

**REPUBLIC OF KENYA**



**MINISTRY OF HEALTH**

**THE NATIONAL  
POSTABORTION CARE HANDBOOK  
for Service Providers**

**May, 2018**



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Design, Layout and Print: Jotham G. M., +254 721 491 338



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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 353/100,000 (2015).

The health of women is 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 National PAC Handbook for service 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 handbook 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 needed PAC services but lack or are limited in knowledge and skills.

This National PAC Handbook is a complementary document to the PAC reference manual, curriculum, other training packages and approaches offered by Ministry of Health.

To develop the handbook, MOH-RHMSU consulted widely with expertise in reproductive health.

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

**Dr. Gondi J.O.**

Head, Reproductive & Maternal Health Services Unit  
Ministry of Health

## Acknowledgements

The National Postabortion Care (PAC) Handbook for service 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 Service Unit (RMHSU) under the leadership of the Ministry of Health. The process of developing this handbook for health 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 National PAC Handbook formulation meeting in Naivasha and the 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 Handbook.

A special word of thanks goes to individuals who tirelessly devoted their time and effort to the production of the final version of the handbook. In particular, special recognition and gratitude is given to the PAC task force- the technical team that has guided the process of developing this handbook 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, University of Nairobi, KOGS, CNS-Kenya, K-MET, FHOK, MKU, RCOG, Ipas, Marie Stopes, Reproductive Health Services and Reproductive and Maternal Health Consortium-Kenya.

The Ministry of Health would also like to acknowledge the efforts of Dr. Joel Gondi and Dr. Wangui Muthigani for efforts in coordinating the development of this handbook.

The development of this handbook would not have been possible without the generous financial support of RCOG, Ipas and Marie Stopes-Kenya.

### **Dr. Gondi J.O.**

Head, Reproductive & Maternal Health Services Unit  
Ministry of Health



## Abbreviations and Acronyms

<b>PAC</b>	-	Postabortion Care.
<b>MMR</b>	-	Maternal Mortality Ratio
<b>FHOK</b>	-	Family Health Options- Kenya
<b>RCOG</b>	-	Royal College of Obstetricians and Gynaecologists
<b>FIGO</b>	-	International Federation of Gynecologists and Obstetricians
<b>KOGS</b>	-	Kenya Obstetrics and Gynecological Society
<b>KMET</b>	-	Kisumu Medical and Education Trust
<b>SDG</b>	-	Sustainable Development Goals
<b>MOH</b>	-	Ministry of Health
<b>RMSHU</b>	-	Reproductive and Maternal Health Service Unit
<b>UON</b>	-	University of Nairobi
<b>WHO</b>	-	World Health Organization
<b>MVA</b>	-	Manual Vacuum Aspiration
<b>EVA</b>	-	Electrical Vacuum Aspiration

## Operational Definition



- Abortion:** The termination of a pregnancy, usually before the embryo or foetus is capable of independent life. In medical contexts, this procedure encompasses both spontaneous and induced abortion.
- Health:** A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
- Hospital:** a health care institution providing patient treatment with specialized medical and nursing staff and medical equipment.
- Post-Abortal Care:** Is the physical (medical), social, psychological and spiritual care and support given to a person after an abortion
- 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
- Sexual Health:** A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled
- Unsafe abortion:** as 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.
- Incomplete abortion:** Abortion in which parts of the products of conception are retained in the uterus.
- Complete abortion:** Complete expulsion of all the products of conception.
- Septic abortion:** Abortion associated with serious infection of the products of conception and endometrial lining of the uterus, leading to a generalized infection.

# chapter 1 : COMPREHENSIVE COUNSELING SERVICES

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.

## Considerations during Post abortion care (PAC) counseling

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

## 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 counselling process involves the following:

### 1. Initial welcoming of the client

- i. Approach the client in a friendly manner, greet and call her by name.
- ii. Re-assure her that she is in good hands and the treatment will be fine.
- iii. Reassure her of privacy and confidentiality.
- iv. Give her moral and psychological support.
- v. Do not be judgmental.
- vi. 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 counselling.

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 session	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 laboratory 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, the possible FP method of choice.

