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Abbreviations

AAR  Africa Air Rescue
ABC  Abstain, Be faithful, use Condom
AIDS Acquired Immunodeficiency Syndrome
ANC  Ante – natal Care
B-HGG Beta sub unit of Human Chorionic Gonadotrophin
BP   Blood Pressure
BUN  Blood Urea Nitrogen
CAT  Cost Analysis Tool
Cm   Centimeter
COC  Combined Oral Contraceptive
D & C Dilatation and Curettage
DHMT District Health Management Team
DIC  Disseminated Intravascular Coagulopathy
DMPA Depo – Medroxy Progesterone Acetate
DOD  Date of Discharge
EC   Emergency Contraception
ECN  Enrolled Community Nurse
ECP  Emergency Contraceptive Pills
ECs  Emergency Contraceptives
FP   Family Planning
Four Cs Condoms, Contact tracing, Compliance, Counselling
GATHER Greet, Ask, Tell, Help, Explain, Refer (as used in counseling technique)
Qid  Four times Daily
Gm/dl Grammes/deciliter
GUD  Genital Ulcer Disease
HAO  Health Administrative Officer
Hb.  Haemoglobin
HBV  Hepatitis B Virus
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<td>HLD</td>
<td>High Level Disinfection</td>
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<td>HO</td>
<td>Hand Out</td>
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<td>HMS</td>
<td>Health Information Management System</td>
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<td>HPV</td>
<td>Human Papiloma Virus</td>
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<td>Full Form</td>
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<tr>
<td>OT</td>
<td>Operating Theatre</td>
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<tr>
<td>PAC</td>
<td>Post-abortion Care</td>
</tr>
<tr>
<td>PATH</td>
<td>Program of appropriate Technology in Health</td>
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<tr>
<td>PCV</td>
<td>Packed Cell Volume</td>
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<tr>
<td>PHC</td>
<td>Public Health Care</td>
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<tr>
<td>PID</td>
<td>Pelvic Inflammatory Disease</td>
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<td>POCs</td>
<td>Products of Conceptions</td>
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<td>POP</td>
<td>Progestin Only Pill</td>
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<td>PR</td>
<td>Pulse Rate</td>
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<td>PRIME</td>
<td>Primary Providers Training in RH</td>
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<tr>
<td>Q&amp;A</td>
<td>Questions and Answers</td>
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<td>RCO</td>
<td>Registered Clinical Officer</td>
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<td>Rh</td>
<td>Rhesus</td>
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<td>RIA</td>
<td>Radio Imuno Assay</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>RTA</td>
<td>Road Traffic Accident</td>
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<td>RTIs</td>
<td>Reproductive Tract Infections</td>
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<td>SC</td>
<td>Sharp Curettage</td>
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<td>SDPs</td>
<td>Service Delivery Points</td>
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<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<tr>
<td>STIs</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TBAs</td>
<td>Traditional Birth Attendances</td>
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<tr>
<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
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<tr>
<td>WHO</td>
<td>World Health Education</td>
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This National Post-Abortion Care Curriculum was borne out of the need to harmonize and standardize the various curricula used in Kenya to train PAC service providers. This effort came in the wake of the Ministry’s decision to allow the training in, and provision of PAC services by nurses and clinical officers, a practice previously reserved for medical doctors only. This adjustment in policy was necessitated by the global and local trends in maternal mortality.

Every year over 600,000 maternal deaths occur worldwide, mostly in the developing countries. These women leave behind millions of motherless children whose survival is precarious due to lack of emotional support and maternal care. In Kenya, the maternal mortality rate stands at 590/100,000 live births. Maternal deaths represent 27 percent of all deaths to women aged 15 – 49 years. Among these deaths, abortion-related complications contribute one third of all the maternal deaths. Abortion-related deaths can be prevented by using strategies such as capacity building for management of complications of abortion by training paramedics in PAC, upgrading rural health facilities to provide PAC services and providing support supervision to rural health workers trained in PAC.

In taking PAC services nearer to the people, the Ministry has embarked on training nurses and clinical officers in the provision of these services. In contrast to the limited number of doctors and their skewed distribution in favour of urban areas and hospitals, health personnel staffing patterns are such that there is at least a nurse or clinical officer at every health facility. Studies have shown that trained nurses and clinical officers can efficiently carry out certain procedures previously reserved for medical doctors, including the provision of PAC services. This competency-based Comprehensive PAC Curriculum is targeted at meeting the pre-service and in-service skills needs of the various PAC service providers, be they doctors, clinical officers or nurses. To meet both needs, this curriculum has been designed in a modular format to allow for easy learning and application.

I note with appreciation that a lot of work has gone into the preparation of this document. It is my wish and desire that many clinical officers and nurses will be trained in, and take the lead in providing comprehensive PAC services, particularly at health centre level to supplement the services currently being provided by the few doctors in public service.

Dr. Richard O. Muga, MBS, OGW
Director of Medical Services
Ministry of Health
ACKNOWLEDGEMENTS

The development of this Postabortion Care Curriculum has involved wide consultation with many individuals and organizations involved in reproductive health work in Kenya. Undertaken under the auspices of the Ministry of Health, the work has benefited from inputs made in meetings and workshops attended by reproductive health experts, managers, trainers and implementers. Based on the logic that it is better to adopt and adapt existing material and technology than re-invent the wheel, advantage was taken of PAC curricula and materials used and available in and outside Kenya. The curricula and materials used in this effort are included in the References section of this curriculum.

The Ministry of Health would like to thank institutional and individual members of the Kenya PAC Working Group who spearheaded and guided this effort. Thanks are also due to the Ministry’s own Regional Reproductive Health Supervisors who, in collaboration with selected experts, reviewed and refined the contents and presentation of this curriculum in a series of meetings and workshops sponsored by the USAID-financed AMKENI Project.

The Ministry would also like to acknowledge the efforts of the Division of Reproductive Health, which in collaboration with the Nursing Council of Kenya, the Clinical Officers Council, the Kenya Medical Training College and the University of Nairobi’s departments of Obstetrics and Gynaecology and Nursing, guided the development of this curriculum to completion.

Finally, this product would not have been possible without the contributions of many individuals and organizations. The following organizations and personnel are recognized for their efforts:

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Thank you all for rising to the challenge.

Dr. Josephine G. Kibaru
Head, Division of Reproductive Health
Ministry of Health
This curriculum has been presented in sixteen interrelated modules as listed in the table of contents. A brief overview and general objectives are presented at the beginning of each module. Trainer preparation and materials required are also included. Each module consists of several sessions. Training methodology and evaluation approaches are also suggested. The trainers may adapt these and or employ others to suit the particular learner group. The trainer is urged to deepen his/her knowledge through review of the suggested references.

The trainer will note that the schedule introduces Clinical Practice and MVA earlier than in the traditional approaches of beginning with general and moving to the specific. This is done to help trainees to be prepared for the first day in the comprehensive PAC training site.

**Primary User of this Curriculum**

The primary user of this curriculum are comprehensive PAC TRAINERS.

**Other Users of the Curriculum**

These are listed below:

**a) On-Site or distance based reproductive health supervisor.**

- He/she will use:
  - The checklists and appropriate FP/PAC/RH service to identify technical assistance needed to strengthen the PAC providers skills/practice. He/she will ensure this assistance is provided in a timely manner.
  - The list of equipment, supplies and materials needed for providing quality comprehensive PAC service, to ensure a sustainable system for availing those is in place.
  - PAC provider guidance in record keeping ensuring that in the long term, PAC data will be integrated with other RH data.
b) Programme Manager will use the curricula to ensure that the:

- Post training tasks of the trained comprehensive PAC service provider will be recognized officially and explicitly reflected in the job description of the comprehensive PAC provider.

- Support to the supervisors and in turn the comprehensive PAC provider does lead to “training that has impact/results on service.”

c) Technical Assistance to providers and funding agencies

- They will use the curriculum to ensure it is part of the assistance provided to Kenya Ministry of Health.

**Trainee Selection Criteria**

- Currently licensed and practicing as a nurse/midwife clinical officer or medical Doctor in Kenya (FP training is an added advantage).

- Must be able to conceptionalize the benefits of comprehensive PAC and practice it.

- Must be working in areas dealing with Reproductive health clients including the casualty department.

- Post-training deployment should be to RH areas i.e, MCH/FP, Obs/gynaec casualty).

- Must demonstrate willingness and ability to offer comprehensive PAC services within 3 months after training.

- Show willingness to conduct on-job training for others at the his/her working station.

**Planning The Centralized Group Training**

- It is anticipated that each training team will adopt and/or adapt the curriculum to suit the trainees’ and trainer team’s characteristics as well as the format recommended by the trainer team’s organization.

- At least five planning days are suggested before starting the first training and one before subsequent training. During this period trainers should:

  - Review the whole curriculum to familiarize themselves with all the materials presented in order to identify the training materials that need to be prepared such as newsprints, handouts, monitoring tools that require modification. Also to assemble and familiarize in the use of available equipment, CD-Rom, slides and video films.
- Model session plans for each module applies the seven step “Experiential Learning Cycle” (ELC). The use of seven step ELC is one of the training standards for session presentation. It is our sincere belief that all sessions will be presented using ELC.

- Prepare other additional/required training materials, including trainees materials.

- Visit the practical area e.g. (gynae ward/or PAC/MVA room and/or community) and in consultation with the officer in-charge or leader identify clients or community members who could agree to participate in trainee clinical or community involvement practice sessions. Be oriented to the procedure of the ward or PAC/MVA room on PAC client care in order that the training should not interfere with that section's practices. Similarly, if community involvement practice, is scheduled, learn how your trainees and trainers are expected to behave in the community.

- Review registers and other forms used for recording comprehensive PAC activities and relevant Health Management Information System (HIMS) documents before training and plan how you will guide trainees in using them.

- Prepare simulations that will be conducted to help each trainee acquire safe and acceptable exit level of competence.

**Expected Outcome After Training**

- Because the comprehensive PAC trainees have adequate entry level FP/RH and resuscitative skills, by the end of training they are expected to have achieved the following:
  - Positive attitudes towards post abortion clients and comprehensive PAC generally.
  - Updated FP, STD skills including care during interaction, MVA and other procedures.
  - Updated community involvement skills.
  - Updated infection prevention skills.
  - Updated skills in record keeping, screening and treating clients.
  - Developed individual skills application action plans which include establishing and strengthening the involvement of the community in their catchment areas for comprehensive PAC service access.
  - Identified how to advocate comprehensive PAC and source of comprehensive PAC messages.
  - Commitment to train at least one co-worker on job as comprehensive PAC provider.
Creating A Positive Training Climate

A positive training environment does not come about by accident, but through careful planning. This planning takes thought, time, preparation and often some study on the part of the clinical trainer. Although no one can anticipate everything that can happen during a training course, the objective is to minimize the unexpected and then deal with any unplanned events as gracefully as possible.

- It is important for the clinical trainer to know basic information about participants:
  - **How many** participants will be attending the course. For the clinical trainer to plan for seating arrangements, course materials and clinical activities.
  - **Why** the participants enrolled in the course. Knowing why they are attending and how they feel about coming to the course is important for the clinical trainer.
  - **The experience and educational background** of the participants. The clinical trainer should attempt to gather as much information as possible about participants prior to training. The trainer will therefore ensure that each trainee completes a biodata form on the day of arrival before the training starts to assist the trainer meet the trainee’s needs without wasting time on what he/she already knows or is doing.
  - **The types of clinical responsibilities** participants will perform in their daily work after training. Knowing the exact nature of the work that participants must perform after training is critical to the clinical trainer. It is important to use appropriate, job-specific examples throughout the course so that participants can draw connections between what is being taught and what they will need to do. This is an excellent way to reinforce the importance of what is being learned.
  - **The socio-cultural background** of the participants. Beliefs and values are a critical part of acceptance or rejection of postabortion care services. Thus they must be considered when conducting the training course.
  - In some cases the clinical trainer may be responsible for selecting the training methods and activities to be used in the course. Increasingly, however, clinical trainers are given a training package consisting of a reference manual, course schedule and outline, audiovisuals and competency-based knowledge and skill (performance) assessments. In this instance, clinical trainers may need to adapt the course to the local setting. Occasionally, supplemental or new materials needed to customize or localize the course must be developed in advance of training.
  - Even if most training activities and methods (e.g., case studies, group discussion, brainstorming, use of assessment instruments) are specified in a training package, considerable thought and planning are needed to determine the **timing, sequence** and
progression from one activity to another.

- Establishing and maintaining a positive training climate during training depends on how the clinical trainer delivers information because the trainer sets the tone for the course. In any course, how something is said may be just as important as what is said.
  - Try to make logical and smooth transitions between topics. Where possible, link topics so that the concluding review or summary of one presentation introduces the next topic. In any case, clearly state the beginning of a new topic and use audiovisual aids (flipchart or projection screen) to show it. Abrupt transitions between topics can cause confusion.
  - Remember that comprehensive PAC involves consideration of intimate issues. Sexual matters may be difficult to talk about because they involve strongly held views, taboos and religious beliefs. Using simple words that are acceptable to participants will encourage them to do the same when they work with clients and fellow staff members.

**Opening Activities**

During the opening session, participants should be introduced to the course and to each other. As a group, they will discuss the goals, objectives, schedule, logistical arrangements and general organization of the course. Begin with the following:

- **Welcome** the participants to the training facility. Introduce yourself and other clinical trainers and support staff.

- **Introduce** participants to each other using a warm up activity. Even when participants already know each other, the clinical trainer needs to become acquainted with the participants.

- **Survey** participant expectations about the course, using an exercise such as one of the following:
  - Give participants slips of paper and ask them to write down at least three things they would like to learn during the training. Ask them to attach their slips to a poster board or piece of flipchart paper which is posted in the classroom. The clinical trainer can then review these expectations with the group and tell them which topics will and will not be covered. This activity also can help the clinical trainer focus the course on individual or group learning needs and interests.

  - Brainstorm a list of topics the participants would like to learn about during training.

  - Ask the participants to complete the following statements and write their responses on a piece of paper:

    “In this course, I expect to learn the following about (course
subject; for example, comprehensive PAC)…”
“I have the following questions about (Comprehensive PAC services)....”
“My greatest concern about learning (Comprehensive PAC) is. . .”

- Divide the participants into small groups. Ask each group to discuss their responses and compile a list of their expectations. As each group reports back, record their expectations on a flipchart.

- For each of these activities, the clinical trainer should conclude by discussing which expectations can or will be met during the course and how the course schedule can be modified if necessary.

The final stage of clinical skill development involves performing the procedure with clients. Anatomic models, no matter how realistic, cannot substitute entirely for the reality of performing the procedure with a living, breathing, feeling and reacting human being.

The disadvantages of using real clients during clinical skills training are obvious. Clients may be subjected to increased discomfort or even increased risk of complications when procedures are performed by unskilled clinicians. To minimize these risks, it is recommended that the following guidelines be observed:

- When possible and appropriate, participants should be allowed to work with clients only after they have demonstrated skill competency and some degree of skill proficiency on an anatomic model or in a simulated situation.

- During pre-operative counseling, clients should be informed that their procedure will be performed by a clinician-in-training under the supervision of an experienced clinical trainer. Standard clinic practices regarding counseling and signed informed consent should be followed.

- The clinical trainer should be present in the operating or procedure room when participants are performing clinical procedures. Furthermore, the clinical trainer should be ready to intervene if the client’s safety is in jeopardy or if the client is experiencing severe discomfort.

- Clients should be chosen carefully to ensure that they are appropriate for clinical training purposes. For example, participants should not work with “difficult” clients until they are proficient in performing the procedure.
Client’s Rights During Clinical Training

- The rights of the client to privacy and confidentiality should be considered at all times during a clinical training course. When a client is undergoing a physical examination it should be carried out in an environment in which the right to bodily privacy is respected. When receiving counseling, undergoing a physical examination, or receiving surgical contraceptive services, the client should be informed about the role of each individual involved (e.g., clinical trainers, individuals undergoing training, support staff, researchers, etc.).

- The client’s permission should be obtained before having a clinician-in-training observe, assist with or perform any services. The client should understand that s/he has the right to refuse care from a clinician-in-training. Furthermore, a client’s care should not be rescheduled or denied if she does not permit a clinician-in-training to be present or provide services. In such cases, the clinical trainer or other staff member should perform the procedure. Finally, the clinical trainer should be present during any client contact in a training situation.

- Clinical trainers must be careful about how coaching and feedback are given during training with clients. Corrective feedback in a client situation should be limited to errors that could harm or cause discomfort to the client. Excessive negative feedback can create anxiety for both the client and the clinician-in-training.

- It can be difficult to maintain strict client confidentiality in a training situation when specific cases are used in learning exercises such as case studies and clinical conferences. Such discussions should always take place in a private area where other staff and clients cannot overhear and should be conducted without reference to the client by name.

Being a Good Clinical Trainer

Health professionals conducting clinical training courses are continually changing roles. They are trainers or instructors when presenting illustrated lectures and giving classroom demonstrations. They act as facilitators when conducting small group discussions and using role plays and case studies. Once they have demonstrated a clinical procedure, they then shift to the role of the coach as the participants begin practicing.

- Coaching is a training technique in which the clinical trainer:
  - Describes the skills and client interactions that the participant is expected to learn.
  - Demonstrates (models) the skill in a clear and effective manner using training aids such as slide sets, videotapes and anatomic models.
  - Provides detailed, specific feedback to participants as they
practice the skills and client interactions using the anatomic model and actual instruments in a simulated clinical setting and as they provide services to clients.

- Some of the characteristics of an **effective coach** include:
  - Being patient and supportive.
  - Providing praise and positive reinforcement.
  - Correcting participant errors while maintaining participant self-esteem.
  - Listening and observing.

Every presentation (training session) should begin with an introduction/climate setting to capture participant interest and prepare the participant for learning. After the introduction/climate setting, the clinical trainer may deliver content using an **illustrated lecture, demonstration or small group activity**. Throughout the presentation, **questioning** techniques can be used to encourage interaction and maintain participant interest. Finally, the clinical trainer should conclude the presentation with a summary of the key points or steps.

- The first few minutes of any training session are critical. Participants may be thinking about other matters, wondering what the session will be like, or have little interest in the topic. The introduction should:
  - Capture the interest of the entire group and prepare participants for the information to follow.
  - Make participants aware of the trainer’s expectations.
  - Help foster a positive training climate.

- A **summary** is used to reinforce the content of a presentation and provide a review of its main points. The summary should:
  - Be brief;
  - Draw together the main points;
  - Involve the participants.

**Guidelines for Small Group Activities**

There are many times during training that the participants will be divided into several small groups that usually consist of four to six participants. Examples of small group activities include:

- **Solving a problem** that has been presented by the clinical trainer or another participant.
- **Reacting to a case study** that may be presented in writing, orally by the clinical trainer or introduced through
• Preparing a role play within the small group and presenting it to the entire group as a whole.

