoprostol Dose: _____ Route: _____ <input type="checkbox"/> Vacuum Aspiration: Manual <input type="checkbox"/> Electric <input type="checkbox"/> <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Referred (specify reason and place) _____
<b>Discharge Drugs (Name, Dose)</b>
Analgesic _____
Antibiotic _____
Other (specify) _____
Referral (reason and place) _____
<b>Contraceptives and Family Planning</b>
Counseling provided Yes <input type="checkbox"/> No <input type="checkbox"/>
Method chosen _____
Method provided _____
Referred (reason and place) _____
Return date _____
Place _____
Provider Name _____ Sign _____
Cadre _____



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## NOTES

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Reproductive and Maternal Health Services Unit  
Ministry of Health  
P.O. Box 30016-00100, NAIROBI.