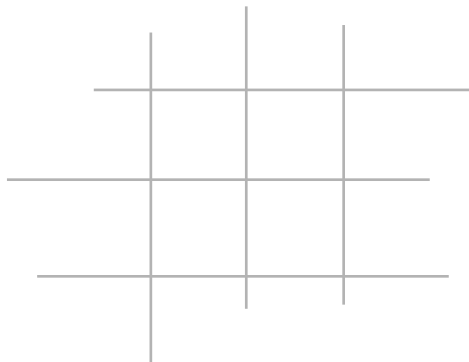
## 3. Counseling during the treatment

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

## 4. Counseling after the treatment.

- Explore patient's feelings, questions, and concerns and provide encouragement and support.
- Remind patient of possible side effects, risks, and warning signs; patient should return when warning signs occur;
- 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.
- iv. Remind client of the importance of follow-up; return to fertility in 10 days; resumption of sexual activity.
  - v. Advice on nutrition and iron supplements.
  - vi. Discuss available contraceptive methods as appropriate.
  - vii. Discuss Reproductive Tract Infections/Sexually Transmitted Infections including HIV.
  - viii. 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.





## Chapter 2: Management of incomplete abortion and the complications

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

### i) 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:

#### Physical Examination

Personal data	Name, Age, contact information
Reason for seeking medical care	Circumstances of pregnancy, 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, significant 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>

General health assessment	<p>Observe general appearance (signs of weakness, lethargy, anemia or malnourishment and state of mind e.g. agitated, depressed and clothes soaked in blood).</p> <p>Observe vital signs: BP, pulse rate, respiratory rate and temperature</p> <p>Carry out general physical examination as indicated</p>
Abdominal examination	<p>Inspect abdomen for appearance of scarring , tenderness and abnormal masses on the abdomen.</p> <p>Palpate the abdomen for areas of tenderness or masses and to estimate size of uterus.</p>
Pelvic examination	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).
• Visual examination of genitalia	
• Speculum examination	Check for bleeding, cervica dilation, tears or lacerations
• Bimanual pelvic examination.	Check the status of the cervix (open and soft) and precense of POCs and cervical motion tenderness/ excitation to exclude sepsis.

### Laboratory Tests and Ultrasound

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

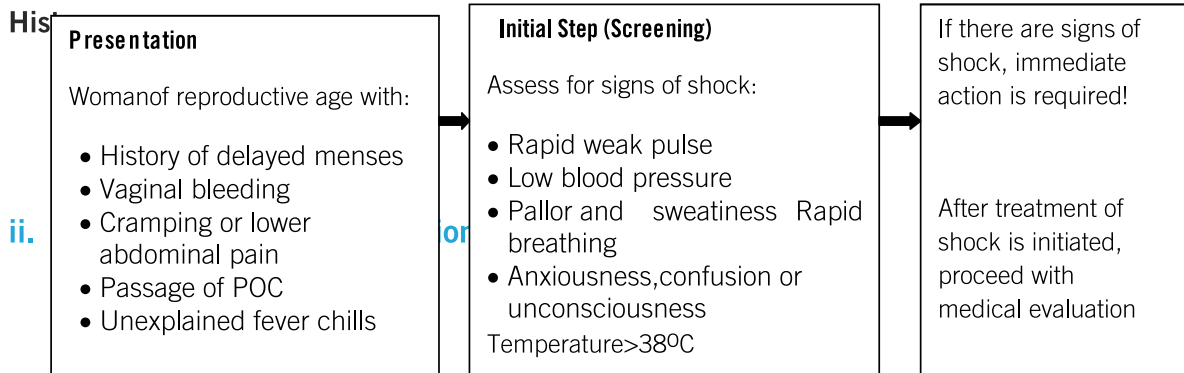
Blood group and Rhesus factor is not mandatory in the 1st trimester of pregnancy but anti-D immunoglobulin should be given to Rhesus negative women when indicated.

Haemoglobin /Haematocrit may be done if anaemia is suspected.