• Small group activities offer many advantages including:
  - Providing participants an opportunity to learn from each other;
  - Involving all participants;
  - Creating a sense of teamwork among members as they get to know each other;
  - Providing for a variety of viewpoints.

• Once the groups have completed their activity, the clinical training facilitator will bring them together as a large group for a discussion of the activity. This discussion might involve:
  - Reports from each group;
  - Responses to questions;
  - Role plays developed in each group and presented by participants in the small groups;
  - Recommendations from each group.

• It is important that the clinical trainer provide an effective summary discussion following small group activities. This provides closure and ensures that participants understand the point of the activity.

Case Study

A case study is a training method using realistic scenarios that focus on a specific issue, topic or problem. Participants typically read, study and react to the case study in writing or orally during group discussion. The primary advantage of the case study is that it focuses the attention of the participant on a real situation. Participants may work separately or in small groups to solve or complete a case study.

Advantages of using a case study are listed below:

• It is a participatory method of training that actively involves participants and encourages them to interact with each other.

• Participants react to realistic and relevant cases that directly relate to the training course and often to their work environment.

• Reactions often provide different perspectives and different solutions to problems presented in the case study.
Reacting to a case study helps participants develop problem-solving.

Case studies can be developed by the clinical trainer or the participants. Situations for the case studies can be found in one or more of the following sources:

- Clinical experiences;
- Medical histories/records, clinical journals, etc.;
- Experiences from clinic staff, participants or clients;
- After the participants have read the case study, either individually or in small groups, they should be given the opportunity to react to it. Typical reaction exercises include:
  - **Analysis of the problem.** The participants are asked to analyze the situation presented in the case study and determine the source of the problem.
  - **Focused questions.** These inquiries ask the participants to respond to specific questions.
  - **Open-ended questions.** These questions provide the participant more flexibility in responding.
  - **Problem solutions.** The participant is asked to offer suggestions regarding the situation being presented.

Once participants have reacted to the case study they should be given the opportunity to share their reactions. This sharing might take the form of one or more of the following:

- **Reports** from individuals or small groups;
- **Responses** to questions about the case study;
- **Role plays** presented by individuals or small groups;
- **Recommendations** from individuals or small groups.

The clinical trainer should then summarize the results of the case study activity prior to moving on to the next topic.

**Role Play**

A role play is a training method in which participants play out roles in a situation related to the training objectives. **Advantages** of role plays include:

- Role plays can create a highly motivational climate because participants are actively involved in a realistic situation.
- Participants can experience a real life situation without having to take real life risks.
- Role play gives participants an understanding of the client’s situation.

To conduct the role play, the clinical trainer should:

- Decide what the participants should learn from the role play
(the objectives);
- Devise a simple situation;
- Explain what the participants should do and what the audience should observe;
- Discuss important features of the role play by asking questions of both the players and observers;
- Summarize the session, what was learned and how it applies to using the clinical skill or activity being learned.

The **group discussion is a training method in** which most of the ideas, thoughts, questions and answers are developed by the participants. The clinical trainer typically serves as the **facilitator** and guides the participants as the discussion develops.

- **Group discussion is useful:**
  - At the conclusion of a training session;
  - After viewing a videotape;
  - Following a clinical demonstration;
  - After reviewing a case study;
  - After a role play;
  - Any other time when participants have prior knowledge or experience related to the topic.

- In addition to group discussion which focuses on the session objectives, there are two other types of discussions that may be used in a training situation:
  - **General discussion** that addresses participant questions about a training event (e.g., why one technique of tubal occlusion is preferred over another in minilaparotomy);
  - **Panel** discussion in which a moderator conducts a question and answer session between panel members and participants.

**Conducting an Effective Clinical Demonstration**

- When introducing a new clinical skill, a variety of methods can be used to demonstrate the procedure. For example:
  - Show **slides** or a **videotape** in which the steps and their sequence are demonstrated in accordance with the accepted performance standards.
  - Use **anatomic models** such as pelvic models to demonstrate the procedure and skills.
  - Perform **role plays** in which a participant or surrogate client simulates a client and responds much as a real client would.
- Demonstrate the procedure with clients in the operating or procedure room.

- In addition, participants should use a clinical skills learning guide developed specifically for the clinical procedure to observe the clinical trainer’s performance during the initial demonstration. Doing this:
  - Familiarizes the participant with the use of competency-based learning guides;
  - Reinforces the standard way of performing the procedure;
  - Communicates to participants that the clinical trainer, although very experienced, is not absolutely perfect and can accept constructive feedback on her/his performance.

- As the role model the participants will follow, the clinical trainer must practice what s/he demonstrates (i.e., the approved standard method as detailed in the learning guide). Therefore, it is essential that the clinical trainer use the standard method. During the demonstration, the clinical trainer also should provide supportive behavior and cordial, effective communication with the client and staff to reinforce the desired outcome.

**Using Anatomic Models for Clinical Training**

Anatomic models often used in clinical training courses include:

- ZOE gynecologic simulator (a full-sized, adult female lower torso [abdomen and pelvis]), used for training in:
  - Bimanual pelvic examination including palpation of normal and pregnant uteri;
  - Vaginal speculum examination;
  - Visual recognition of normal and abnormal cervices;
  - Uterine sounding;
  - IUD insertion and removal;
  - Diaphragm sizing and fitting;
  - Laparoscopic inspection and occlusion of fallopian tubes (Falope rings or other clips);
  - Minilaparotomy (both interval and postpartum tubal occlusion);
  - Treatment of incomplete abortion using manual vacuum aspiration (MVA).

- The advantages of using anatomic models include:
  - Clients are not harmed or inconvenienced if a mistake is made.
  - The demonstration or practice can be stopped at any time for further explanation or correction by the clinical trainer.
  - Several participants can practice simultaneously, reducing
training time.
- Practice is not limited to the clinic or operating room or during the time when clients are scheduled.
- Practice of a skill or sequence of steps can be repeated at any time and as often as needed.
- Clinical skills training is possible even where the client caseload is low because fewer cases are needed for participants to attain skill competency.
- Training time is reduced.
- When using models in clinical skills training, it is important that:
  - Sufficient models are available (usually one model for two, or at most, three participants).
  - The model is positioned as if it were a client. This enables the participant to perform the skill/activity as it will be performed with clients.
  - Conditions, such as instruments used to perform the procedure and recommended infection prevention practices, duplicate the real situation as much as possible.
  - The model is treated gently and with the same respect given an actual client.

1. Climate Setting
   - What the trainer does in order to:
     - Develop an atmosphere for learning.
     - Help learners begin thinking about the theme of the session
     - Stimulate learner interest, curiosity and create readiness for learning about the subject.
     - Link the session to previous ones and show where it fits in the training activity.

2. Objectives (session objectives)
   - Presenting objectives provides a chance for learners to describe what they will do or display as a result of the training/learning activities/experience of the session
   - Objectives give a list of ideas on which to base self-learning by the end of the session

3. Experience
   - Activities in which the learner will be involved that enable the achievement of the objectives shared during Step 2 of the ELC. The content of the training is presented during this step.
• Commonly used “experiences” are participatory training methods such as small group work, demonstration, genuine lecture discussion, brainstorming, practice, role play, project, games, drama.

• Provides learner experiences based on which he/she will link real life to new learning and draw more learning’s for applying in work or real life situations.

4. **Processing**
   • Provides learner to share individual feelings and reactions to the experience.
   • Learner analyses and thinks through the various experiences he/she has just undergone
   • *NB: Should some learners share learning’s or applications of learning to work or life situations instead of reactions, the facilitator acknowledges them using feedback rules. Facilitator may then record them during the next step or step 6.*

5. **Generalizing**
   • Facilitator finds out from learners what:
     - Conclusions individuals have drawn from the experiential learning (step 3)
     - Major learning’s of individuals
   • Should learners express having had difficulty in any area, the facilitator notes these and informs the particular learner how to solve them or corrects the matter or plans with the learner next steps. These are also recorded on Newsprint for reference in subsequent sessions, if appropriate.

   *This is one of the times to remind participants to use their personal journal.*

6. **Application**
   • Facilitator reviews shared learning’s or summarizes them and asks individuals to:
     - Share how they will use the learning’s in the workplace or during the training
     - Or what they will do differently as a result of the learning’s.

   *Again this information is appropriate for individual journals.*

7. **Closure**
   • Facilitator reviews the session objectives to see whether they have been achieved
   • Facilitator him/herself or jointly with learners summarize the session, learning’s and applications in relation to objectives.
• He/she thanks the learners/participants for active and productive participation or other specific point.
• Links the session with next or provides an assignment/homework or distributes handouts for the session being closed.
• Informs the learners that the session is over
• Participants fill their journals after closure of session

**Conducting The Training**

• Use the session plans and other materials developed during the planning phase.
• Monitor knowledge and skills acquisition as described below and in other trainers guidelines. Be available for individual participants as needed.
• PAC procedures must be demonstrated by trainers and trainees observe and do a return demonstration through simulation and/or models before practicing on actual clients. Follow principles of using a Demonstration and the “Do as you Say” training approach, during demonstrations.
• During training, if the pace of trainee’s skill requisition does not match with the process and time suggested review and modify training methods and materials. Ensure that the set general and specific objectives are noted. Also negotiate with trainee’s extra curricular time for conducting training/learning activities which cannot be covered during the regular time.
• The curriculum may require use of the overhead projector, computer CD-Rom/DVD, LCD, TV monitor, video cassettes player (VCR) and 35mm slides and projector. Trainers who do not have overhead projector or slide projector may use the content meant for slides as handouts or trainee’s materials or newsprint.
• During the centralized training practicum, trainer should also provide one-on-one guidance to trainees. She/he should ensure that each trainee provides emergency care including at least 3 MVA procedures for incomplete abortion, practices new skills such as using chemicals for high level disinfection; taking history for comprehensive PAC service, recording client care provided, counseling for emotional support of a postabortion clients, holding a meeting for community involvement in comprehensive PAC service delivery etc.
• Throughout the training period trainer should encourage trainees to document what changes/applications of learning they intend to make in their work site and let them compile those which they feel are a priority at the end of the training, for application.

**Monitoring The Training**
• Outcomes of monitoring the training contribute to end of training recommendation for certifying participant.

• Trainer and trainee use the comprehensive PAC Performance Standards, FP Procedure Manual, STD Syndromic Charts, Checklists and steps of providing comprehensive PAC including Infection Prevention procedures to monitor skills acquisition. Conduct daily process reviews after each practicum. Provide immediate guidance and support to the trainee during training for upholding clients’ rights and service quality.

• Encourage individual trainee/trainer consultations or guidance.

• Help trainee’s link theory and practice through identifying opportunities during actual client care that build on theory provided.

• Remind the trainees that they too will monitor their own skills acquisition using the comprehensive PAC Performance Standards, FP Procedure Manual, STD Syndromic Management Charts, checklists and the Skills application Action Plans developed for their work sites.

**Evaluating Training**

• Use all the tools and methods of trainee assessment:
  - Administer the knowledge pre/post Training Questionnaire and share results with individual trainees during first week of training.
  - Use checklists/skills assessment tools, PAC Performance Standards and the Ministry of Health Kenya STD syndromic management flowcharts.
  - Administer participant reaction forms to evaluate the whole training.
  - Through daily and weekly trainers’ process reviews document the status of each trainee’s competence. Use this report.
  - Share daily relevant outcomes of evaluation with trainees and re-plan if appropriate.
  - Conduct a grand (end-of-training) process review.

**Certification**

**Trainers:**

• Recommend for certification or issue Certificates of competence immediately after completing the two weeks training, if the following has happened:
- Participant has performed all comprehensive PAC skills according to all standards based on a standard checklist.

- Or alternatively recommend for:

  (a) Certification and issuing Certificate of Competence at a later date, if:

    - Participant’s continuous skills assessment during training reveals limitation in critical skills for offering a complete comprehensive PAC service. Critical skills include those which:
      - Make comprehensive PAC service incomplete
      - Influence the safety of the comprehensive PAC services.

  (b) On job guidance or self directed learning that is needed to get the trainee reach certification level. Recommend a person to guide the participant at the practice site/work station.

- The two weeks training enables the graduate to achieve acceptable exit level of competence. Proficiency is expected to occur following deployment as a comprehensive PAC provider. However, as a newly qualified PAC service provider, one to one guidance at the work site would contribute to maintaining the skills acquired. It is hoped that the trainee’s supervisor will make this possible.

- Trainer must:

  - Help trainee to continue with learning through using job aids provided during the training and various procedures on FP/PAC/STD/HIV/AIDS. The source of these job aids include the FP Procedures Manual, and STD/HIV/AIDS manual, leaflets and posters.

  - Encourage the on-site supervisor to provide an atmosphere for self-directed learning.
## PROTOTYPE TRAINING SCHEDULE

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<th>TIME</th>
<th>1ST DAY</th>
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</table>
| 8.00 – 8.30 am | **Module 1 Session I**  
- Registration  
- Welcome |  
- Agenda  
- Warm up  
- Recap |  
- Agenda  
- Warm up  
- Recap |  
- Agenda  
- Warm up  
- Recap |  
- Agenda  
- Warm up  
- Recap | **PRACTICALS**  
(Optional) | **Tea break** |  
- **Module 5:**  
Pain control for MVA  
(1hr 40 min) |  
- **Module 7:**  
Infection Prevention and Processing of MVA Equipment  
(2hrs) |  
- **Module 10 cont’d:**  
(Effective Communication Skills)  
(3hrs 10 min) |  
- **Module 11 cont’d:**  
Effective communicatio n skills |
## PROTOTYPE TRAINING SCHEDULE

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</thead>
</table>
| 11.00 - 1.00 pm | **Module 1:** Session II: Introduction to Comprehensive PAC (1 hr)  
**Module 2:** Concept of Comprehensive PAC (1 hr 30 mins) | **Module 6:** Performing MVA Procedure (2 hrs 30 mins)  
**Module 9:** Values and attitudes related to PAC (2 hrs 30 min) | **Module 11:** Postabortion Counselling (4 hrs 30 min)  
**Module 12:** Post-abortion Contraception (3 hrs) | Site visit | Site visit | Site visit | Site visit |
| 1.00 - 2.00 pm | Lunch break                                   |                                             |                                             |                                             |                                             |                                             |                                             |
| 2.00 - 3.30 pm | **Module 3:** MVA Facts (1 hr)  
**Module 7:** cont’d Infection Prevention  
& Processing of MVA equipment for re-use (4 hrs) | **Module 10:** Effective Communication Skills (3 hrs 10 min)  
**Practicals (Flexible depending on availability of clients)** |                                             |                                             |                                             |                                             |                                             |
| 3.30 - 4.00 pm | Tea break                                     |                                             |                                             |                                             |                                             |                                             |                                             |
| 4.00 - 5.00 pm | **Module 4:** Client Assessment and Preparation (2 hrs)  
**Module 8:** Abortion Complications and Management (2 hrs) | **Practicals (Flexible depending on availability of clients)** |                                             |                                             |                                             |                                             |                                             |
| 5.00 - 5.30 pm | • End of day evaluation  
• Summary  
• Reading Assignment  
• End of day evaluation  
• Summary  
• Reading Assignment | • End of day evaluation  
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• Reading Assignment |

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*National Post Abortion Care Curriculum for Service Providers*  
*xxxiii*
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<tr>
<th>TIME</th>
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<td>• Module 7:</td>
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<td>10.30 – 11.00 a.m.</td>
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<td>1.00 – 2.00 p.m.</td>
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<td>(Infection Prevention Continued)</td>
<td>(Postabortion counseling continued)</td>
<td>(Keeping and maintaining Records)</td>
<td>(Community and service provider partnerships)</td>
<td>Assessment Action Plan</td>
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<td>4.30 – 5.00 p.m.</td>
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<td>CLOSING CEREMONY</td>
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| 2.00 - 4.30 pm | **PRACTICALS**  
(Flexible depending on availability of clients) |
|----------------|-----------------------------------------------|
|                | • End of day evaluation  
• Summary  
• Reading Assignment | • End of day evaluation  
• Summary  
• Reading Assignment | • End of day evaluation  
• Summary  
• Reading Assignment |
Total Time
2 hrs
(Including Background)

Module 1 - Session 1

Developing a Climate for Learning

Session Summary:
The climate setting session orients the trainee to the PAC training as part of other Reproductive Health Services in the country and districts. The need for working in partnership with other providers, all sectors and the community is emphasized from the start of the two weeks training program. Participants get the feel of taking an active part in their learning through sharing expectations and norms, reviewing the objectives and monitoring evaluation approached.

General Objective
By the end of this session, participants will be able to:
1. Develop a climate for learning.

Specific Objectives
By the end of this session, participants will be able to:
1. Address at least half of their fellow participants and facilitators by preferred names
2. Identify their individual strengths and limitations based on pretraining knowledge questionnaire.
3. Share individual expectation about the training
4. Agree on the norms set by participants and facilitators
5. Explain in their own words, the rationale of the Comprehensive PAC Clinical Skills Training and relation to other RH activities in their district or work stations.
6. Cite:
   - Post Training tasks of a Comprehensive PAC provider
   - Comprehensive PAC Program Goal.
   - Comprehensive PAC Training General and Specific Objectives
7. Explain the monitoring and evaluation system used in Comprehensive PAC training.
1.2 Trainee Materials

**Handouts**

1. Participants’ biodata form.
2. Training schedule.
3. Pre-course knowledge questionnaire
4. Trainee’s Journal
5. Trainee’s Daily Evaluation form
## PROTOTYPE TRAINING SCHEDULE

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- Recap  
- Agenda  
- Warm up  
- Recap  
- Agenda  
- Warm up  
- Recap  
- Agenda  
- Warm up  
- Recap | Tea break | Tea break | Tea break | Tea break | Tea break | PRACTICALS (Optional) |
| 8.30 – 10.30 am| Introduction  
- Participants’ expectations  
- Group norms  
- Pre Course questionnaire  
- Biodata form  
- Logistics/admin. Issues  
- Course goal, objectives and schedule  
- Review of course materials  
- Review of course evaluation system  
- Opening (2hrs) | Module 5: Pain control for MVA (1hr 40 min) | Module 7: Infection Prevention and Processing of MVA Equipment (2hrs) | Module 10 cont’d: (Effective Communication Skills) (3hrs 10 min) | Module 11 cont’d: Effective communication skills |
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<td><strong>Module 2: Concept of Comprehensive PAC (1hr. 30 mins)</strong></td>
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<td><strong>Module 16</strong> (Sustainability continued)</td>
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Participants Bio Data form:
Comprehensive Postabortion Care Clinical Skills Training

Instructions
The trainee, at the beginning of the training, should complete this form. The information helps the trainer to verify the consistency of the trainee’s background selection criteria and the training being undertaken.

Activity Title _________________________________________________________

Date of Activity __________________________________

General Information
1. Participant Name_________________________________________________________________________________
   Surname          First          Middle          Mrs ( )  Miss ( )  Mr ( )  Dr ( )

2. Sex: Male____ Female____

3. Job Title/Designation ______________________________________  Position_____________________________________

4. Contact Address
   (a) Name of Facility/Work station_____________________________ (b) Facility Address___________________________
   (c) Location ___________ (d) Division ___________ (e) District ___________ (f) Province_______________________
   (g) Facility Contact: Phone number_______________ (h) Fax number___________ (i) E-mail____________________
   (j) Personal mobile phone No.________________ (k) Section where deployed/Stationed ________________________

5. Number of Years of formal Education
   a. ....................... Years of primary school
   b. ....................... Years of secondary school
   c. ....................... Years of basic professional training school
   d. ....................... Years of university training

6. What is your current qualification? (Tick only ONE)  

<table>
<thead>
<tr>
<th>Professional category</th>
<th>Tick if Yes</th>
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<tbody>
<tr>
<td>Enrolled Nurse/Enrolled community Nurse/Enrolled Midwife</td>
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<tr>
<td>Registered Clinical Officer</td>
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<tr>
<td>Registered Nurse/Registered Community Health Nurse/Registered Midwife</td>
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<tr>
<td>Doctors</td>
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<tr>
<td>BSc Nursing</td>
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<td>Other, specify</td>
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7. Are you currently providing family planning services?  Yes___ No___

8. Have you ever attended any other reproductive health training course?  Yes___ No___
If yes, tick ALL that apply and list the year(s) attended and the sponsoring organization

National Post Abortion Care Curriculum for Service Providers
Trainees Handbook
1-6
<table>
<thead>
<tr>
<th>Type of Course</th>
<th>Tick if yes</th>
<th><strong>Level</strong></th>
<th>Year attended</th>
<th>Sponsoring Organization</th>
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<tbody>
<tr>
<td>Counselling STI/HIV/AIDS</td>
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<td>FP counselling Skills Course</td>
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<td>ML/LA training</td>
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<td>Performance Improvement (PIA)</td>
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<td>PAC training</td>
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<td>NS Vasectomy</td>
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<td>Norplant Insertion/removal</td>
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<td>STI Synchronous management</td>
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<td>Certificate Course (basic family planning; 6week)</td>
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<td>Contraceptive Technology Update (CTU)</td>
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<td>IUCD on the job Training Program</td>
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<td>Dispensary/8-Day course</td>
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**Level 1= Refresher  2= Orientation  3= Skills  4= Update**

9. How many years have you been in health service? ________ Years

10. What are your responsibilities at your current workstation? (Rank main responsibility as number 1)

   ___ Provider of MCH/FP services
   ___ Provider of obs/gynae services
   ___ In service trainer (DTC trainee, other in service trainer)
   ___ Preservice tutor (Nursing school tutor, clinical officer instructor)
   ___ Clinical preceptor/ Clinical officer instructor (designated clinical trainer)
   ___ Other (Specify: __________________________________________________________)

11. Indicate the type of work station/ Facility where you are currently posted, according to the list below:

   ___ Hospital (or equivalent) ___ Health Centre/Clinic (or equivalent)
   ___ Dispensary (or equivalent) ___ Nursing/Midwife/Clinical Officer School (or equivalent)
   ___ Other (Specify: __________________________________________________________)

12. Is this work station/Facility **tick only one**:

   ___ Ministry of Health ___ Local Government
   ___ NGO (FPAK, CHAK, SDA) ___ Private (nursing home, industry-based)
   ___ Other (specify: __________________________________________________________)
13. Professional Experience: What FP jobs do you do? Please tick (✓) in appropriate column and indicate for how long you have done them.

<table>
<thead>
<tr>
<th>Jobs</th>
<th>Length (weeks)</th>
<th>Months</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Client Education</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>b. Counselling clients for FP methods</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>c. Providing different FP methods</td>
<td></td>
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<tr>
<td>• IUCD</td>
<td></td>
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<tr>
<td>• Pills</td>
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<tr>
<td>• Injectables (Depo Provera)</td>
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<td></td>
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<tr>
<td>• Norplant/Jadell</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• LAM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Male condoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Female condoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Foaming Tablets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tubal ligation (BTL)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Vasectomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Natural FP Methods (CMM/BOM, Calendar)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. supervising FP services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Incharge of FP clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Other jobs, please specify</td>
<td></td>
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</tr>
</tbody>
</table>

14. Is your workplace

Urban ______________________________ Rural _____________________________ Both __________________
(tick as appropriate)
Trainee’s Journal

**Purpose**
- To have information important to you as the trainer or the trainee recorded for use during the training and after, at your work-site.

**Examples of important information**
- What I have learned from the sessions and experiences during training
- What I intend to do in order to keep improving on the new skills and knowledge that I have acquired.
- What Will I now do differently as a result of this training?
- What help do I need to perform the new acquired skills and apply the knowledge at my worksite?
- Who Will I contact for this assistance?

**How to keep the journal**
- Use a recording method of your choice, but it must be easy to find when needed.

**When do you collect the information?**
- During the session e.g. when discussing learning insights, what to do differently, what would I apply at my work.

**When will you use the information?**
- Any time during the training
- Near the end of the training for including in the skills application (back home) plan
- After the training, at your work-site

**Instructions**
- Use the information during all sessions when giving feedback or comments to speaker. (Trainer or trainee, client, community).
1. Which topic was most useful to you?

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..........................................................................................................................................................................................
..........................................................................................................................................................................................
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2. Which topic was least useful to you?

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3. Which topic was repetition to you?

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..........................................................................................................................................................................................

4. What other issues do you suggest to improve this workshop?

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..........................................................................................................................................................................................
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Introduction to Comprehensive PAC

Module Summary
This module describes magnitude of maternal mortality and morbidity globally and in sub-Saharan Africa, why women resort to abortion and the laws of Kenya regarding abortion. It touches on the constitutional law with regards to “the right to life”, the statutory law with regards to various felonies and effects of laws and regulations on provision of postabortion care.

General Objective
1. Demonstrate an understanding of the scope of abortion and its consequences globally, in Sub-Sahara Africa, in Kenya and within their communities.
2. Explain possible reasons why women resort to both safe and unsafe abortion
3. Explain the rationale of PAC services and its elements through a system that is widely accessible, cost effective and sustainable.

Specific Objectives
At the end of this session, the participants will be able to:
1. Discuss the magnitude of abortion globally, in sub-Sahara Africa and in Kenya.
2. Describe the consequences of unsafe abortion and its relationship with sexuality and method failure.
3. Describe the importance of integration of the components of RH services.
4. Describe the socioeconomic factors influencing RH status.
5. Describe the abortion Laws and Regulations in Kenya and how they impact on RH services.
Trainee Materials

• Handouts 1.5 - 1.9
Every year, nearly 600,000 maternal deaths occur worldwide, 99% of them in the developing countries and most of them preventable. Current maternal mortality ratios for almost all countries in Sub-Saharan Africa are still alarming as shown on the table below.

**Table 1-1: current Maternal Mortality ratios**

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>Maternal Mortality Ratio Per 100,000 Live Births</th>
<th>Total Fertility Rate</th>
<th>Rate of Use of Modern Methods of Family Planning among Currently Married Women</th>
<th>% of pregnancy related mortality attributable to unsafe abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia</td>
<td>871</td>
<td>5.9</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Guinea</td>
<td>750</td>
<td>5.5</td>
<td>4.9%</td>
<td>8%</td>
</tr>
<tr>
<td>Kenya</td>
<td>590</td>
<td>4.7</td>
<td>32%</td>
<td>35%</td>
</tr>
<tr>
<td>Malawi</td>
<td>560</td>
<td>6.8</td>
<td>6.3%</td>
<td>30%</td>
</tr>
<tr>
<td>Nigeria</td>
<td>1,000</td>
<td>6.0</td>
<td>3.5%</td>
<td></td>
</tr>
<tr>
<td>Tanzania</td>
<td>529</td>
<td>5.6</td>
<td>16%</td>
<td>20%</td>
</tr>
<tr>
<td>Uganda</td>
<td>1,200</td>
<td>6.9</td>
<td>8%</td>
<td></td>
</tr>
</tbody>
</table>

1Ethiopia DHS, 2001  
2Guinea DHS, 1993  
3Kenya DHS, 1998  
41990 figure from WHO World Health Report  
5Uganda DHS, 1995 (includes WHO estimates)  
61998 figure from 1999 WHO World Health Report  
8Guinea DHS, 1999  
9Malawi DHS 1992

Many pregnancy-related deaths are due to delays. These include delays in:

- **Recognizing** that a problem exists (many feel that certain problems are “normal” in pregnancy);
- **Deciding** to seek care (gender roles sometimes dictate who can decide when a woman seeks health care, women who have received poor quality care in the past may be reluctant to seek care, and women...
suffering from abortion-related complications may fear reprisals or negative attitudes);

- **Reaching** a health facility (rural populations may have little access to transportation and roads, are often poor, especially during rainy seasons); and

- **Receiving** care once at the facility (many facilities do not offer comprehensive essential obstetric care including comprehensive postabortion care. Poorly staffed and equipped sites may result in delays in treatment. Service provider may also have negative and punitive attitude to postabortion clients, which may lead to more delay.

- These women leave behind millions of motherless children whose survival is precarious due to lack of maternal support and care. Children who are left motherless due to maternal mortality are up to ten times more likely to die within two years that children with two living parents (Safe Motherhood Website 2002). In developing countries alone, maternal mortality ratios range from 190 per 100,000 live births in Latin America and the Caribbean to 870 per 100,000 in Africa. Overall ratios of more than 1000 per 100,000 are found in Eastern and Western Africa. Of all women who become pregnant, half of them are unplanned and some resort to abortion by unskilled persons or in conditions where minimum health standards are not maintained.

- An estimated 36 to 53 million induced abortions are performed each year worldwide, and almost half of these – (up to 20 million) are unsafe, 40 each minute and 95% in developing countries. There are 80,000 abortion related deaths annually; 13% of all maternal deaths worldwide. In other words, between 30-50% of maternal mortality is contributed to by unsafe abortion. For every woman who dies of unsafe abortion, many more suffer serious injuries and permanent disability.

<table>
<thead>
<tr>
<th>Lifetime Risk of Dying from Unsafe Abortion (WHO Estimates, 1998)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Europe</td>
</tr>
<tr>
<td>Latin America</td>
</tr>
<tr>
<td>Asia</td>
</tr>
<tr>
<td>Africa</td>
</tr>
</tbody>
</table>

- It is estimated that between 10% - 50% of all women who endure unsafe abortion need medical care for complications. The most common complications are incomplete abortions, sepsis, haemorrhage and intra-abdominal injury (i.e. perforation and tearing of the uterus). Common long term health problems caused by unsafe abortion include: chronic pelvic pain and PID, tubal blockage
and secondary infertility. Other potential consequences of unsafe abortion include ectopic pregnancy and increased risk of spontaneous abortions and premature delivery in subsequent pregnancies.

- In Kenya, maternal mortality in 1998 was 590:100,000 live births though WHO update states it as 650:100,000. Maternal deaths represent 27 percent of all deaths to women 15-49 years of age. On average, a Kenyan woman bears 4.7 children. A Kenyan woman has a lifetime risk of 1 in 36 chance of dying from maternal causes, though WHO update states it is 1 in 20.

<table>
<thead>
<tr>
<th>Lifetime Risk of dying from Pregnancy or Childbirth (WHO Estimates, 1997)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweden</td>
</tr>
<tr>
<td>United States</td>
</tr>
<tr>
<td>Kenya</td>
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<tr>
<td>Malawi</td>
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<tr>
<td>Nigeria</td>
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<tr>
<td>Senegal</td>
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<tr>
<td>Uganda</td>
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<tr>
<td>Ethiopia</td>
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<tr>
<td>Guinea</td>
</tr>
</tbody>
</table>

- Doctors constitute only 4% of all health workers in Kenya, and are mostly in urban areas. Doctor: population ratio is 1:10,000. The non-physician cadres cover primary health care institutions where traditionally, there were no doctors. There is at least one nurse or clinical officer at every health facility and they serve the majority of patients in the urban and rural areas.

- Comprehensive Postabortion care (PAC) is an approach for reducing morbidity and mortality from incomplete and unsafe abortion and resulting complications and for improving women’s sexual and reproductive health and lives. The five essential elements of comprehensive PAC are:

  - **Community and service provider partnerships** for prevention (of unwanted pregnancies and unsafe abortion), mobilization of resources (to help women receive appropriate and timely care for complications from abortion), and ensuring that health services reflect and meet community expectations and needs;

  - **Counselling** to identify and respond to women’s emotional and physical health needs and other concerns;

  - **Treatment of incomplete and unsafe abortion** and complications that are potentially life-threatening;
- **Contraceptive and family planning services** to help women prevent an unwanted pregnancy or practice birth spacing; and

- **Reproductive and other health services** that are preferably provided on-site or via referrals to other accessible facilities in providers’ networks.

"Taking Post-abortion Care Services to Scale International workshop" held in Mombasa in May, 2000, the MOH – Kenya made the following goal statement:

> Every woman in Kenya shall have access to high quality comprehensive PAC as a component of integrated RH services.

- One of the objectives under the goal statements was to amend the existing policy to provide for the expansion of comprehensive PAC provision by doctors and mid level providers, including nurses and clinical officers.

**Barriers to Quality Comprehensive PAC Services**

1. **Negative provider and Community Attitude**

   Though medical science has confirmed that 1/3 of pregnancies will end up in abortion, both the service providers and the community in Kenya associate any woman who has lost or is in the process of losing pregnancy to have interfered with it. This leads to a situation where the community do not empathize with a woman whose life is at risk and do not support or assist her to go to a facility where she can get appropriate life saving services. If the woman manages to somehow reach the health facility, the service providers often do not take immediate and appropriate action. In some instances, patients may be kept waiting two or more days from the time they get to the facility to the time they get emergency care, or until elective theatre is free for evacuation to be carried out. There is therefore need to train the service providers and to carry out community sensitization to make their attitude more supportive.

2. **Lack of Knowledge and skills among primary health care service providers**

   Until recently, the policy in Kenya was that only doctors could be trained in providing comprehensive PAC services especially emergency care. However, this has led to a lot of suffering among patients since qualified doctors in the country are very few and are mostly urban-based while rural areas are under-served. The poor status of the economy has made it impossible for most Kenyans to pay fares for long distances to public hospitals where doctors are found in addition to cost sharing that is now expected of them in the health facilities. Though the national health network provides a primary health facility within five kilometres radius, staffed by nurses and clinical officers, this cadre of personnel generally have not been trained to manage emergency postabortion care. The government has, therefore, found it necessary to train the clinical officers and nurses down to
enrolled community nurse (ECN) level so that they can initiate essential treatment. These include antibiotic therapy, intravenous fluid replacement, oxytocics and uterine evacuation during the first trimester. Manual Vacuum Aspiration (MVA) was introduced in Kenya in 1987 by the PAC pilot as a preserve for physicians only. Another pilot project in 1997 to 1999 (Prime I), which was the first time when private nurse/midwives (mid-level service providers) were trained, proved that they could empty the uterus using MVA kit just as safely as the physicians. The need for community awareness at the grass-root level by the service providers was also identified. The 1997 Ministry of Health Reproductive Health Guidelines and Standards for Service Providers state: "The prompt treatment of Postabortion complications is an important part of health care that should be available at every district level hospital", but since then, this has been extended down to primary health institutions. These guidelines do not restrict providers of comprehensive PAC services to specific cadres of health providers. The PAC pilot project mentioned above demonstrated that enrolled community nurse midwives and other non physician health providers can be trained to safely and competently provide comprehensive PAC services to patients with incomplete abortion and related complications.
Why Women Resort To Abortion

- It is useful for providers of postabortion care or family planning to be aware as to why women seek unsafe abortion even when safe or legal abortion is available, or when it conflicts with a woman’s own traditional or religious beliefs.

- There are multiple reasons why women may resort to abortion when faced with unplanned or unwanted pregnancy. Often a woman’s felt need for abortion stems from her lack of power to negotiate sex and/or the use of contraception. Some of these reasons are:

1. *Economical problems such as:*
   - Low income to care for the baby;
   - Lack of employment;
   - She already has the number of children she wants.

2. *Social and cultural problems such as:*
   - A student who wants to finish school;
   - Getting pregnancy out of the wedlock;
   - Someone is forcing her to have an abortion;
   - Cultural and religious stigma;
   - She was raped.

3. *Medical problems such as:*
   - Failure to get FP services;
   - Lack of information on FP; worldwide, more than 350 million couples lack access to contraceptives.
   - Lack of access to FP services;
   - Contraceptive method failure;
   - She knows the child will be born with serious health problems.

- In many cases if women had better information about and access to family planning services, the need for abortion would be eliminated.

- The social and cultural environment in which a woman lives, the dominant religion, and her own personal beliefs all contribute to the decisions she makes regarding unintended pregnancy and the services she receives which in turn affect the mortality and morbidity associated with abortion. In addition, the
socio-cultural perspectives and religious beliefs of health workers affect their attitudes towards women who need abortion care and the services they provide.

- Some of the socio-cultural elements that can affect abortion mortality and morbidity rate include:
  
  - Women’s ability and willingness to seek care promptly when they experience complication of abortion. Women may need their husbands or guardians’ permission to seek and use health service. For many women, an unintended pregnancy or use of abortion services can lead to social ostracism or rejection by family members. To avoid such rejection, women will often delay seeking care, even to the point of death. Health care providers must not contribute to this judgment of the woman. Rather, they must provide care that is accessible and supportive, encouraging the woman to seek, rather than hide from, medical help.

  - Women’s decision to seek to terminate a pregnancy and the sources and methods that they prefer. Cultural factors may lead women to seek abortions that are dangerous. The reasons for these choices are many including trust in traditional providers, desire for secrecy, belief that non-medically induced abortions are not actual abortions, and referrals from family and friends.

  - Importance of fertility. In many societies, a woman’s fertility is central to her acceptance by the community. She may be unwilling to use modern contraception because she perceives it as harmful to her fertility. This behaviour increases her chances of unwanted pregnancy and thus the risk of unsafe abortion.

  - Providers’ attitudes towards women’s abortion care needs. Studies have documented that women are unwilling to seek care from facilities that make them feel uncomfortable or where they have been treated badly. It is particularly important that clinic and hospital staffs are aware of and sympathetic to cultural factors when women from diverse cultural groups are cared for at the same facility.
Legal Provisions

• The Laws of Kenya are based on the British legal system, like most other Commonwealth countries. However, abortion laws do not follow the current practice. While Britain has modified its laws, Kenya has not yet attempted to update or revise its laws regarding abortion. The Constitution of Kenya spells out the right to life of all people within its borders, and for this, the law permits abortion only in “the preservation of the woman’s life”. The circles and people have used that loophole to procure abortion on the pretext that the woman’s life is in danger.