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



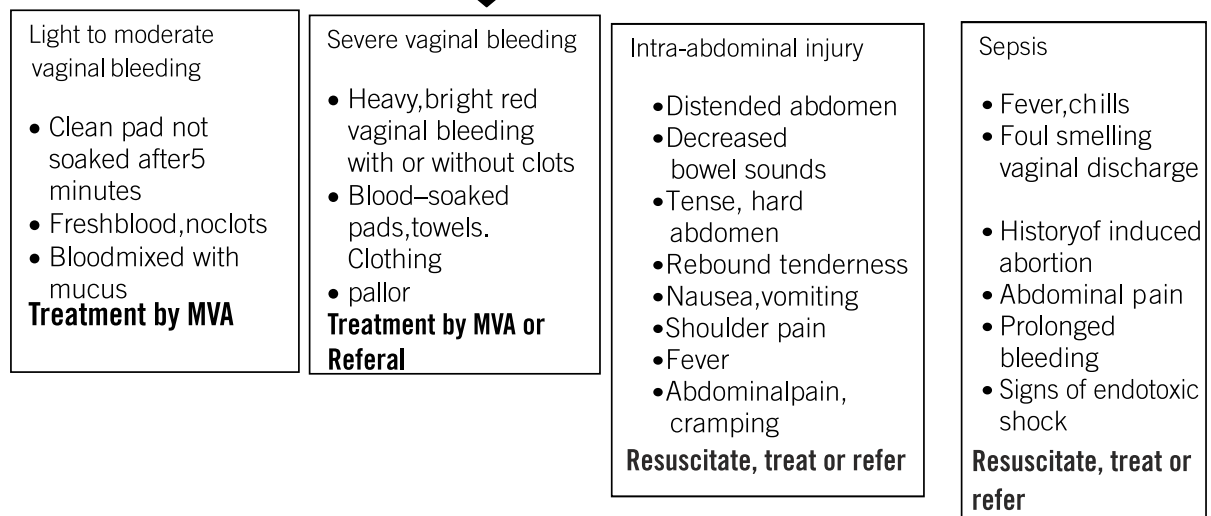
## Summary of Key Steps in Evaluating and Treating Clients with Incomplete Abortion (WHO)



### Medical Evaluation

History	Date of LMP, duration and amount of bleeding, duration and severity of cramping, contraceptive method, abdominal pain, shoulder pain, drug allergies, bleeding or clotting disorder
Physical exam	Vital signs, examination of heart, lungs, abdomen and extremities indication of systemic problem (sepsis, intra-abdominal haemorrhage)
Pelvic Exam	Vaginal or cervical trauma, pus, cervical motion tenderness; uterine size, position and tenderness; cervical dilatation; POCs or blood on examining fingers, presence of foreign bodies. PV bleeding and open cervix is present.
Other	Remove any visible POC; If possible, determine Rhesus factor and tetanus status.

### Treatment





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.

#### a) Surgical Methods of Uterine Evacuation

##### ⦿ Manual Vacuum Aspiration (MVA)

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

- 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.

#### b) Medical Methods of uterine evacuation (Figo Table)

##### *Misoprostol Dosage for PAC by Route of Administration*

### iii. Infection Prevention and Control

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	95%

**a) Principles of Infection Prevention and Control**

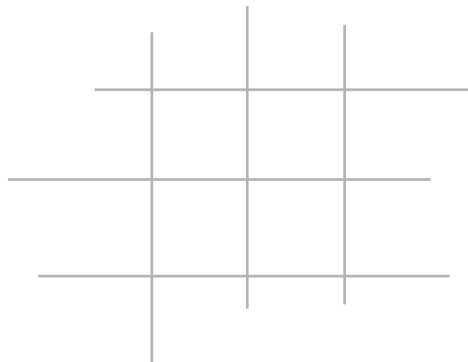
- i). Hand Hygiene
- ii). Personal Protective Equipment (PPE)
- iii). Processing Instruments for Re-use
- iv). Prevention of spread of communicable diseases

**b) Processing Instruments for Re-use**

- i). Decontamination
- ii). Cleaning
- iii). High-Level Disinfection
- iv). Sterilization
- v). Storage

**c) Segregation of Waste and Cleaning the Procedure Room**

- i). Separate waste into sharps, soiled waste, blood products and used equipment and instruments.
- ii). Clean the mackintosh on the couch with 0.5% solution of Chlorine before another client is served.