Constitutional law

The right to life

• The Constitution of Kenya explicitly protects each person within its borders in terms of the right to life under Chapter V, Section 70 and 71 (as revised in 1983). The details of this protection are however left to the parliament and Courts of Law to define, in the statutory and case laws respectively. Section 70 states that:

Whereas every person in Kenya is entitled to the fundamental rights and freedoms of the individual, that is to say, the right, whatever his race, tribe, place of origin or residence or other local connection, political opinions, colour, creed or sex, but subject to respect for the rights and freedoms of others and for the public interest, to each and all of the following, namely,

1. Life, liberty, security of person and the protection of law;
2. Freedom of conscience, of expression and of assembly and association; and
3. Protection for the privacy of his home and other property without compensation.

• The provision of this chapter shall have effect for the purpose of affording protection to those rights and freedoms subject to such limitations of that protection as are contained in those provisions, being limitations designed to ensure that the enjoyment of the said rights and freedoms does not prejudice the rights and freedoms of others or the public interest”.

• This Constitution, as it is, does not regard the right to life as an inalienable right. The clauses ‘subject to respect…..’ and for ‘the public interest’ indicate that the rights as stated may be altered in circumstances which may be deemed in ‘public interest’ by the government.
Statutory law

- Kenyan statutory law recognizes three felonies and one misdemeanour which bear on the act of abortion. Under the Penal Code (Chapter 63 of the Laws of Kenya), the felonies include “Abortion” “Supplying implements of abortion” and ‘Killing an unborn child”. It is a misdemeanour to “Conceal a birth”. It is illegal to take part in the publication of any advertisement for drugs or appliances for procuring abortion according to the Pharmacy and Poisons Act, chapter 244, Laws of Kenya. These are explained under the Penal Code as follows.

Abortion

\[\text{Abortion}\]

“Any person who, with intent to procure miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious things, or uses force of any kind, or uses any other means whatever, is guilty of a felony and is liable to imprisonment for fourteen years” (Section 158 of the Kenya Penal Code).

Any woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind or uses any other means whatever, is guilty of a felony and is liable to imprisonment for seven years. (Section 159 of the Kenya Penal Code).

- These two sections, while inflicting punishment on both the person performing the abortion and the woman in question, are slightly different. In the latter case, the woman must be pregnant for conviction to occur. Secondly, the sentences are different for the two, although the offences are essentially the same.

Supplying implement of abortion

- The Penal Code goes on to state that:

\[\text{Supplying implement of abortion}\]

“All persons who unlawfully supplies to, or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman whether she is or is not with child, is guilty of felony and is liable to imprisonment for three years.” (Section 160 of the Penal Code of Kenya)
Killing of an unborn child

- This felony is also related to the crime of child destruction. The relevant section states that:

> “Any person who, when a woman is about to be delivered of a child, prevents the child from being alive by any act or omission of such a nature that, if the child had been born alive and had then died, he or she would be deemed to have unlawfully killed the child and is guilty of a felony and is liable to imprisonment for life.” (Section 228 of the Kenya Penal code).

- The severity of punishment in this case puts the crime at par with manslaughter.

Concealing birth

- According to the Penal Code Section 227, it is a misdemeanour to conceal a birth:

> “Any person who, when a woman is delivered of a child, endeavours by any secret disposition of the dead body of the child to conceal the birth, whether the child died before, at or after its birth is guilty of a misdemeanour.”

- This section seems to have been made to help in the proper determination of the cause of death of a new-born baby as well as keeping statistics and proper legal records. Under this section many women have appeared in the Kenyan law courts. Many are the times when one hears or reads of a child dumped in a latrine, dustbin, and bush or bus station either alive or dead.

Advertising drugs of appliances for abortion

- Subject to the provisions of this Act, no person shall take part in the publication of an advertisement referring to a drug, appliance or article of any description in terms that are calculated to lead to the use of drug, appliance or article for procuring the miscarriage of women. (Section 38 of the Pharmacy and Poisons Act of the Laws of Kenya, chapter 244, as revised in 1983). One convicted of conflicting with this section of the law, faces, on the first conviction a fine of not more than one thousand shillings. Upon subsequent convictions for this crime, the violator becomes liable to a fine of not more than two thousand shillings, or not more than three months imprisonment, or both the fine and the prison term. (Section 40 of the Pharmacy and Poisons Act).
Distinction between killing an unborn child and murder of a newly born child

- According to the Kenya Penal Code:

  "... a child becomes a person capable of being killed when it has completely proceeded in a living state from the body of its mother, whether it has breathed or not, and whether it has an independent circulation or not and whether the naval-string is severed or not" (Section 214).

- This means that should a child be inflicted for instance with a fatal wound during but while still in the mother's womb, the person who inflicted the wound would be liable to persecution for murder or manslaughter. However, killing of an unborn child is still a very serious offence in Kenya for which the maximum punishment is life imprisonment.

- The “good faith” clause in Section 240 states that:

  "A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case."

- Although the law is explicit on abortion, there are some loopholes. Illegal abortions are being done in Kenya, though as stated earlier, the extent is not clear. Court cases under this section are very few indeed and are more for causing death of the woman rather than the procurement of abortion per se (Ref. The case of Mehar Singh Bansel v.R. in 1959).

- As mentioned earlier, abortions continue to be done on the pretext that the woman’s life is in danger. It is difficult to define what this means in different situations. When a pregnant woman’s life is in danger because of the pregnancy, it therefore requires legitimizing abortion; in other cases the woman may not be in danger (Mehar Singh Bansel v. R. 1959). Another loophole is in the section of supplying implements of abortion. The offence occurs when a person willingly and knowingly supplies poison, drugs or instruments to be used for the purposes of abortion. The commonly used defence is to insist that the person supplying the implements did so without knowing that they were intended for use in abortion, since many of the instruments used for abortion procedures may also be used for other “acceptable procedures”.

- One may also be forgiven for assuming that the law as it is does not consider abortion to be destruction of a human life because of the differences in punishments for abortion and killing of an unborn child. The line between the two is at times very thin or non-existent, especially when the termination is done...
late in pregnancy. Further confusion is added when one considers Section 214 of the Penal Code of the Laws of Kenya regarding when an unborn child is considered to be a human being.

**Effects of Laws and Regulations on Provision of Postabortion Care**

- Although each country decides for its own policy on the legal status of induced abortion, the provision of postabortion care need not be affected by whether abortion itself is legal or not. Emergency care for the complications of abortion (postabortion care), both spontaneous and induced, is legal and not punishable by any part of Kenya laws. Comprehensive PAC is a life saving procedure that should be available to all women and provision of comprehensive postabortion care does not lead to punishment or withdrawal of registration of the service provider. The medical profession has the responsibility to provide comprehensive postabortion services including family planning to all women who need them, to the full extent of the legal limits. Emergency abortion care (postabortion care) is a requirement of the ethical practice of medicine in every country, as this care is often essential to save a woman’s life and preserve health (*Kleinman, 1998*). Because the laws and regulations regarding postabortion are not often clear, either to women needing care or to the health care providers, these services are not put in place. Lack of knowledge of the law also leads to the fear of criminal prosecution by provider, and mistreatment of women needing care because they are regarded as criminals.
Global and Regional Annual Estimates of Incidence and Mortality from Unsafe Abortions, 1995

<table>
<thead>
<tr>
<th>Region</th>
<th>Estimated number of unsafe abortions (000s)</th>
<th>Incidence rate (unsafe abortions per 1000 women 15-49)</th>
<th>Incidence ratio (unsafe abortions per 100 live births)</th>
<th>Estimated number of deaths due to unsafe abortion</th>
<th>Mortality ratio (deaths due to unsafe abortion per 100 000 live births)</th>
<th>Proportion of maternal deaths (% due to unsafe abortion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Total</td>
<td>20 000</td>
<td>13</td>
<td>15</td>
<td>78 000</td>
<td>57</td>
<td>13</td>
</tr>
<tr>
<td>More Developed Regions</td>
<td>900</td>
<td>3</td>
<td>7</td>
<td>500</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Less Developed Regions</td>
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* Japan, Australia and New Zealand have been excluded from the regional estimates, but are included in the total for developed countries

** For regions where the incidence is negligible, no estimates are shown

### Fertility Planning Status

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Module Summary

Postabortion care is an approach for reducing morbidity and mortality from incomplete and unsafe abortion and resulting complications and for improving women’s sexual and reproductive health and lives. This module will address concepts of comprehensive PAC elements, a brief introduction of rationale and the five PAC elements.

General Objectives

1. Describe the concept and elements of comprehensive PAC.
2. Explain the rationale of comprehensive PAC services and its elements through a system that is widely accessible, cost effective and sustainable.
3. Link PAC clients to other RH, Medical, social, legal services and maintain records.

Specific Objectives

At the end of this session, the participants will be able to:

1. Describe the concept of comprehensive PAC.
2. Describe the elements of comprehensive PAC.
3. Explain the benefits of comprehensive PAC.

2.1 Trainee Materials

- Handout 2.1
- Roleplay 2.1
- Observation checklist
Definition of Postabortion Care

Postabortion care is an approach for reducing morbidity and mortality from incomplete and unsafe abortion and resulting complications and for improving women’s sexual and reproductive health and lives.

Postabortion care defined in a broader sense, is the total physical, social and psychological care and support given to an individual seeking or being offered post-abortion services, or is at risk of sustaining postabortion related complications, including repeat abortion.

In this broader definition, postabortion care also includes:

- Prevention of the unsafe abortion through effective information, education, and communication (IEC) for RH as well as the provision of appropriate services, such as contraception to individuals at greatest risk of unwanted pregnancy and/or induced abortion.

- Psycho-social support to clients on short, medium and long term basis.

Rationale for Postabortion Care

There is strong evidence, which shows that member states of sub-Saharan Africa have some of the highest levels of maternal mortality globally. Up to 50% of maternal deaths in the sub-Saharan Africa region are abortion related. Most of the abortion-related deaths and morbidity in sub-Saharan Africa can be attributed in part to:

- Restrictive national health policies, abortion laws and practices.

- International, national, local, and institutional policies and norms that restrict programs related to abortion.

- Inappropriate attitudes of health care providers towards women with abortion complications or those seeking abortion and postabortion care services.

- Failure/refusal by health care providers or the health care system to offer appropriate postabortion care services to women in need. Due to logistical problems, administrative barriers, inappropriate policies, individual, and religious beliefs

- Delay in seeking or being offered appropriate and adequate postabortion cares services

- Clandestine induction of abortion by untrained persons using dangerous techniques, drugs and/or unsterile instruments.

- Negative attitudes and lack of support of communities and government towards women who undergo unsafe abortions.

- Lack of social and psychological support for individuals who undergo or sustain complications from abortion.
• Individual’s misconceptions, fears, and lack of awareness of reproductive health matters, which make them vulnerable to unwanted pregnancy and unsafe abortion.

• Women’s low socioeconomic status, which make ill-health and/or deaths amongst them be seen as insignificant health, social or economic problems.

**Elements of Postabortion Care**

Comprehensive postabortion care services should include both medical and preventive health care. The five key elements of postabortion care are:

- **Community and service provider partnerships** for prevention (of unwanted pregnancies and unsafe abortion), mobilization of resources (to help women receive appropriate and timely care for complications from abortion), and ensuring that health services reflect and meet community expectations and needs;

- **Counselling** to identify and respond to women’s emotional and physical health needs and other concerns;

- **Treatment of incomplete and unsafe abortion** and complications that are potentially life-threatening; using sharp curette, electric vacuum aspiration, manual vacuum aspiration or misoprostol where available.

- **Contraceptive and family planning services** to help women prevent an unwanted pregnancy or practice birth spacing; and

- **Reproductive and other health services** that are preferably provided on-site or via referrals to other accessible facilities in providers’ networks.

WHO has identified the prompt treatment of incomplete abortion as an essential element of obstetric care that should be available at every district-level hospital. Fortunately treatment of uncomplicated incomplete abortions also can be provided at the primary care level or in family planning clinics through the use of manual vacuum aspiration (MVA) or provision of misoprostol where available.

**Rationale for each Essential Element of the Comprehensive PAC**

**Community and Service Provider Partnerships**

To achieve universal local access to sustainable, high-quality comprehensive PAC and other health services, community members, lay health workers and traditional healers and formally trained service providers must work in partnership.
This partnership includes:

- Education to increase family planning and contraceptive use, thus preventing unwanted pregnancies, assisting women with birth spacing and planning healthy pregnancies, and reducing the need for unsafe abortion;

- Education about the risks and consequences of unsafe abortion;

- Participation by community members in decisions about which sexual and reproductive health services are offered, when, where, by whom, for whom and at what cost;

- Education about and promotion of client-centred, human rights-based sexual and reproductive health services, including comprehensive PAC, that meet communities’ expectations, priorities and needs;

- Education about the signs and symptoms of obstetric emergencies such as postabortion complications to promote appropriate care-seeking behaviours;

- Mobilization of community resources to ensure that women suffering from incomplete abortion and other obstetric emergencies receive the care they need in a timely manner, including transportation to a facility where such care is available;

- Access for special populations of women, including adolescents, women with HIV/AIDS, women who have experienced violence, women with female genital cutting (FGC), women who partner with women, refugees commercial sex workers and cognitively and physically disabled women to PAC and other sexual and reproductive health services; and

- Planning for the sustainability of PAC and other sexual and reproductive health services.

**Counselling**

Effective counselling for women who are experiencing incomplete abortion and possible complications should permeate every component of services, from first contact between the woman and provider to the last contact and cover more than family planning and contraception. The aims of counselling as an essential element are to:

- Solicit and affirm women’s feelings and provide emotional support throughout the entire postabortion care visit;

- Ensure that women receive appropriate answers to their questions or are otherwise provided with information about medical conditions, test results, treatment and pain management options and follow-up care, and that they understand how to prevent post-procedure complications and when and where to seek care for complications if they arise;

- Help women clarify their thoughts about their pregnancy, incomplete abortion, treatment, resumption of ovulation and reproductive health future;
- Listen and ask questions to help the provider better understand and respond to other needs and concerns that could potentially impact their care; for example, if women are infected with HIV, have STIs or are at risk of STI/HIV, or if women are survivors of sexual or gender-based violence; and,

- Address other concerns women may have.

**Treatment**

In many cases, an incomplete abortion will need to be treated by uterine evacuation using MVA, EVA, SC or chemical e.g., misoprotol. Incomplete and unsafe abortions do not always involve complications, are not always life threatening and treatment is therefore not always an emergency. Nonetheless, PAC complications are potentially life threatening without swift and appropriate medical attention. High-quality treatment uses manual vacuum aspiration (MVA) wherever possible or in absence of that electric vacuum aspiration (EVA), sharp curettage (SC) or misoprotol where available and depending on local conditions, and includes standard infection prevention precautions, informed consent, appropriate pain management, sensitive physical and verbal patient contact and follow-up care.

**Contraceptive and Family Planning Services**

Despite increases in modern contraceptive use in the last decade, significant numbers of women of childbearing age want to delay or avoid pregnancy, or practice birth spacing, but are not using contraception. Access to a wide range of contraceptive methods to prevent unwanted pregnancy and help women practice birth spacing, including emergency contraception, are effective strategies for preventing future unwanted pregnancies and unsafe abortion and helping women achieve their reproductive goals. For women who do not desire pregnancy or are clinically advised against an immediate pregnancy, if they are not offered contraceptive methods in the same facility following treatment for abortion complications, they may not return or follow up on a referral for provision of a contraceptive method. For women who desire pregnancy, family planning services may still be essential for ensuring adequate spacing for healthy pregnancies and healthy children.

**Reproductive and Other Health Services**

Counselling is one of these mechanisms to help ensure that appropriate reproductive and other health needs and concerns are assessed and the services available at the treatment facility are offered at the time of treatment, or that these services are offered via referral to another facility. Encourage providing postabortion women with reproductive and other health services at the same facility as treatment services, when possible and appropriate. When it is not possible for a facility to provide needed additional services, functional referral and counter-referral systems and follow-up mechanisms, including record keeping, should be established or improved and monitored to ensure that women’s needs are being met.
Reproductive and other health services might include:

- STI/HIV prevention education, screening, diagnosis and treatment
- Screening for sexual (including incest) and/or domestic violence, immediate treatment as needed, and referral for medical/social/economic services and support
- Screening for anaemia, and treatment and/or nutrition education
- Infertility diagnosis, counselling and treatment
- Nutrition education
- Hygiene education; and,
- Cancer screening and referral, as needed.

**Benefits of effective comprehensive PAC**

- Provides emergency RH services
- Entry point to other RH services
- Linkage to other health related services (medical/social/cultural/legal);
- Gives the provider confidence in managing emergency
- Provides holistic approach to manage clients with abortion complications

**In Communities**

- Increases knowledge about comprehensive PAC services and where they are provided
- Increases access to and use of comprehensive PAC and other health services, including by adolescents and other special populations of women
- Increases acceptability of comprehensive PAC and other health services
- Earlier emergency care sought by women with postabortion complications
- Increases contraceptive use, fewer unwanted pregnancies and fewer repeat abortions
- Increases community member satisfaction with comprehensive PAC and other health services.
At health care facilities

- Comprehensive PAC services respond to and address community members’ perceived needs, priorities and expectations
- Increases quality and use of comprehensive PAC and other health services, per community member definition of quality and access
- Improves performance of providers in meeting the comprehensive PAC and other health needs, including those of adolescents and other special populations of women
- Improves record keeping to contribute to evidence demonstrating increased access and use of high-quality postabortion care and other health services
- Improves referral and counter-referral systems and follow-up mechanisms for comprehensive PAC and other health services
Role-play No. 2.1

Client

- You are Mrs. Makau married for the last 2 years. You have been trying hard to have a child but every time the pregnancy comes out at 2-3 months. You don’t know why this happens. Last night you started bleeding again and you have been taken to Matumaini Health Centre by your husband and a neighbour.

Service Provider

- You are a nurse/midwife/PAC trainee at Matumaini Health Centre. You are also the in-charge of the facility during the current shift.

- A 24 year old woman is brought to the health centre by relatives. She gives a history of having been 3 months pregnant and had started bleeding the night before. This is the fourth pregnancy that has ended in a miscarriage. She is pale looking. On speculum examination you observe an unusual colour of the cervix.
### Instruction: Observe the Role play and check (✓) at the relevant column

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<td>2 Does the provider identify problems she/he cannot manage?</td>
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<td>3 Does the provider know where the solutions of the problems are?</td>
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<td>4 Does the provider have the contact of the referral site?</td>
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<td>5 Does the provider discuss effectively the concerns fears and needs of client in a thorough and empathetic manner?</td>
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<td>6 Does the provider have feedback and follow-up mechanism in place?</td>
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Summary
Manual vacuum aspirations (MVA) is a safe, effective, and low-cost method of uterine evacuation used for endometrial biopsy and treatment of abortion complication. MVA can be used in outpatient settings, thus extending women’s access to care.

Specific objectives
At the end of this session, the participants will be able to:
1. Describe how MVA works.
2. List the advantages of the MVA procedure over other mechanical methods of uterine evacuation.
3. Identify the parts of the MVA instruments.
4. Describe MVA indications, contraindications, warning signs and precautions.