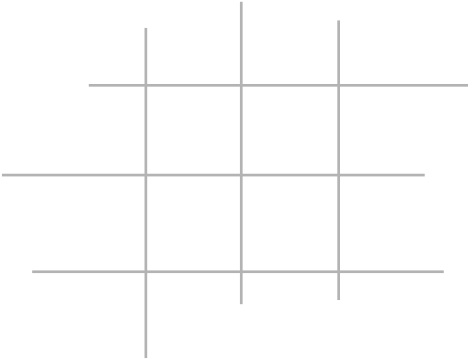


#### iv. Pain Management

##### a) Pain control during uterine evacuation

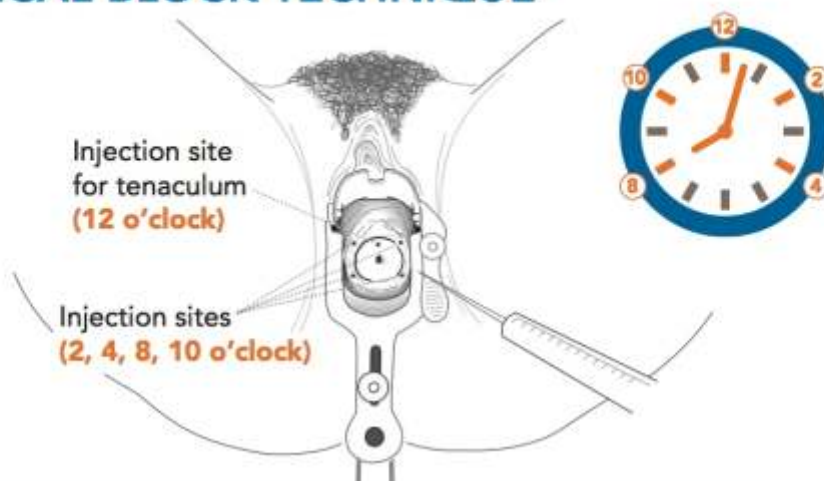
Type of intervention	Examples	Possible adverse effects, complication and management	Notes
<b>Analgesic</b>	<ul style="list-style-type: none"> <li>Ibuprofen 400-800mg</li> <li>Diclofenac injection 75mg or 100mg suppository</li> </ul>	<ul style="list-style-type: none"> <li>Possible gastrointestinal upset 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>
<b>Anxiolytic/Sedative</b>	<ul style="list-style-type: none"> <li>Diazepam 5-10mg 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>
<b>Local anaesthesia: Paracervical block using lignocaine</b>	<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> </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>

<b>General Anaesthesia</b>	<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.





# PARACERVICAL BLOCK TECHNIQUE



- 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).

## **v. Management of Complications of incomplete abortion**

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

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

### **ii. Management of shock**

### **iii. Management of severe vaginal bleeding**

### **iv. management of intra-abdominal injury**

### **v. Management of sepsis**

### **vi. Management of genital injuries**

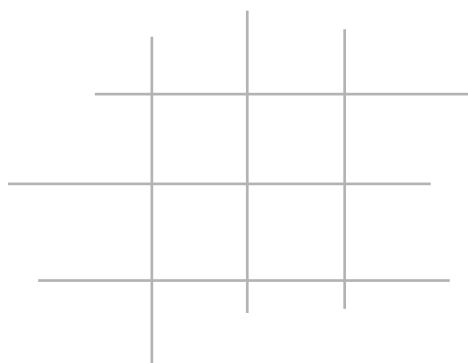
*Refer to relevant MOH guidelines*

## **vi. Prevention of incomplete abortion/ unsafe abortion.**

Most of the incomplete abortion cases are related to unsafe abortion.

The following are the steps to prevent incomplete abortion and unsafe abortion.

- i. Effective post abortion counselling to break the cycle of unintended pregnancy**
- ii. Social Protection to support those who wish to carry the pregnancy to term**
- iii. Economic gender empowerment e.g. encourage them to initiate income generating activities such as table banking, merry go round, chamas and small business**
- iv. Provide care of the pregnant woman to avoid unsafe abortion.**
- v. Implement evidence-based interventions to prevent unsafe abortion**
- vi. Re-integration of women with unplanned pregnancy into the society to reduce stigma and discrimination.**
- vii. Prevention of unintended pregnancy which might lead women to seek unsafe abortion.**



## Chapter 3 : Post abortion Contraception and Family Planning Services.

### Introduction

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

Where a desired FP 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.