3.1 Trainee Materials:
- Reducing Resource Use: Advances in Abortion Care Vol.2.
- MVA package.
- MVA Facts slide presentation.
Slide Guide: MVA Facts

Slide 1

MVA Instruments

Slide 2

MVA Advantages

MVA Facts

Studies of Effectiveness, Vacuum Aspiration, 1987-92

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Adapted from Greenslade et al., 1993.

Slide 3

Effectiveness

- MVA is more effective than sharp curette (SC) in collecting diagnostic tissue samples
- MVA is equally good at detecting endometrial cancer

Adapted from Suarez, 1983.

Slide 4

MVA Advantages

- Flexible cannula has rounded tip, narrow, uniform width:
  - little dilation required
  - gentle to uterine lining

Handout 3.1
Slide 5

MVA Facts

Safety: Comparison of Complication Rates of Vacuum Aspiration and Sharp Curettage in Induced Abortion

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Adapted from Grimes et al., 1977

Slide 6

MVA Facts

Safety: Selected Studies Comparing Complications of MVA & Sharp Curettage

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Gestational age ranges from 5 to 12 weeks LMP size. Adapted from Greenslade et al., 1993.

Slide 7

MVA Facts

Studies comparing complications of vacuum aspiration (VA) and sharp curettage (SC)

Finding: Complication rate for VA is lower or equal to that for SC

- Excess blood loss: 10 out of 13 studies
- Pelvic infection: 7 out of 9 studies
- Cervical injury: 8 out of 7 studies
- Uterine perforation: 10 out of 12 studies

Gestational age ranges from 5 to 12 weeks LMP size. Adapted from Greenslade et al., 1993.

Slide 8

MVA Facts

MVA Advantages

- Outpatient procedure
- Pain Control = Oral Analgesia 30 mins before procedure + Para cervical Block
- Oral analgesia
- Heavy sedation is not necessary
- Patients recover more quickly

Slide 9

MVA Facts

MVA Advantages

Cost Reduction in Kenya

- MVA vs. Sharp Curettage

MVA Reduced Time & Resources in Mexico

Cost Reduction in Mexico

- MVA vs. Sharp Curettage

National Post Abortion Care Curriculum for Service Providers
Trainees Handbook

3-3
Slide 10

**MVA Facts**

**MVA Advantages**
- Syringe and cannula made of durable plastic

---

Slide 11

**MVA Facts**

**Indications**
- Endometrial biopsy
- Treatment of incomplete abortion up to 12 weeks LMP size
- First-trimester abortion/MR

---

Slide 12

**MVA Facts**

**Contraindications**
- Biopsy: suspected pregnancy
- Incomplete Abortion: pregnancy over 12 weeks LMP size
- Induced Abortion: pregnancy over 12 weeks LMP

---

Slide 13

**MVA Facts**

**Contraindications**
- Acute cervicitis or pelvic infection (except in emergency)
- Large fibroids (unless emergency backup available)
- History of blood dyscrasia

---

Slide 14

**MVA Facts**

**Possible Complications**
- Incomplete evacuation
- Uterine or cervical perforation
- Hypotension
- Vaginal erosion
- Pelvic infection
- Hemorrhage
- Acute hematometra
- Air embolism
**Slide 15**

MVA Facts

- Proceed with caution if...
  - History of bleeding disorder
  - Hemodynamic instability
  - Uterine fibroids which make it impossible to assess duration of gestation
  - Suspected prior uterine perforation (incomplete abortion)

**Slide 16**

MVA Facts

- and ...

  In the presence of infection, the procedure should be done under antibiotic cover.
MVA Instruments Labels

Plunger Handle

Collar Stop

Barrel

Valve Liner

Valve

Double-Valve Syringe

'O' - Ring

Single-Valve Syringe

Aperture

Cannulae
Module 4

Client Assessment and Preparation

Summary
This module presents the process of client assessment and preparation. Thorough client assessment, including history, physical exam, pelvic exam, and laboratory tests, is critical to the formulation of a correct diagnosis for the emergency care including MVA procedure. "Cutting corners" in the assessment may lead to more difficult procedures and higher complication rates.

Specific Objectives
After this session, participants will be able to:

1. Define different types of abortion.
2. Perform according to standards, client assessment and examination, including:
   - Quick client assessment to rule out life threatening conditions;
   - Taking complete history;
   - Performing physical examination;
   - Assess uterine size and position by bimanual examination;
   - Determine whether cervix is dilated (and how much);
   - Perform speculum examination.
3. Demonstrate ability to obtain appropriate laboratory tests.
4. Demonstrate ability to prepare the client for uterine evacuation using the MVA, EVA, sharp curettage or chemical (misoprostal) procedure (see also module 8) - counselling:
   - Cleanse external genital area, if necessary;
   - Drape client with HLD drapes;
   - Swab cervix, vagina with antiseptic.
4.1 Trainee Materials

- Client assessment record.
- Decision Tree Chart 3 "Moderate to light Vaginal Bleeding".
- Clinical Guidelines for Emergency Treatment of Abortion Complications.
- Uterine sizing handout.
Initial Assessment

- Health workers should consider the possibility of incomplete abortion in any woman with symptoms of abortion, whether or not she knows or suspects she is pregnant and regardless of her obstetric, menstrual or contraceptive history.

Background

- The first step in providing care to a woman suspected of having an incomplete abortion is to assess her clinical situation. The initial assessment may reveal or suggest the presence of immediate life-threatening complications such as shock, severe vaginal bleeding, infection/sepsis or intra-abdominal injury. These problems should be addressed without delay in order to save the clients life or keep her condition from worsening. Even without complications, incomplete abortion can become life threatening if definitive treatment (removal of any retained products of conception) is delayed. The initial assessment should be followed by prompt treatment or, if indicated, stabilization and transfer of the client to a higher level facility.

Signs and Symptoms

- Incomplete abortion should be considered in any woman of reproductive age who has:
  
  - Missed period (delayed menstrual bleeding - more than a month has passed since her last menstrual period).
  
  - With either:
    
    - Vaginal bleeding,
    
    - Cramping or lower abdominal pain similar to labour contractions or passage of pregnancy tissue (placental fragments).
  
  - If none of the above symptoms is present, you should consider another diagnosis (e.g., pelvic infection). Attempts to end a pregnancy through unsafe means by putting unclean instruments, rubber tubes or even sticks into the womb are major causes. For personal, socio-cultural and legal reasons, many women may not provide this important information initially. Therefore, this possibility should always be kept in mind while assessing the physical signs and symptoms.

Medical Evaluation

- If the vital signs are normal and the woman does not appear to be infected (temperature < 38°C) or have intra-abdominal injury (non-rigid abdomen), the next step is to determine the cause of her vaginal bleeding. Taking a thorough reproductive history, performing careful physical and pelvic examinations and (where necessary) obtaining appropriate laboratory tests are important to making an accurate diagnosis and treatment plan.
Due to issue and circumstances that may surround incomplete abortion, the quality and completeness of the information the woman gives about her condition and medical history often depends upon the quality of the communication between service provider and client. It is important to respect the woman's needs and to provide care without expressing judgment, either verbally or nonverbally. (See Module 8 Postabortion Counselling).

**Medical History:**

- Specific **reproductive information** that should be obtained include:
  - Missed period from the (date when her last menstrual period began);
  - Current contraceptive method (IUD, Norplant implants and progestin-only injectables and pills can be associated with a bleeding that may be mistaken for incomplete abortion);
  - Vaginal bleeding (duration and amount);
  - Cramping (duration and severity);
  - Fainting (syncope);
  - Fever, chills or general malaise;
  - Abdominal or shoulder pain (may indicate intra-abdominal injury);
  - Tetanus vaccination status and possible exposure to tetanus (insertion of unclean instruments or other materials into the uterus).

- Medical Information which may be important includes:
  - Drug allergies (e.g., to local anaesthetics or antibiotics)
  - Bleeding disorders (e.g. sickle cell or thalassemia, haemophilia or platelet disorder).
  - Chronic medications (e.g. corticosteroids).
  - Whether client has taken any herb or medicine (poison) that may cause serious side effects.
  - Other health conditions (e.g., malaria during this pregnancy).

**Physical Examination:**

- During the physical examination it is important to:
  - Check and record the client's vital signs (i.e. temperature, pulse, respirations and blood pressure.
  - Note the general health of the woman (i.e. whether she is malnourished anaemic or in general poor health.
  - Examine her lungs, heart and extremities.
• **Abdominal Examination**
  - Check for:
    - Masses or gross abnormalities.
    - Distended abdomen with decreased bowel sounds.
    - Rebound tenderness with guarding.
    - Suprapubic or pelvic tenderness.

• **Pelvic Examination:**
  - The **purpose** of the pelvic examination is to **determine** the **size**, **consistency** and **position** of the uterus, to check for tenderness and to determine the degree of cervical dilation. Careful assessment of the vagina and cervix to check for tears and bleeding is essential.
  - Prior to the pelvic examination explain the purpose of the examination to the client and be sure she has emptied her bladder. For the exam, the client should be on an examination table equipped with stirrups and she should be covered with a cloth or drape to protect her dignity and privacy. The clinician should wear new undamaged sterile gloves.

• **Speculum Examination:**
  - Before inserting the speculum:
    - Look at the genital area to see if there is bleeding and if so, how much;
    - Check the odour and colour of the vaginal blood or discharge;
    - Next, insert the speculum to look at the cervix. Remove any visible POC (products of conception) from the vaginal canal or cervical os and keep the tissue for examination;
    - Note any abnormal-smelling discharge, the amount of bleeding and whether the cervix is open (dilated), check for cervical or vaginal tears or perforations, or pus in the cervix. Cervical infection increases the chance of postoperative uterine infections, including acute pelvic inflammatory disease (PID). If infection is present or suspected, take samples for bacteriological culture if possible and begin antibiotic treatment with broad-spectrum antibiotics before performing MVA.
• **Bimanual Examination**

  - Assess the size of the uterus. Compare the actual size of the uterus with date of the last menstrual period (LMP). With an incomplete abortion, the uterus usually is smaller than the LMP might suggest.

  - **Assess the shape and position of the uterus.** Correctly determining the shape and position of the uterus is critical to the safety and success of the procedure.

  - If the uterus is larger than expected, it may indicate:
    - A more advanced pregnancy than the LMP suggest;
    - Presence of multiple pregnancies;
    - A uterus filled with blood clots (i.e. postabortal syndrome);
    - A molar pregnancy (i.e. trophoblastic disease);
    - Presence of uterine fibroids (i.e. smooth muscle tumours of the uterine wall).

  - If the uterine size is difficult to assess, it may be because the uterus is tilted backward (retroversion), the client is overweight or has abdominal guarding (not relaxing the abdomen so that the uterus cannot be felt). It is important not to begin MVA procedure for incomplete abortion until the size of the uterus has been determined. If problems in determining the size or position of the uterus are encountered, have a more experienced clinician (if available) assess the uterine size. If there is any doubt, treat the woman as if the pregnancy was advanced further than suspected initially.

  - **Anteverted uterus** (tilted forward) if the uterus is excessively anteverted (anteflexed), the clinician must be especially careful during the procedure because the risk of perforation may be increased when performing MVA.

  - **Retroverted Uterus** (tilted backwards). A mildly retroverted uterus may be best palpated by recto-vaginal examination. (perforation may be more likely if the clinician is not aware that the uterus is markedly retroverted).
Laterally displaced uterus (tilted to one side): if the uterus is pushed laterally to one side or the other, the clinician must be especially careful during the procedure or the risk of perforation may be increased.

**Laboratory Tests**

- Blood group and Rhesus status should be determined in pregnancy, it should be done during the clinical assessment in cases of incomplete abortion as well for women who are Rh negative, give Rh (D) immune globulin if available.

**Summary**

- The steps in performing the **medical evaluation** are briefly summarized in **Handout 4-1**.

**Vaginal Bleeding in Early Pregnancy (See table 4.1)**

Vaginal bleeding occurring during the first 22 weeks of pregnancy.

**Types of abortion**

<table>
<thead>
<tr>
<th>Type of Abortion</th>
<th>Description</th>
</tr>
</thead>
</table>
| Spontaneous Abortion    | Defined as the loss of a pregnancy before foetal viability (22 weeks gestation). The stages of spontaneous abortion include:  
- Threatened abortion (pregnancy may continue);  
- Inevitable abortion (pregnancy will not continue and will proceed to incomplete /complete abortion);  
- Incomplete abortion (products of conception are partially expelled);  
- Complete abortion (products of conception are completely expelled). |
| Induced abortion        | Defined as a process by which pregnancy is terminated before foetal viability.                                                                                                                                 |
| Unsafe abortion         | Defined as a procedure performed either by persons lacking necessary skills or in an environment lacking minimal medical standards or both.                                                                  |
| Septic abortion         | Defined as abortion complicated by infection. Sepsis may result from infection if organisms rise from the lower genital tract following either spontaneous or unsafe abortion. Sepsis is more likely to occur if there are retained products of conception and evacuation involving instrumentation. |
General Management

- Make a rapid evaluation of the general condition of the woman including vital signs (pulse, blood pressure, respiration, temperature).
- If shock is suspected, immediately begin treatment (refer to Module 10).
- Even if signs of shock are not present, keep shock in mind as you evaluate the woman further because her status may worsen rapidly.
- If the woman is in shock, consider ruptured ectopic pregnancy.
- Start an IV infusion.

Diagnosis

- Consider ectopic pregnancy in any woman with anaemia, pelvic inflammatory disease (PID), threatened abortion or unusual complaints about abdominal pain.

Note:
If ectopic pregnancy is suspected, perform bimanual examination gently because an early ectopic pregnancy is easily ruptured.

- Consider abortion in any woman of reproductive age, who has a missed period (delayed menstrual bleeding with more than a month having passed since her last menstrual period) and has one or more of the following: bleeding, cramping, partial expulsion of products of conception, dilated cervix or smaller uterus than expected.
- If abortion is a possible diagnosis, identify and treat any complications immediately (refer to Table 4-2).
Table 4-1: Diagnosis of Vaginal Bleeding in Early Pregnancy

<table>
<thead>
<tr>
<th>Presenting Symptom and Other Symptoms and Signs Typically Present</th>
<th>Symptoms and Signs Sometimes Present</th>
<th>Probable Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Light bleeding</td>
<td>• Cramping/ lower abdominal pain</td>
<td>• Threatened abortion</td>
</tr>
<tr>
<td>• Closed cervix</td>
<td>• Uterus softer than normal</td>
<td></td>
</tr>
<tr>
<td>• Uterus corresponds to dates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Light bleeding</td>
<td>• Fainting</td>
<td>• Ectopic pregnancy</td>
</tr>
<tr>
<td>• Abdominal pain</td>
<td>• Tender adnexal mass</td>
<td>• (Table 4-3)</td>
</tr>
<tr>
<td>• Closed cervix</td>
<td>• Amenorrhoea</td>
<td></td>
</tr>
<tr>
<td>• Uterus slightly larger than normal</td>
<td>• Cervical motion tenderness</td>
<td></td>
</tr>
<tr>
<td>• Uterus softer than normal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Light bleeding</td>
<td>• Light cramping/lower</td>
<td>• Complete abortion</td>
</tr>
<tr>
<td>• Abdominal pain</td>
<td>• Abdominal pain</td>
<td></td>
</tr>
<tr>
<td>• Closed cervix</td>
<td>• History of expulsion of products conception</td>
<td></td>
</tr>
<tr>
<td>• Uterus smaller than the dates</td>
<td>• Cramping/lower abdominal pain</td>
<td></td>
</tr>
<tr>
<td>• Uterus softer than normal</td>
<td>• Partial expulsion of products of conception</td>
<td></td>
</tr>
<tr>
<td>• Heavy bleeding</td>
<td>• Partial expulsion of products of conception</td>
<td>• Inevitable abortion</td>
</tr>
<tr>
<td>• Dilated cervix</td>
<td>• Cramping/ lower abdominal pain</td>
<td></td>
</tr>
<tr>
<td>• Uterus corresponds to dates</td>
<td>• Partial expulsion of products of conception</td>
<td></td>
</tr>
<tr>
<td>• Heavy bleeding</td>
<td>• Nausea/vomiting</td>
<td>• Molar pregnancy</td>
</tr>
<tr>
<td>• Dilated cervix</td>
<td>• Spontaneous abortion</td>
<td></td>
</tr>
<tr>
<td>• Uterus larger than dates</td>
<td>• Cramping / lower abdominal pain</td>
<td></td>
</tr>
<tr>
<td>• Uterus softer than normal</td>
<td>• Ovarian cysts (easily ruptured)</td>
<td></td>
</tr>
<tr>
<td>• Partial expulsion of products of conception which resemble grapes</td>
<td>• Early onset pre-eclampsia</td>
<td></td>
</tr>
<tr>
<td>• No evidence of a foetus</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Light bleeding: takes longer than 5 minutes for a clean pad or cloth to be soaked.
b. Heavy bleeding: takes less than 5 minutes for a clean pad or cloth to be soaked.
### Table 4-2: Diagnosis and Management of Complications of Abortion (See Also Module 10)

<table>
<thead>
<tr>
<th>Symptoms and signs</th>
<th>Complication</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lower abdominal pain</td>
<td>• <strong>Infection/sepsis</strong></td>
<td>• Begin antibiotics as soon as possible before attempting manual vacuum aspiration</td>
</tr>
<tr>
<td>• Rebound tenderness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tender uterus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prolonged bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Malaise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Foul- smelling vaginal discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Purulent cervical discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cervical motion tenderness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptoms and signs</th>
<th>Complication</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cramping/ abdominal pain</td>
<td>• <strong>Uterine, vaginal or bowel injuries</strong></td>
<td>• Perform a laparotomy to repair the injury and perform manual vacuum aspiration simultaneously. Seek further assistance if required</td>
</tr>
<tr>
<td>• Rebound tenderness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Abdominal distension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Rigid (tense and hard) abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Shoulder pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nausea /vomiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fever</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Give ampicillin s g IV every 6 hours PLUS gentamicin 5 mg/kg body weight IV every 24 hours PLUS metronidazole 500 mg IV every 8 hours until the woman is fever free for 48 hours

### Management

If unsafe abortion is suspected, examine for signs of infection or uterine, vaginal or bowel injury (Table 4-2), and thoroughly irrigate the vagina to remove any herbs, local medications or caustic substances.
**Threatened Abortion**

- Medical treatment is usually not necessary.
- Advise the woman to avoid strenuous activity and sexual intercourse. Bed rest may be necessary.
- If **bleeding stops**, follow up in antenatal clinic. Reassess if bleeding recurs.
- If **bleeding persists**, assess for foetal viability (pregnancy test/ ultrasound) or ectopic pregnancy (ultrasound). Persistent bleeding, particularly the presence of a uterus larger than expected, may indicate twins or molar pregnancy.

**Note:**

Do **not** give medications such as hormones (e.g. oestrogens or progestins) or tocolytic agents (e.g. salbutamol or indomethacin) as they will not prevent miscarriage.

**Inevitable Abortion**

- If **pregnancy is less than 16 weeks**, plan for evacuation of uterine contents. If **evacuation is not immediately possible:**
  - Give ergometrine 0.2 mg IM (repeated after 15 minutes if necessary) OR misoprostol 400 mcg by mouth (repeated once after 4 hours if necessary);
  - Arrange for evacuation of uterus as soon as possible.
- If **pregnancy is greater than 16 weeks:**
  - Await spontaneous expulsion of products of conception and then evacuate the uterus to remove any remaining products of conception.
  - If necessary, infuse oxytocin 40 units in 1 litre of IV fluids (normal saline or Ringer’s lactate) at 40 drops per minute to help achieve expulsion of products of conception.
- Ensure follow-up of the woman after treatment

**Incomplete Abortion**

- If **bleeding is light to moderate** and **pregnancy is less than 16 weeks**, use fingers or ring (or sponge) forceps to remove products of conception protruding through the cervix.
- If bleeding is heavy and pregnancy is less than 16 weeks, evacuate the uterus:
  - Manual vacuum aspiration is the preferred method of evacuation of incomplete abortion less than 12 weeks of gestation. Evacuation by sharp curettage should be preferred for incomplete abortions above 12 weeks of gestation.
- If evacuation is not immediately possible, give ergometrine 0.2 mg IM (repeated after 15 minutes if necessary) OR misoprostol 400 mcg orally (repeated once after 4 hours if necessary)

**If pregnancy is greater than 16 weeks:**

- Infuse oxytocin 40 units in 1 L IV fluids (normal saline or Ringers lactate) at 40 drops per minute until expulsion of products of conception occurs;

- If necessary, give misoprostol 200 mcg vaginally every 4 hours until expulsion, but do not administer more than 800 mcg;

- Ensure follow-up of the woman after treatment (see below).

**Complete Abortion**

- Evacuation of the uterus is usually not necessary.

- Observe for heavy bleeding.

- Ensure follow-up of the woman after treatment:

**Follow-up**

- Before discharge, tell a woman who has had a spontaneous abortion that spontaneous abortion is common and occurs in at least 15% (one in every seven) of clinically recognized pregnancies. Also reassure the woman that the chances for a subsequent successful pregnancy are good unless there has been sepsis or a cause of the abortion is identified that may have an adverse effect on future pregnancies (this is rare).

- Some women may want to become pregnant soon after having an incomplete abortion. The woman should be encouraged to delay the next pregnancy until she is completely recovered.

- It is important to counsel women who have had an unsafe abortion. If pregnancy is not desired, certain methods of family planning can be started immediately (within 7 days) provided;

  - There are no severe complications requiring further treatment;

  - The woman receives adequate counselling and help in selecting the most appropriate family planning method;

  - (This is discussed in details in Module 12).

- Also identify any other reproductive health services that a woman may need. For example some women may need:

  - Tetanus prophylaxis or tetanus booster;
- Treatment/Management for sexually transmitted diseases (STDs)/HIV;
- Cervical cancer screening.
- Counselling support for rape/incest
- Support from wife battering, etc.

**Ectopic Pregnancy**

- An ectopic pregnancy is one in which implantation occurs outside the uterine cavity. The fallopian tube is the most common site of ectopic implantation (greater than 90%).
- Symptoms and signs are extremely variable depending on whether or not the pregnancy has ruptured (Table 4-4). Culdocentesis (cul-de-sac puncture) is an important tool for the diagnosis of ruptured ectopic pregnancy, but is less useful than a serum pregnancy test combined with ultrasonography. If non-clotting blood is obtained, begin immediate management.

**Table 4-3: Symptoms and Signs of Ruptured and Unruptured Ectopic Pregnancy**

<table>
<thead>
<tr>
<th>Unruptured ectopic pregnancy</th>
<th>Ruptured ectopic pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Signs and Symptoms of early pregnancy</strong></td>
<td><strong>Signs and Symptoms of shock</strong></td>
</tr>
<tr>
<td>- Irregular spotting or bleeding,</td>
<td>- Collapse and weakness</td>
</tr>
<tr>
<td>- Nausea</td>
<td>- Fast, weak pulse (110 per minute or more)</td>
</tr>
<tr>
<td>- Swelling of breasts</td>
<td>- Hypotension</td>
</tr>
<tr>
<td>- Bluish discoloration of vagina and cervix</td>
<td>- Hypovolaemia</td>
</tr>
<tr>
<td>- Softening of cervix</td>
<td>- Acute abdominal and pelvic pain</td>
</tr>
<tr>
<td>- Slight uterine enlargement</td>
<td>- Abdominal and pelvic pain</td>
</tr>
<tr>
<td>- Increased urinary frequency</td>
<td>- Rebound tenderness</td>
</tr>
<tr>
<td>- Abdominal and pelvic pain</td>
<td>- Pallor</td>
</tr>
</tbody>
</table>

*A distended abdomen with shifting dullness may indicate free blood.*
Differential Diagnosis

- The most common differential diagnosis for ectopic pregnancy is threatened abortion. Others are acute or chronic PID, ovarian cysts (torsion or rupture) and acute appendicitis.

- If available, ultrasound may help distinguish a threatened abortion or twisted ovarian cyst from an ectopic pregnancy.

Immediate Management

- Cross-match blood and arrange for immediate laparotomy. **Do not wait for blood before performing surgery.**

- At surgery, inspect both ovaries and fallopian tubes:
  - If there is **extensive damage to the tubes**, perform salpingectomy (the bleeding tube and the products of conception are excised together). This is the treatment of choice in most cases;
  - Rarely, if there is **little tubal damage**, perform salpingostomy (the product of conception can be removed and the tube conserved). This should be done only when the conservation of fertility is very important to the woman, as the risk of another ectopic pregnancy is high.

Auto-transfussion

- If **significant haemorrhage occurs**, auto-transfusion can be used if the **blood is unquestionably fresh and free from infection** (in later stages of pregnancy, blood is contaminated with amniotic fluid, etc. and should not be used for auto-transfusion). The blood can be collected prior to surgery or after the abdomen is opened:
  - When the woman is on the operating table prior to surgery and the abdomen is distended with blood, it is sometimes possible to insert a needle through the abdominal wall and collect the blood in a donor set.
  - Alternatively, open the abdomen:
    - Scoop the blood into a basin and strain through gauze to remove clots;
    - Clean the top portion of a blood donor bag with antiseptic solution and open it with a sterile blade;
    - Pour the woman’s blood into the bag and re-infuse it through a filtered set in the usual way;
    - If a donor bag with anticoagulant is not available, add sodium citrate 10 ml to each 90 ml of blood.
**Subsequent Management**

- Prior to discharge, provide counselling and advice on prognosis for fertility. Given the increased risk of future ectopic pregnancy, family planning counselling and provision of a family planning method, if desired, is especially important (Table 12-1).

- Correct anaemia with ferrous sulfate or ferrous fumerate 60 mg by mouth daily for 6 months.

- Schedule a follow-up visit at 4 weeks.

**Molar Pregnancy**

- Molar pregnancy is characterized by an abnormal proliferation of chorionic villi.

**Immediate Management**

- If the **diagnosis of molar pregnancy is certain** evacuate the uterus:
  - If cervical dilatation is needed, use a paracervical block (see Module 5);
  - Use vacuum aspiration. Manual vacuum aspiration is safer and associated with less blood loss. The risk of perforation using a metal curette is high;
  - Have three syringes cocked and ready for use during the evacuation. The uterine contents are copious and it is important to evacuate them rapidly.

- Infuse oxytocin 20 units in 1 Litre of I.V. fluids (normal saline or Ringer's lactate) at 60 drops per minute to prevent haemorrhage once evacuation is under way.

**Subsequent Management**

- Recommend a hormonal family planning method for at least 1 year to prevent pregnancy (**Module 12**) Voluntary tubal ligation may be offered if the woman has completed her family.

- Follow up every 8 weeks for at least 1 year with urine pregnancy tests because of the risk of persistent trophoblastic disease or chorocarcinoma. If the **urine pregnancy test is not negative after 8 weeks** or becomes positive again within the first year, refer the woman to a tertiary care for further follow-up and management.
Summary of Key Steps in Evaluation and Treating Clients with Incomplete Abortion

**Presentation**
- In a woman of reproductive age who has:
  - History of delayed menses
  - Vaginal bleeding
  - Cramping or lower abdominal pain
  - Passage of POC
  - Unexplained fever chills

**Initial step (screening)**
- Assess for signs of shock:
  - Rapid weak pulse
  - Low blood pressure
  - Pallor and sweatiness
  - Rapid breathing
  - Anxiousness, confusion or unconsciousness
  - Temperature > 38°C

**If there are signs of shock, immediate action is required!**

**Treatment:**
- **Module 8**
- After treatment of shock is initiated, proceed with medical evaluation

**Medical Evaluation**

**History**
- Date of LMP (missed period), duration and amount of bleeding, duration and severity of cramping, types of contraceptive (IUD, implants, injectables), abdominal pain, shoulder pain, drug allergies, bleeding or clotting disorder

**Physical exam**
- Vital signs, examination of heart, lung, abdomen and extremities
- Indication of systemic problem (sepsis, intra-abdominal haemorrhage)

**Pelvic Exam**
- Vaginal/cervical trauma, pus, pain on motion; uterine size, position and tenderness;
- Stage of abortion

**Other**
- Remove any visible POC, if possible, determine Rh and tetanus status

**Treatment**

- **Moderate to light vaginal bleeding**
  - Clean pad not soaked after 5 minutes
  - Fresh blood, no clots
  - Blood mixed with mucus
  - Treatment by MVA

- **Severe vaginal bleeding**
  - Heavy, bright red vaginal bleeding with or without clots
  - Blood – soaked pads, towels. Clothing pallor
  - Treatment by MVA or referral

- **Intra-abdominal Injury**
  - Distended abdomen
  - Decreased bowel sounds
  - Tense, hard abdomen
  - Rebound tenderness
  - Nausea, vomiting
  - Shoulder pain
  - Fever
  - Abdominal pain, cramping
  - Treatment or referral:

- **Infection (sepsis)**
  - Fever, chills
  - Foul smelling vaginal discharge
  - History of unsafe abortion
  - Abdominal pain
  - Prolonged bleeding
  - Flu-like symptoms
  - Treatment or referral

---

*National Postabortion Care Curriculum for Service Providers*
*Trainees Manual*
## Handout 4.3

### Hint for determining Uterine Size in the First Trimester

<table>
<thead>
<tr>
<th>Weeks LMP</th>
<th>Cervical Signs</th>
<th>Uterine Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>None (Non pregnant Uterus)</td>
<td></td>
<td>Uterus is about 7-8 cm long, 4-6 cm wide</td>
</tr>
<tr>
<td>5&lt;sup&gt;th&lt;/sup&gt; – 7&lt;sup&gt;th&lt;/sup&gt; week</td>
<td></td>
<td>Localized softening over the site of the placenta. Enlargement of uterus usually not palpable on examination.</td>
</tr>
<tr>
<td>6&lt;sup&gt;th&lt;/sup&gt; – 8&lt;sup&gt;th&lt;/sup&gt; Week</td>
<td><strong>Chadwick’s sign:</strong> Cervix becomes bluish colour (due to increased blood supply). Cervix softened, can be compressed during bimanual exam.</td>
<td>Uniform softening, round in shape.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Uterus slightly enlarged.</td>
</tr>
<tr>
<td>12&lt;sup&gt;th&lt;/sup&gt; week or greater</td>
<td>Cervix bluish, soft</td>
<td>Uterus soft round.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Uterus palpable above pubic symphysis during abdominal examination. Enlarged size dependent on gestational age.</td>
</tr>
</tbody>
</table>
1. **Socio-Demographic Data:**

   Date: ___________ Clinic Name: ____________________________________ Clinic No: __________

   Client’s Full Names: ________________________________________________________________
   
   First         Middle         Surname

   Client’s Address: Ward: ____________________ Village/Estate: ____________________
   
   Street: ____________________ District: ____________________

   Age: ___________ Occupation: ____________________________________________

   Education Level: ____________________________________________________________


   Husband/Partner’s Name: ________________________________________________________

   Husband/Partner’s Occupation: __________________________________________________

   Number of Children: Living: ________________ Dead: ________________

   Age of Last Living Child: ________________ Previous Conception Practice: Yes ________ No ________

   If yes, method used: ________________________________________________ Date of last visit to clinic: __________

2. **Medical History:**

   a. LMP: ____________________________ No. of bleeding days: __________________________

   b. **Current Medical History:**

      Any current illness? Yes ________ No ________

      Taking Medication? Yes ________ No ________

   c. **Past Medical History:**

      Severe Headaches? Yes ________ No ________

      Severe varicosis? Yes ________ No ________

      Jaundice? Yes ________ No ________

      Renal Disease? Yes ________ No ________

      Blood Pressure? Yes ________ No ________

      STD? Yes ________ No ________

      Epilepsy? Yes ________ No ________

      Tuberculosis? Yes ________ No ________

      Heart Problems? Yes ________ No ________

      Allergies? Yes ________ No ________

      Last PAP smear? Yes ________ No ________

      Grade  Date
      I
      II
      III
      IV
3. Examination:
   a. Physical:
      Blood Pressure: ___________  Pulse: ___________  Respiration: ___________
      Weight: ___________  Temperature: ___________  Pallor: yes: ___________  No ___________
      Breast: ___________  Heart: ___________  Abdomen: ___________
   b. Pelvic Examination:
      External Genitalia: __________________________________________________________________________
      Speculum:  Vagina: __________________________________________________________________________
      Cervix: __________________________________________________________________________
      Others: __________________________________________________________________________
      Discharge: __________________________________________________________________________  Type: ___________
      Digital:  Uterus: __________________________________________________________________________
      Size: __________________________________________________________________________  Consistency: ___________
      Adenexa: __________________________________________________________________________  Cervical Dilation: ___________
      Presence of POC: yes: ______  No: ______ others (state): __________________________________________________________________________
   c. Laboratory Tests:
      Urine:  Sugar: ___________  Albumin: __________________________________________________________________________
      Pregnancy Test:  Positive: ___________  Negative: __________________________________________________________________________

4. Diagnosis:
   a. Incomplete Abortion: _______________________________________________________________________
   b. Complete Abortion: _________________________________________________________________________
   c. Complications (Specify): ___________________________________________________________________
   d. Others (Specify): __________________________________________________________________________
   f. Cadre of Provider: __________________________________________________________________________
   g. Pain Management: Yes: ______  No: ______ Others (specify): __________________________________________________________________________

5. Management:
   a. Medicines:  At Facility _______/ Home Prescription _______/ Follow-up Date: ___________
   b. Counselling:  Pre ___________  Intra ___________  Post: __________________________________________________________________________

6. Method of Contraception Adopted before discharge:
   Pill:  Type: ___________________________________________________________________________  No of Cycles: ___________
   IUCD:  Type: ___________________________________________________________________________
   Condoms: ___________________________________________________________________________  No Issued: __________________________________________________________________________
   Depo Provera*: __________________________________________________________________________
   Norplant*: ___________________________________________________________________________
   Tubal Ligation __________________________________________________________________________
   Others (Specify): _______________________________________________________________________
   Non: (Reason): _________________________________________________________________________
7. **Referred to:**

   Name of Facility: ___________________________ Date: _______________________
   Time: ___________________ Contact Person: _____________________________
   Method of Referral: _________________________________________________________
   Expected Method of Feedback: ________________________________________________
   Date of Discharge: _______________ Name of Provider Discharging: ___________________
   General Remarks: __________________________________________________________________
   _______________________________________________________________________________
   _______________________________________________________________________________
   _______________________________________________________________________________
Summary

Using MVA outside a hospital’s major surgical suite encourages the use of analgesics or if necessary local anaesthesia with or without mild tranquilization rather than riskier general or regional anaesthetics. Lighter levels of pain control medication are not only appropriate for MVA, but also safer for clients and require fewer health system resources.

Because the woman is awake during the MVA procedure, clinicians must be very attentive to the management of pain through supportive interaction and proper medication and gentle operative technique. While each health facility needs an overall protocol for pain control medication, the individual service provider must respond to the individual particular needs of each woman treated.

Objectives

At the end of this session, the participants will be able to:

1. Describe the goal of pain control, especially for the MVA procedure.
2. List types of pain control and available methods in each type.
3. Describe the types of pain women may experience from incomplete abortion, and from the MVA procedure.
4. Demonstrate ability to select and administer appropriate pain control to meet the client’s needs.
5. Monitor the client’s status, make corrections in pain control medication if required, recognize symptoms of complication of anaesthesia, and treat if necessary.

5.1 Trainee Materials

- Handout 5:1.
Pain Control for MVA

Slide Guide

Slide 1

Pain Control for MVA

Slide 2

Goal of Pain Control: to ensure that the woman suffers minimum of anxiety and discomfort with least risk to her health.

Slide 3

Types and origins of pain experienced:

- Deep, intense pain from cervical dilation and/or stimulation.
- Diffuse lower abdominal pain with cramping from movement of uterus, scraping of uterine wall, uterine muscle spasms.
Slide 4

Nerves that transmit pain from cervix and uterus: note there are two different pathways.

Slide 5

General requirements of pain control:
- Quiet, non-threatening treatment room.
- Friendly, calm, attentive health workers.
- Clear explanations of what is happening.
- Efficient, well-trained team; gentle operative technique.
- Appropriate medications.

Slide 6

Types of pain control medication:
- Analgesia – eases sensation of pain.
- Anxiolytic – depresses central nervous system functions (reduces anxiety, relaxes muscles).
- Anaesthetic – deadens all physical sensation.
Effective Pain control for MVA is generally some combination of drug types with gentle handling, reassurance, and clear communication. However, in most cases of incomplete abortion where the cervix is open, analgesics at least 30 minutes before the evacuation would suffice.