### Family planning following PAC

1. Assess the client's suitability for each method using the WHO Medical Eligibility Criteria Wheel.
2. The oral contraceptive pill, injectable, implants, condoms, IUCD (in the absence of sepsis or severe genital tract injury).
3. Fertility awareness methods: Standard days method, cervical mucus method, symptothermal method, etc.- Use with caution after recent abortion
4. The diaphragm and cervical cap are unsuitable until six weeks after abortion
5. Post-abortion voluntary female sterilization and male sterilization should only be provided after non-complicated abortion patients have completed desired family size and only after appropriate and adequate counselling for informed and voluntary consent.

According to a Nairobi birth survey, there is always a desire by the woman to replace the lost baby.

### Post-abortion medical eligibility for contraceptive use

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

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

*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.

## Chapter 4: Integration and Management of other Reproductive Health Conditions.

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 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 postabortion sepsis, though.
2. Human Immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).
3. Cervical lesions, both benign and malignant.
4. Pelvic pathology including ovarian cysts, 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 required by the patient must be taken care of, for completeness of care.

## Chapter 5: Community Engagement for PAC services.

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 community, to reduce maternal mortality and morbidity due to unsafe abortion.

The effectiveness of PAC services depends on active community involvement using the SPEECS approach: S – Social, P- Political, E – Environmental, E- Economic, C- Culture and S-Spiritual. These steps are to help the service providers in situation analysis.

### Community Entry

The purpose of community entry is to build and nurture sustainable relationship. The process involves the following:

#### 1. Carry Out A Rapid Needs Assessment.

Develop or adopt a tool depending on the needs of that specific community. This will help you understand the key things about the community e.g culture, insights on reproductive health needs of the community, understand the decision makers in the community.

#### 2. Mapping the community:

Use a tool to map the community for accurate information on the following areas:

- ◉ Who are the key leaders?
- ◉ What resources are available?
- ◉ Which is the acceptable language to use e.g. miscarriage /abortion?
- ◉ How does the religion affect the Reproductive health seeking behaviour?
- ◉ Where do people seek help when unwell?
- ◉ Are there any other PACs initiatives in the community?
- ◉ Who are the like-minded CSOs working in the community?
- ◉ Are there CHVs and YPPs in the community?
- ◉ Who can be RH champions in the community?
- ◉ How are schools involved in ASRH?
- ◉ Are issues of ASRH discussed in the community?

#### 3. Plan of Action (POA)

Once the community identifies the problem/s, have a plan of action involving all community members. e.g. Men, youth, women and all opinion leaders' members.

##### Messages Development.

Have messages appropriate for all groups in collaboration with the community members. Keep it simple and smart. This will include advocacy, PAC services and prevention messages.

##### Messaging

elect the channel appropriately for effective communication to the target groups. One or mixed channels can be used including: Social platforms, role plays, skits, and media (print and electronic).

This should be done in collaboration with the community and the **PAC community initiative team** which should comprise of:

- ◉ Sub county RH coordinator.
- ◉ Sub county community strategy focal persons.
- ◉ Catchment area facility in charge.
- ◉ Community Health Assistants (CHAs)
- ◉ Community Health Volunteers (CHVs)
- ◉ Youth Peer Providers (YPP)
- ◉ Media

### **Implementation**

Training of the Community Health Volunteers and Youth Peer Providers

Develop or adopt a community PAC training guide by PAC consortium for training CHAs, CHVs and YPPs who will be involved in mobilization, education and Advocacy in the community.

### **Community sensitization and Education**

- ◉ About FP/Contraceptives methods
- ◉ On the danger signs of abortion-related complications, locations of services, and family planning (FP)–related information and services
- ◉ Male involvement
- ◉ Need for timely referrals
- ◉ Facilities in the community offering PAC services
- ◉ PAC related policies

### **Advocacy**

- ◉ Increase community knowledge on the dangers of abortion-related complications, locations of PAC services, and family planning (FP)–related information and services.
- ◉ Train community advocates to break the silence on unsafe abortion and reduce the stigma associated with PAC
- ◉ Collect and use, data relevant case studies and stories to engage communities
- ◉ Support PAC advocates to reduce stigma within the community through support groups.
- ◉ Review and strategize based on lessons learnt.

### **Sample of Advocacy planning tool**

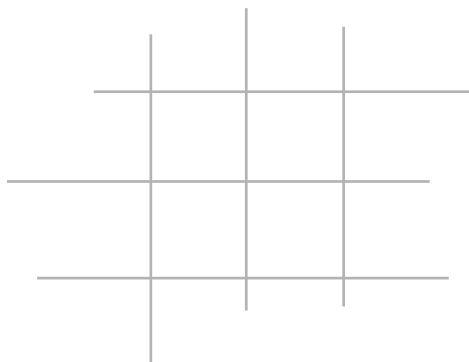
Who?	What?	How?	Where?	When?	Why?
e.g. SCHMT	Elements of PAC	Lecture/di scussion	Board room	Friday (date & Time)	To create awareness on PAC
CHVs	Consequences of unsafe abortion. o	Health talk	Chief's Barasa	Monday (Date & Time)	Sensitize them on their role

### **Creating Linkages and networking with other partners**

- ◉ RMNCH facilities
- ◉ Youth Friendly clinics
- ◉ SGBV Care and management.
- ◉ Gender and economic empowerment services
- ◉ Social welfare services
- ◉ Schools and colleges
- ◉ Churches
- ◉ Media
- ◉ Civil society organizations

### **Follow-up**

- ◉ Review and revise the existing Community strategy tools to include community PAC activities.
- ◉ Conduct monthly consultative meetings and report writing during dialogue and open days
- ◉ Use the data obtained to improve community PAC strategies.
- ◉ Establish Quality assurance and clinical audit teams
- ◉ Conduct operational research that engages quantitative and qualitative studies and address health system strengthening
- ◉ Linkages with other reproductive health programs and address vulnerable populations
- ◉ Liaise with MPDSR Committee, verbal autopsy committee and DHIS platforms towards legislative policy reforms and improvement of PAC tools





## CHAPTER 6: Establishing PAC 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 PAC services;

### Site Set-Up for Abortion Care:

While setting up PAC services it is important to consider

- a. **Space available and existing infrastructure for site set up**
- b. **Integration of PAC services with existing maternal health services- (Cervical cancer screening, family planning, HIV-counselling and Testing)**
- c. **Cadre and Number of Personnel available to provide PAC**
- d. **Where possible, the PAC room should be separate from the delivery room**
- e. **Where possible, PAC services should be offered in the outpatient department.**

### 1. Infrastructure:

Each facility should have a Post abortion care room or Post abortion care centre

The PAC room or the PAC Centre :

- Should be established with adequate space to facilitate service delivery

The PAC service set-up should have the following;

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

### 2. Equipment and supplies:

- i. **A PAC center/ room should be a one stop shop for provision of PAC and related linkage services.**
- ii. **It should contain the following 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> </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 needed medicine and supplies for post abortion care (MVA and MA)</i></p>		

### 3. Personnel

- a. The PAC centre or PAC room should be headed by a health care provider trained to provide and manage PAC services.
- b. All staff working in the PAC center and PAC room should be value clarified.
- c. Health care providers providing PAC 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).
- d. All Staff in the PAC unit should be trained and retained in the Unit to ensure continuity of PAC services and enhance on job training.

### 4. Access to services

- a. PAC services must be available as an emergency in all health care facilities.
- b. Proper referral pathways must be established in all health care facilities where service provision is not possible.
- c. Integrate PAC with other existing RH services including HIV counselling, Cervical cancer

screening and other RH services.

- d. On job training should be carried out in the PAC room/ PAC centre for service continuation.

## 5. Information Provision

- a) Avail information for PAC services in a language the woman understands.
- b) Provide counselling and decision- making support for PAC to the woman
- c) Informed consent should be obtained.

## 6. Arrangement and preparation for the procedure

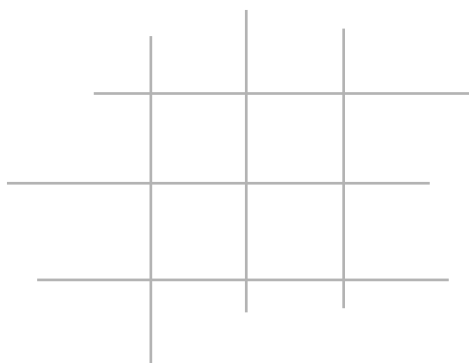
- a. The procedure room and equipment set up should be ready at all times (see site set -up checklist in relevant sections of this document).
- b. Accurate and complete patient and service documentation should be done in the relevant tools
- c. Ensure the privacy, respect and dignity of the patient at all points of the PAC counselling and procedure.