### Use of Analgesia in MVA

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Mode</th>
<th>Duration of Effect</th>
<th>Common Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pethidine</td>
<td>IV, IM, or oral</td>
<td>2 hrs.</td>
<td>Drowsiness, light-headedness, weakness, euphoria, dry mouth</td>
</tr>
<tr>
<td>Paracetamol (acetaminophen) with Codeine</td>
<td>oral</td>
<td>3-6 hrs.</td>
<td></td>
</tr>
<tr>
<td>Diclofenac</td>
<td>oral</td>
<td>2 hrs.</td>
<td>Possible gastrointestinal upset</td>
</tr>
<tr>
<td>Aspergic</td>
<td>oral</td>
<td>up to 5 hrs.</td>
<td></td>
</tr>
<tr>
<td>Mefenamic Acid</td>
<td>oral</td>
<td>up to 4 hrs.</td>
<td></td>
</tr>
<tr>
<td>Ibuprofen (brufen)</td>
<td>oral</td>
<td>up to 5 hrs.</td>
<td></td>
</tr>
<tr>
<td>Paracetamol</td>
<td>oral</td>
<td>up to 4 hrs.</td>
<td></td>
</tr>
<tr>
<td>Ketamine (ketalar)</td>
<td>IV</td>
<td>10-15 min.</td>
<td></td>
</tr>
</tbody>
</table>
**Slide 10**

Use of Anxiolytics in MVA

<table>
<thead>
<tr>
<th>Drug Name (Generic)</th>
<th>Mode</th>
<th>Duration of Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valium (diazepam)</td>
<td>IV, oral</td>
<td>2 hrs.</td>
</tr>
</tbody>
</table>

**Slide 11**

Backup required for narcotics and anxiolytics:
- Clinicians trained in resuscitation
- Appropriate antagonist drugs
- Resuscitative equipment:
  - Ambu bag
  - Oxygen
  - Oral airway

**Slide 12**

Types of Anesthesia:
- **General** -- affects pain receptors in brain, produces complete unconsciousness.
- **Regional** -- blocks sensation from a specific point on the spine, patient awake.
- **Local** -- interrupts transmission of sensations in local tissue only.

Backup required for narcotics and anxiolytic: clinicians trained in resuscitation, appropriate antagonist drugs, resuscitative equipment.

Types of anaesthesia:
- **General** – affects pain receptors in brain, produces complete unconsciousness.
- **Regional** – blocks sensation from a specific point on the spine.
- **Client awake.**
- **Local** – interrupts transmission of sensations in local tissue only.
Slide 13

<table>
<thead>
<tr>
<th>Characteristics of Anesthesia</th>
<th>Pain Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of Complication</td>
<td>Recovery Time</td>
</tr>
<tr>
<td>Local</td>
<td>lower</td>
</tr>
<tr>
<td>Regional</td>
<td>higher</td>
</tr>
<tr>
<td>General</td>
<td>higher</td>
</tr>
</tbody>
</table>

If anaesthesia has to be used in MVA clinical situations, **local is safest!**

Slide 14

<table>
<thead>
<tr>
<th>Anesthetics for Paracervical Block</th>
<th>Pain Control</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Xylocaine (lidocaine)</td>
</tr>
<tr>
<td>Duration</td>
<td>60-90 min.</td>
</tr>
<tr>
<td>Advantages</td>
<td>Rare allergic reactions</td>
</tr>
<tr>
<td>Disadvantages</td>
<td>More toxic due to slow breakdown</td>
</tr>
<tr>
<td>Side Effects</td>
<td>Buzzing in ears, numbness of mouth, tongue, metallic taste</td>
</tr>
</tbody>
</table>

**Which local** to use for paracervical block.

Slide 15

<table>
<thead>
<tr>
<th>Paracervical Block</th>
<th>Pain Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>✦ Use 22 gauge spinal needle or needle extender with 10 cc syringe aspirate before each injection.</td>
<td></td>
</tr>
<tr>
<td>2-3ml (1% lidocaine/lignocaine without adrenaline) at 3, 5, 7, 9 o'clock. Wait 2-4 minutes for effect.</td>
<td></td>
</tr>
</tbody>
</table>
Slide 16

**Pain Control**

**Paracervical Block, con’t.**
- 2 ml lignocaine into each injection site
- 2-3 ml lignocaine at 3, 5, 7, 9 o'clocks (maximum dose = 16ml)
- Wait 2-4 minutes for effect

Slide 17

**Pain Control**

**Suggested Drug Combinations**

Analgesia + Anxiolytic + Paracervical Block

- pethidine + diazepam + paracervical block (oral)
- fentanyl + midazolam + paracervical block (IV)

**Suggested drug combinations:**
analgesia plus anxiolytic plus paracervical block
Oral:  pethidine plus diazepam plus paracervical block
IV:    fentanyl plus midazolam plus paracervical block

Slide 18

**Pain Control**

**Complications of Narcotic Analgesics & Treatment**
- Respiratory Depression: assist respiration with Ambu bag and oxygen
- Reverse pethidine or fentanyl with naloxone 0.4 mg IV

Complications or Narcotic Analgesics & Treatment
Respiratory Depression: assist ventilation with Ambu bag and oxygen
### Slide 19

**Complications of Anxiolytics & Treatment**
- Respiratory Depression: assist respiration with Ambu bag and oxygen
- Reverse benzodiazepines with flumazenil 0.2 mg IV

### Slide 20 (OPTIONAL)

**Complications of Local Anaesthetics & Treatment**
- Allergic reaction (rare):
  - If rash develops, give diphenhydramine (Benadryl) 25-50 mg IV
  - If respiratory distress, give epinephrine 0.4 mg subcutaneously, and support respiration

### Slide 21

**Complications of Local Anaesthetics & Treatment, con’t.**
- Toxic reaction (rare): Avoid by using smallest effective dose, aspirating before each injection
  - If mild, give verbal support, monitor closely for a few minutes
  - If severe, give immediate oxygen and slow IV diazepam 5 mg.
Postabortion Care Counseling

Summary:
The module addresses the importance of Postabortion counselling touching on definition, rights of a client, free and informed choice, counselling norms, addressing clients’ concern and needs and the three phases of counselling a PAC client including post procedure instructions.

Objectives
By the end of this session, participants will be able to:

1. Define Postabortion care counselling.
2. Describe the basic rights of the clients.
3. Define free and informed choice.
4. Describe the purpose and three phases of counselling for Postabortion client.
5. Describe norms for counselling.
6. Discuss PAC counselling in the context of existing PAC services.
7. Identify concerns and need of the client during the Postabortion medical procedure.
8. Describe post procedure instructions for the client.

11.1 Trainee Materials
- Learners Guide/Checklist.
Postabortion Care Counselling Definition

Description

- PAC counselling activities focus on helping individuals to make choices and to cope with the emotions raised by their situation.
- PAC counselling goes beyond just giving facts; it enables clients to apply information to their particular circumstances and to make informed choices.
- PAC counselling includes a discussion of feelings and concerns, since they are relevant to the client’s choices, particularly regarding sexual behaviour, reproductive health, and fertility.
- Counselling always involves two-way communication between the client and the provider, in which each spends time talking, listening, and; asking questions.

World Health Organisation Description:

“Counselling—face-to-face communication in which a counsellor assists the woman in making her own decisions and acting on them – must be a part of all postabortion (abortion) care..... Ideally, the same counsellor should provide support before, during, and after treatment; however, this is often difficult in a health care facility with limited staff and high caseloads. Nevertheless, a supportive and caring staff can do much to meet the psychological and emotional needs of women seeking postabortion (emergency abortion) care.

Counselling in abortion care can be provided by a variety of staff members, including nurses, midwives, physicians, social workers or nurse aides. Volunteers have been used successfully in some situations. A professional counsellor is not necessary; however, training in counselling techniques should be provided for any staff functioning as counsellors.

Staff who provides counselling must be non-judgmental, extremely sensitive to and respectful of the woman’s emotions and feelings, in order to adapt the session to the woman’s specific needs. Counsellors should be knowledgeable, well trained, and able to give accurate information. Counselling staff must always be aware of the need for privacy, confidentiality, and, in some cases, anonymity...Critical elements of all good counselling include the ability of the counsellor to elicit and listen to a woman’s needs, concerns and questions, and to inform, educate and reassure using language and terms that the woman understands... It is also useful to augment verbal explanations with written and pictorial materials to reinforce what has been said in the counselling sessions”
Rights of the Client

Every family planning client has the right to:

1. **Information**  
   To learn about the benefits and availability of family planning.

2. **Access**  
   To obtain services regardless of gender, creed, marital status, or location.

3. **Choice**  
   To decide freely whether to practice family planning and which method to use.

4. **Safety**  
   To be able to practice safe and effective family planning.

5. **Privacy**  
   To have a private environment during counselling or services.

6. **Confidentiality**  
   To be assured that any personal information will remain confidential.

7. **Dignity**  
   To be treated with courtesy, consideration, and attentiveness.

8. **Comfort**  
   To feel comfortable when receiving services.

9. **Continuity**  
   To receive contraceptive services and supplies for as long as needed.

10. **Opinion**  
    To express views on the services offered.
Client’s Rights and Needs of Service Provider:

### Handout 11.2b

#### Comprehensive PAC Client’s Rights

The comprehensive postabortion client has the same rights as the FP client.

<table>
<thead>
<tr>
<th>Right to:</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Information</strong></td>
<td>All members of the community have a right to information on the benefits of comprehensive PAC for themselves and their families. They also have a right to know where and how to obtain more information and services for planning or caring for their families.</td>
</tr>
<tr>
<td><strong>2. Access</strong></td>
<td>All members of the community have a right to receive comprehensive PAC services from health facilities or existing programs, regardless of their social status, economical situation, political belief, ethnic origin, marital status or geographical location. Access includes freedom from barriers such as policies, standards and practices that are not scientifically justifiable.</td>
</tr>
<tr>
<td><strong>3. Choose</strong></td>
<td>Individuals and couples have the right to decide freely where to receive comprehensive PAC services and whether or not to practice family planning. When seeking comprehensive PAC services, clients should be given the freedom to choose which method of contraception or reproductive health service to use.</td>
</tr>
<tr>
<td><strong>4. Safety</strong></td>
<td>Clients have a right to safety during comprehensive postabortion care.</td>
</tr>
<tr>
<td><strong>5. Privacy</strong></td>
<td>When discussing her postabortion care concerns, the client has a right to do this in an environment in which she feels confident that her conversation with the counsellor or service provider will not be listened to by other people. When a client is undergoing a physical examination it should be carried out in an environment in which her right to bodily privacy is respected.</td>
</tr>
<tr>
<td><strong>6. Confidentiality</strong></td>
<td>The client should be assured that any information she provides or any details of the service received will not be communicated to third parties without her consent.</td>
</tr>
<tr>
<td><strong>7. Dignity</strong></td>
<td>PAC clients have a right to be treated with courtesy, consideration, and attentiveness and with full respect of their dignity regardless of their level of education, social status or any other characteristics that would single them out or make them vulnerable to abuse.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>8. Comfort</strong></td>
<td>PAC clients have the right to feel comfortable when receiving services. This right of the client is intimately related to adequacy of service delivery facilities and quality of services.</td>
</tr>
<tr>
<td><strong>9. Continuity</strong></td>
<td>PAC clients have a right to receive reproductive health services including supply of contraceptives and other services for as long as they need them.</td>
</tr>
<tr>
<td><strong>10. Opinion</strong></td>
<td>PAC clients have a right to express their views on the services they receive.</td>
</tr>
</tbody>
</table>
Free and Informed Choice

Free and informed choice
Means that the clients are making free choices about their fertility. The three words free, informed and choice are all key to understanding the concept.

Free
Refers to a decision made without coercion, constraints or other forms of pressure. The word voluntary is sometimes used to express this concept.

Informed choice
Requires full information about the nature, risks and benefits of the available options.

Choice
Means that the client can decide whether or not to use the available options and can choose among them.

Ensuring free and informed choice
Is one of the goals of counselling Postabortion clients.
Confidentiality Means not discussing the woman’s personal information with her partner, the family member(s) accompanying her, or staff members not directly involved in her treatment (except where required in a life threatening emergency). Personal information includes her medical history and the conditions bringing her to seek care, the services provided to her, and the family planning decision she makes. (If she wants to involve a spouse or partner in decision-making, however, her wishes should be followed.)

Privacy Is critical to protecting the client’s confidentiality, sense of security and dignity, and willingness to communicate honestly. Often simple changes in the physical setting where clients are treated or counselled will offer them more privacy.

Dignity Means that a person can feel self-worth and honour, regardless of his or her physical circumstances. Ensuring privacy and confidentiality can help a client to maintain dignity.

Situations That May Encourage the Client’s Confidentiality, Privacy and Dignity jeopardised

- Leaving the client lying in a busy open area.
- Facing her feet toward the door, with her genitals exposed.
- Not using screens or curtains around her.
- Not adequately draping her.
- Openly discussing her case with anyone who walks in.
- Allowing people to walk in and out of the area frequently.
- Having casual conversations.
- Attempting to discuss discharge information or provide counselling in a busy, non private environment.
Before The PAC Procedure

• It is important to obtain sufficient medical information to make an accurate diagnosis and develop a treatment plan. Assure the client that these questions are being asked to get the information needed to best treat her medical condition. Examples of questions that should be asked are:
  - When did the bleeding start? Is it a lot or a little
  - How did the bleeding start? Was something done to start the bleeding? (Ask these questions with sensitivity and discretion)
  - Have you passed anything from the vagina besides blood? Did it look like skin or clotted blood with tissue?
  - Do you have pain? Where? When did it start? How bad is it?
  - Have you had a fever? Chills?
  - Have you felt weak? Fainted? Collapsed?

• All women being treated for abortion complications have a right to information about their condition, including:
  - Her overall physical condition.
  - Results of physical and pelvic examinations and lab tests.
  - The time frame for treatment.
  - The need for referral and transport to another facility.

Providers must have the client’s consent for treatment or, if she is unable, that of a family member or other responsible adult.

• Be sensitive to the client’s physical and emotional condition when providing information; forcing her to listen when she’s not ready will just be a waste of your time and hers.

• Always ask if the client has any questions for you.

• Explore her needs and feelings about her situation, and future plans, if her condition permits.
Counselling Postabortion
Client

• Assess client’s ability/capacity to give or receive information.
• Explore client’s needs and feelings.
• Examine values and life plans.
• Based on the woman’s condition, provide information about the following, as appropriate:

Pre-procedure
• Treatment procedure/pain management;
• Possible side effects/complications/risks;
• Human reproductive processes;
• Available contraceptive methods;
• Exams, findings.

During procedure:
Maintain emotional support by providing:
• Positive, empathetic, verbal/non-verbal communication;
• Gentleness while performing the procedure.

After procedure:
• Explore client’s feelings, questions, and concerns after procedure – provide support, encouragement;
• Remind client of possible side effects, risks, and warning signs – client should return when warning signs occur;
• Tell client how to take care of herself at home;
• Give written post-procedure information;
• Remind client of the importance of follow-up;
• Discuss available contraceptive methods as appropriate;
• Discuss RTIs/STDs;
• Assess the need for additional counselling and/or referral for other reproductive health needs or non-medical issues.
Post Emergency Procedure Counselling Guidelines for the Provider

**Handout 11.7**

**After the PAC Procedure**

- Approach the client when she is already calm and recovering from the procedure. Be sensitive to the client’s physical and emotional condition; forcing her to listen when she’s not ready will just be a waste of your time and hers.

- Be flexible about where you do counselling – sometimes clients may feel strong enough to get up and talk to the provider in a separate room; others may prefer to stay in bed and have counselling while still in recovery room.

- Be aware that the important thing is to provide the client with useful information that is suitable to her needs.

- If others have accompanied the client to the service site, ask if she would like to include them in the discussion.

- Start the counselling by exploring the client’s feelings, questions, and concerns after the Postabortion procedure.

- Follow the Postabortion counselling diagram (Handout 11:6) to check what information may be given to the client.

- Explore the client’s postprocedure plans.

- Provide the client with the *Postprocedure Information Sheet* and review it with her (and others, as appropriate).

- Offer to help her with whatever she needs, as appropriate, before saying goodbye.
Postabortal Syndrome

What Is It?

- Postabortal syndrome (also called postabortal hematometra) is severe cramping and discomfort due to the collection of blood in the uterus that can occur following evacuation of the uterus. Postabortal syndrome can present either immediately following the procedure or several days later.

What Causes It?

- Normally, following curettage or aspiration, the endometrial lining and any remaining pregnancy tissue flow out through the cervix. In the case of postabortal syndrome, after the procedure:
  - The cervical os becomes blocked;
  - The uterus fills with clots and continues to bleed;
  - The uterus cannot contract.

What are the Symptoms and Signs

- The symptoms include:
  - Severe cramping;
  - Sweating;
  - Light-headedness;
  - Nausea;
  - Vomiting and diarrhoea (occasionally).

- On exam, the client may exhibit the following signs:
  - Sweating;
  - Paleness;
  - Slight tachycardia;
  - Uterus is tense, tender, and enlarge on bimanual exam (often equal to or larger than the uterine size before the procedure).

- If postabortal syndrome occurs immediately following the procedure, the client generally reports increasing cramping and discomfort rather than the expected decreasing of these symptoms. With delayed onset, the client will usually report feeling well until the sudden onset of symptoms and signs, often with very light or no bleeding following the procedure.
How Is It Treated?

- Prompt re-evaluation of the uterus produces rapid relief of symptoms. Aspiration will yield blood and clots. There is rarely any remaining pregnancy tissue; however, it should be ensured that the uterus is completely evacuated.

How Can It Be Prevented?

- It is not possible to prevent all cases, but the incidence of postabortal syndrome can be reduced by:
  - Using the most appropriate-sized cannula;
  - Ensuring the completeness of the uterine evacuation;
  - Careful monitoring of clients in the recovery area, including their level of comfort and amount of bleeding, in order to detect early symptoms of postabortal syndrome.

What Else Should Be Considered?

- The following conditions and their treatments should also be taken into account when considering a diagnosis of postabortal syndrome:
  - Retained products of conception:
  - Reevacuate the uterus
    - Uterine perforation:
      - Avoid repeat aspiration if perforation was suspected at the time of the procedure, though the cervix and uterus may be carefully probed with a cannula or uterine sound. This may relieve blockage of the internal cervical os.
      - Infection:
        - Infection is less likely with immediately onset of symptoms. The clinical presentation of uterine tenderness and symptoms mimicking mild shock can be confusing. The history of feeling well up until the sudden onset of symptoms and the immediate relief of symptoms with re-evaluation can help distinguish postabortal syndrome from infection. If there is any question, antibiotics should be initiated.

What Does the Client Need to Know?

- The diagnosis and treatment should be explained in simple terms. The client should be instructed to watch for usual Postabortion warning signs, including fever, heavy bleeding, and abdominal pain. If she experiences any of these symptoms, she should return for immediate care. If she does not experience other complications, no further special care is necessary.
How to Take Care of Yourself:

Resume normal activities only when you feel comfortable enough to do so.

Take the medications you have been given correctly and completely:
______________________________ is an antibiotic to prevent or treat infection.
Take ______ Pills _____ times a day for _____ days until all the pills are gone.
______________________________ is for discomfort.
Take_________pills every _________ hours, as needed.
Iron tablets will make your blood normal and health again. Take _____ times a day.

Keep your follow-up appointment as scheduled on:______________________________.

Return at any time if you have concerns.

If you are interested in using a family planning method, talk to a provider about starting one right way. It is possible to become pregnant as soon as you resume sexual relations.

What to Avoid

• Strenuous activity for 2-3 days.
• Sexual relations until the bleeding has stopped.

What is Normal

• Bleeding and cramping similar to a normal period for up to one week.
• Mild fatigue for a few days.
• Mild depression or sadness for several days.