## 7. Sustainability

- a. Incorporate PAC in the Linda Mama program at your facility.
- b. Health facilities should ensure availability of resources to replenish PAC equipment and supplies.
- c. The hospital management should be engaged and sensitized on PAC services to support resource allocation for service continuity.

## 8. Quality Improvement:

- ⦿ A PAC 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 PAC program quality assurance.



## CHAPTER 7 : 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

#### **PAC data management**

- ⊙ PAC registers will be used to document service data accurately and consistently
- ⊙ PAC registers and all relevant reporting tools should be available in all the health facility offering PAC services

#### **Documentation and Research**

##### **i. Documentation**

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

##### **ii. 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.

#### **Support supervision**

- ⊙ Support supervision must be conducted to evaluate the program and provide and support continuous improvement strategies
- ⊙ PAC 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

### 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	
<p>Per vaginal bleeding Yes <input type="checkbox"/> No <input type="checkbox"/> Duration</p> <p>Pelvic pain or cramping Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Passed tissue Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Using a contraceptive method when conceived? Yes <input type="checkbox"/> No <input type="checkbox"/> Type</p> <p>Current medication</p> <p>Drug or food allergy Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>History of medical condition</p> <p>History of surgery</p>			
<b>Physical Examination</b>			
<p>Vital signs:</p> <p>Temperature _____ BP _____ Pulse _____ Respiration Rate _____</p> <p>Pallor: Yes <input type="checkbox"/> No <input type="checkbox"/></p>			
<p>Uterus:</p> <p>Size: _____ Tenderness: _____</p>			
<p>Speculum Examination:</p> <p>External Genitalia</p> <p>Vagina</p> <p>Cervix: Os open <input type="checkbox"/> Os closed <input type="checkbox"/></p> <p>Blood: (describe) _____</p> <p>Discharge (describe) _____</p> <p>Other signs: (products of conception, injuries, foreign objects, etc)</p> <p>Cervical motion tenderness Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Adnexa: Tenderness Yes <input type="checkbox"/> No <input type="checkbox"/> Mass Yes <input type="checkbox"/> No <input type="checkbox"/></p>			

<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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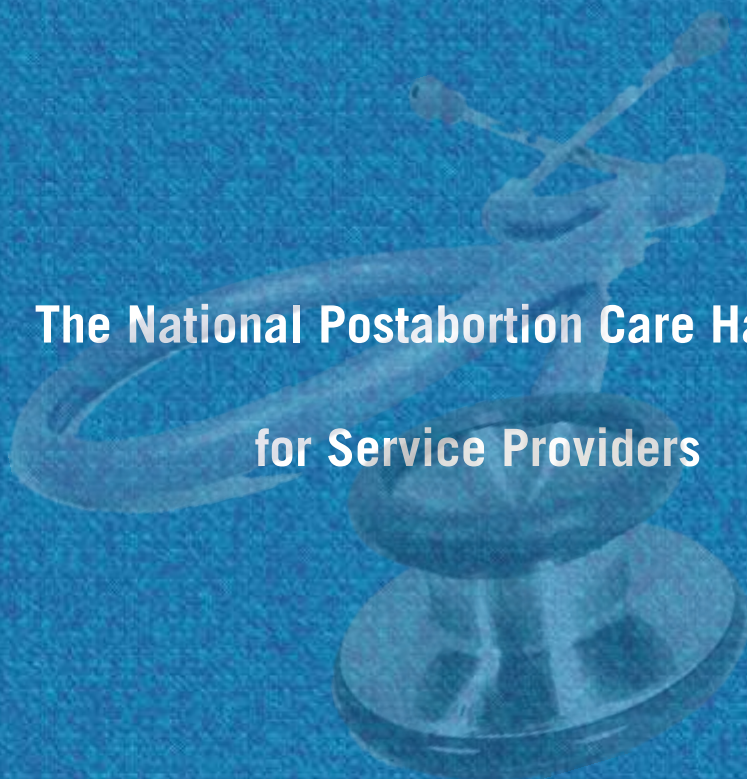




**REPUBLIC OF KENYA**



**MINISTRY OF HEALTH**



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