What is Abnormal

• Fewer.
• Dizziness, light headedness, or fainting.
• Abdominal pain.
• Severe cramping.
• Nausea, vomiting.
• Bleeding that is twice as heavy as a normal period.
• Vaginal discharge that smells bad.
Return **immediately** if you experience any of these symptoms

**Special Instructions**

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
### Assessing PAC Providers Skills in Counselling PAC Clients

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Procedure</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1.</strong> Prepares room, space and materials:</td>
<td></td>
</tr>
<tr>
<td><strong>a) Materials:</strong></td>
<td></td>
</tr>
<tr>
<td>• STI and HIV/AIDS pamphlets or posters</td>
<td></td>
</tr>
<tr>
<td>• Penile and female pelvic models</td>
<td></td>
</tr>
<tr>
<td>• Condoms - male and female</td>
<td></td>
</tr>
<tr>
<td>• Client cards</td>
<td></td>
</tr>
<tr>
<td><strong>b) Space and setting for privacy:</strong></td>
<td></td>
</tr>
<tr>
<td>• Seating for client and self.</td>
<td></td>
</tr>
<tr>
<td><strong>2.</strong> On arrival assess a clinical situation for life threatening complications and whether counselling is appropriate at this time. (If not arrange for her to be counselled later)</td>
<td></td>
</tr>
<tr>
<td><strong>3.</strong> Uses appropriate introductory technique culturally acceptable greeting.</td>
<td></td>
</tr>
<tr>
<td><strong>4.</strong> Use the following communication skills appropriately:</td>
<td></td>
</tr>
<tr>
<td><strong>a) Non technical language</strong></td>
<td></td>
</tr>
<tr>
<td><strong>b) Smiles</strong></td>
<td></td>
</tr>
<tr>
<td><strong>c) Culturally acceptable eye contact</strong></td>
<td></td>
</tr>
<tr>
<td><strong>d) Listening actively, no interruption</strong></td>
<td></td>
</tr>
<tr>
<td><strong>e) Encourages e.g. aha, go on, nod at client</strong></td>
<td></td>
</tr>
<tr>
<td><strong>f) Focusing the discussions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>g) Responding to clients non Verbal communication</strong></td>
<td></td>
</tr>
<tr>
<td><strong>h) Paraphrasing</strong></td>
<td></td>
</tr>
<tr>
<td><strong>i) Summarizing</strong></td>
<td></td>
</tr>
<tr>
<td><strong>j) Allowing client to ask questions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>k) Being open and non judgmental</strong></td>
<td></td>
</tr>
<tr>
<td><strong>5.</strong> Assure the client that all information given will be confidential</td>
<td></td>
</tr>
<tr>
<td><strong>6.</strong> Enquire from the client in a friendly tone</td>
<td></td>
</tr>
<tr>
<td><strong>a) When the bleeding started</strong></td>
<td></td>
</tr>
<tr>
<td><strong>b) How bleeding started</strong></td>
<td></td>
</tr>
<tr>
<td><strong>c) quantity of blood loss so far in terms of number of pads and tissue used, clots passed out</strong></td>
<td></td>
</tr>
</tbody>
</table>
### PRE-PROCEDURE (cont.)

7. a) Sensitively with discretion ask if something was done to start the bleeding.
   
   b) Was the pregnancy wanted or not.

8. Find out whether clots were passed out and if they included any tissue.

9. Enquire about pain when it started, where she feels most and how severe it is.

10. After examination explain in a simple language the client’s overall physical conditions and the findings.

11. Explains to the client in a simple language taking into account the client’s condition what will be done to the client to:
   
   a) Manage her condition
   
   b) Possible side effects or complications
   
   c) Female reproductive process and what is happening in her particular case.
   
   d) Available contraceptive methods. If she chooses IUD inform her that it will be fitted in the same sitting if no infection is found.

12. If referral is necessary inform the client about the timing, nature of referral and where she is being referred to.

### COUNSELING DURING PAC PROCEDURE

1. Greets woman respectfully and with kindness using culturally acceptable appropriate introductory technique.

2. Tells the client what you are going to do and encourage her to ask questions. Tell the client that she can ask for pain medication if the pain is not bearable.

3. Kindly reminds the clients that all the findings will be kept in confidence.

4. Gently covers the client with a draw sheet to reduce her emotional feeling nakedness.

5. Introduces all service providers in the evaluation or MVA room to the client and tell her what their role will be in serving her.

6. Inform the client politely that she is required to lie on her back on the operating table and find out if she has energy to climb or if she needs assistance.

7. Shows client how to take slow deep breathing to minimize the pain. Ask client to breath slowly in through their nose and out through their mouth to help them relax as they focus more on their breathing and less on the pain.

8. Assesses need for pain management medication.

9. Explains each step of the procedure before it is performed.

### STEP/TASK
### COUNSELLING DURING PAC PROCEDURE (cont.)

10. Waits a few seconds after performing each step to enable the client prepare for the next step.

11. Avoid saying things like "this won’t hurt" when it will hurt or "I am almost done" when you are not.

12. Moves slowly, with out jerky or quick motions.

13. Uses instrument with confidence and avoid noisy loud locking metallic instruments, knocking metallic surgical instrument among other metals.

14. Talks with the client throughout the procedure empathetically.

15. Informs the client of the findings when the procedure is over.

16. Kindly finds out from her if she is able with support to walk to resting area or inform that the problem is over and she is safe but for her comfort she has to be taken to the bed in the resting area on a trolley.

### POST MVA COUNSELLING SKILLS

1. Prepares room, space and materials
   - a) Materials
     - STI and HIV/AIDS, PAC pamphlets
     - FP, RH, STI counselling flip charts
     - FP method samples
     - Penile and female pelvic model if available
     - Client cards
   - b) Space to ensure privacy.
     - Seating for client and self

2. Approaches the client when she is already calm and recovering from the procedure

3. Takes care of the client’s physical and emotional condition by considering if the client is strong enough to get up and walk to the separate room or prefers to stay in bed and have counselling.

4. Use appropriate introductory technique culturally acceptable greeting.

5. Use the following communication skills appropriately
   - a) Non technical language
   - b) Culturally acceptable eye contact
   - c) Smiles
   - d) Listening actively, no interruption

---

*National Post Abortion Care Curriculum for Service Providers*  
*Trainees Handbook*  
**11-17**
<table>
<thead>
<tr>
<th>POST MVA COUNSELLING SKILLS (cont.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>e) Encourages e.g. aha, go on, nod at client</td>
</tr>
<tr>
<td>f) Focusing the discussions</td>
</tr>
<tr>
<td>g) Responding to clients non Verbal communication</td>
</tr>
<tr>
<td>h) Paraphrasing</td>
</tr>
<tr>
<td>i) Summarizing</td>
</tr>
<tr>
<td>j) Allowing client questions</td>
</tr>
<tr>
<td>k) Being open and non judgmental</td>
</tr>
</tbody>
</table>

6. Requests the client if she could discuss her future fertility and reproductive health intentions.

7. Asks the client if she would like others who accompanied her to the service site to be included in the discussion.

8. Explores the clients feeling, questions and concerns after the post MVA procedure.

9. Explores the clients post procedure plans.

10. Determines client needs and understanding of FP, STI/HIV/AIDS and other related RH issues.

11. Ask what the client already knows or wishes to know about FP, STI/HIV/AIDS and other related RH issues.

12. Ask if she was using contraception before she became pregnant, if she was, find out if she
   - Used the method correctly
   - Discontinued use
   - Had any trouble using the method
   - Have any concerns about the method.

13. Provide general information about Family Planning.

14. Explore any attitudes or religious beliefs that either favour or rule out one or more methods.

15. Give the woman information about contraceptive choices available and the benefits and limitation of each
   - Show where and how each is used.
   - Explain how the method works and its effectiveness
   - Explain possible side effects and other health problems.
   - Explain the common side effects

16. Discusses the clients’ need, concerns and fears in a thorough empathetic manner.
<table>
<thead>
<tr>
<th>STEP/TASK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>POST MVA COUNSELLING SKILLS (cont.)</strong></td>
</tr>
<tr>
<td>17. Asks what the client already knows or wishes to know about STI/HIV/AIDS.</td>
</tr>
<tr>
<td>18. Asks client what signs or symptoms or situations show possibility of being at STI, HIV risk</td>
</tr>
<tr>
<td>19. Provides the client with information on:</td>
</tr>
<tr>
<td>a) STI, HIV/AIDS risk factors which are:</td>
</tr>
<tr>
<td>- Multiple sexual partners</td>
</tr>
<tr>
<td>- Partner has multiple sexual partners and</td>
</tr>
<tr>
<td>- Client marital status</td>
</tr>
<tr>
<td>- Client occupation</td>
</tr>
<tr>
<td>- Unprotected sex including rape</td>
</tr>
<tr>
<td>- Sharing injection needles.</td>
</tr>
<tr>
<td>- Frequent change of partners</td>
</tr>
<tr>
<td>- Sexual orientation (Anal, homosexuality, oral and Lesbianism)</td>
</tr>
<tr>
<td>- Male or female has frequent bouts of STI:</td>
</tr>
<tr>
<td>- Abnormal genital discharge</td>
</tr>
<tr>
<td>- Genital ulcers</td>
</tr>
<tr>
<td>b) HIV risk factors: Genital ulcers (STI) in male and female.</td>
</tr>
<tr>
<td>c) Reinforces right information and tactfully corrects client’s misinformation.</td>
</tr>
<tr>
<td>20. Providing STI/HIV/AIDS information related to PAC/RH client needs and in build on manner.</td>
</tr>
<tr>
<td>a) Consequences of STI:</td>
</tr>
<tr>
<td>- PID</td>
</tr>
<tr>
<td>- Infertility</td>
</tr>
<tr>
<td>- Mother to child transmission (MCT)</td>
</tr>
<tr>
<td>- HIV</td>
</tr>
<tr>
<td>- Gonorrhoea</td>
</tr>
<tr>
<td>- Syphilis</td>
</tr>
<tr>
<td>- Cancer of cervix (Human papilloma virus)</td>
</tr>
<tr>
<td>b) HIV transmission and progression increased in presence of STI’s</td>
</tr>
<tr>
<td>c) STI and HIV preventive measures are the same.</td>
</tr>
</tbody>
</table>
d) HIV can be transmitted even when symptoms are not evident.

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>POST MVA COUNSELLING SKILLS (cont.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>e)</td>
<td>If adolescent, immature birth canal more prone to STI infection than in adult women.</td>
</tr>
</tbody>
</table>
| f)        | For immediate PAC client is prone to STI or HIV infection due to:  
- Raw tissues (e.g. uterine lining, cervix, vulva/vagina)  
- Having become pregnant (practiced unprotected sex) |
| g)        | Explains that only condoms, not other family planning methods prevent transmission of STI, HIV. |
| h)        | Demonstrate use of condom.  
- Male  
- Female |
| i)        | Assist client to correctly return demonstrations of condom use:  
- Male  
- Female |
| j)        | Elicits/confirms clients understanding of preventing STI or HIV infection:  
- Abstaining from sex  
- Being mutually faithful to a partner who has no other sexual partner.  
- Health sexual styles.  
- Consistent and correct use of condoms even when using another family planning method.  
- Correct use of medicines to prevent drug resistance. |

21. Helping client make decision or plan to prevent STI/HIV/AIDS  
   a) Asks client how she would prevent or her plans to prevent STI/HIV/AIDS.  
   b) Ask reason for the decision or plans shared.  
   c) Helps client to make an appropriate decision, if necessary  

22. Helps the client choose an appropriate Family planning method, RH including STI/HIV/AIDS, social or other services.  

23. Provides the Post PAC, FP, RH including STI/HIV/AIDS, social or other services base on the client’s decision and educational level leaflets/pamphlets and reviews them with her.  

24. Schedules a return visit and or  

25. Refers to other special RH facility including STI/HIV/AIDS, social and other services explaining why, where and to whom, if possible.
<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>POST MVA COUNSELLING SKILLS (cont.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.</td>
<td>To help the client with whatever she needs as appropriate before saying goodbye.</td>
</tr>
<tr>
<td>27.</td>
<td>Record relevant information.</td>
</tr>
</tbody>
</table>
Personal Qualities Needed by A PAC Counsellor

- Desire to work with and help people.
- Belief in the value of family planning.
- Respect for people and for their right to make decisions for themselves.
- Comfort with human sexuality.
- Comfort with the expression of feelings.
- Self-awareness of one’s values and limitations.
- Unbiased attitudes towards different population groups (for example, individuals of different age, ethnicity, religion, race, class, education, or gender).
- Tolerance for values that differ from one’s own.
- Empathy for clients.
- Supportive attitude towards clients.
- Ability to maintain confidentiality.
- Unbiased attitudes towards postabortion clients and various family planning methods.
- Professionalism.
Summary:
A woman’s fertility resumes almost immediately after an abortion (usually within two weeks after a first-trimester abortion). She should consider, therefore whether or not she wants to become pregnant again soon. For many clients, their experience with abortion represents a desire not to be pregnant at this time. Thus, the client, and her partner if she desires, should be offered counselling and information about her return to fertility and available contraceptive options. This is in keeping with the paragraph 8.25 from the International conference on Population and Development (ICPD 1994) Program of Action which states that, “All governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women’s health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services. Prevention of unwanted pregnancies must always be given the highest priority and all attempts should be made to eliminate the need for abortion. Postabortion counselling, education and family planning services should be offered promptly which will also help to avoid repeat abortions.”

According to the 1998 Kenya Demographic and Health Survey (1998 KDHS), the contraceptive prevalence rate (CPR) for the country as a whole was 39% for “currently married women”. However, there was also unmet need and 1 in 4 “currently married women” were in need of family planning, 10% because they wanted to delay their next births and 14% because they had achieved their desired family size. There is also a growing large number of “unmarried individuals” of reproductive age who want and are in need of family planning information and services. “The aim of family planning is to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods (ICPD).” In most instances, the emergency postabortion care setting may be one of the few contacts a client has with the health care system. Therefore, the time when she receives postabortion care is potentially an important opportunity for her to receive contraceptive information and services at the same sitting.
This module is designed for providers who have experience in family planning counselling and service delivery. In some cases, the background and experience of participants on family planning may be varied. The participants’ family planning knowledge should therefore be assessed by trainers and course organizers through completion of biodata forms either before reporting to the training or on the first day of the training. Full information about contraceptive methods and family planning counselling are not included in this module. If participants have not had basic family planning training, arrangement should be made for them to be trained according to national training practices and standards.

**Objectives:**

At the end of this session, the participants will be able to

1. Discuss appropriate use of contraceptive methods for clients after treatment of incomplete abortion.
2. Explain how the presence of infection, severe vaginal haemorrhage/cervical trauma and intra-abdominal injury affect the use of each method.
3. Discuss special considerations for contraceptive use after abortion in the second trimester.
4. Describe the local procedure for dispensing oral contraceptives barrier methods and for delivering clinically based methods according to local service delivery protocols.
5. Explain local referral protocols, where and how to get contraceptive methods and other essential information such as cost of methods.

### 12.1 Trainee Materials

- Handout 12.1 - 12.6
# Table 12.1: Family Planning Methods

<table>
<thead>
<tr>
<th>Type of contraceptive</th>
<th>Advice to start</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hormonal:</strong></td>
<td></td>
</tr>
<tr>
<td>- pills,</td>
<td>• Immediately</td>
</tr>
<tr>
<td>- injections,</td>
<td></td>
</tr>
<tr>
<td>- implants</td>
<td></td>
</tr>
<tr>
<td><strong>Condoms</strong></td>
<td>• Immediately</td>
</tr>
<tr>
<td><strong>Intrauterine device (IUD)</strong></td>
<td>• Immediately or at the same sitting if no infection; or</td>
</tr>
<tr>
<td></td>
<td>• If infection is present or suspected, delay insertion until it is cleared;</td>
</tr>
<tr>
<td></td>
<td>• If Hb is less than 7 g/dL, delay until <strong>anaemia</strong> improves;</td>
</tr>
<tr>
<td></td>
<td>• Provide an interim method (e.g. condom).</td>
</tr>
<tr>
<td><strong>Voluntary tubal ligation</strong></td>
<td>• Immediately if no infection. However, may need thorough screening for possible future regret.</td>
</tr>
<tr>
<td></td>
<td>• If infection is present or suspected, delay surgery until it is cleared;</td>
</tr>
<tr>
<td></td>
<td>• If Hb is less than 7 g/dL, delay until anaemia improves;</td>
</tr>
<tr>
<td></td>
<td>• If any sign of influence by what she has gone through, delay until mentally stable</td>
</tr>
<tr>
<td></td>
<td>• Provide an interim method (e.g. condom).</td>
</tr>
</tbody>
</table>
Cases for Review:

Case 1: A 17 year old woman was treated for incomplete abortion and will be released later today. You check the client's chart and find that she has been treated with MVA and there were no complications. The client's uterus was approximately 8 weeks size before treatment and her overall health status is good. The client says that she does not want to get pregnant again and would like to talk about family planning. She says that she does not want anyone, even her boyfriend to know that she is using family planning.

Case 2: A 30 year old woman was treated for incomplete abortion and is recovering. Her medical chart indicates that fragments of plastic were found in her vagina during her pelvic examination. When asked about her abortion she says that she did nothing to provoke it. She says that she does not want more children for a few years. She had been using POPs since her last child was born. She is also interested in the IUD because she has heard that it is a good method.

Case 3: A 20 year old woman who has 2 living children has just been treated for abortion and says that she does not want to be pregnant for a few years. She says that she wants to use the IUD because her sister has one and likes it. The client has no signs of infection but is probably slightly anaemic because she bled for 5 days before coming in for treatment. When you asked her about the abortion, she just shrugged her shoulders, looked at the floor and said it was surely a shame.

Case 4: A 28 year old woman is treated for incomplete abortion with MVA followed by surgery to repair damage to the uterus and bowel that were discovered during the MVA procedure. She has been hospitalized for several days but is now recovering. She says that she is interested in taking the pill. When you check the client's chart, you find that her blood pressure has been slightly elevated most of the times that it was checked. When you counsel her about the pill you find out that her father had a heart attack as a young man and one sister has mild hypertension.
Case 5: A 33 year old woman was treated for incomplete abortion two weeks ago and has returned to the family planning clinic. She seems to be in a hurry, being very concerned about getting home in time to complete her chores. You find out that the family does not know where she is and she knows that her mother-in-law and husband want her to have many more children. She wants more children too but not for a year or two.

Case 6: A 35 year old woman who has just been treated for incomplete abortion is very interested in Norplant or Jadell she does not want to have more children but just isn't ready for female sterilization. She is diabetic and weighs 73 kg.

Case 7: A 15 year old girl is treated for incomplete abortion with no complications. You suspect that she is a prostitute but you cannot confirm the suspicion. She says that she is interested in the IUD and does not really trust methods with hormones.

Case 8: A 39 year old woman with 7 children tells you that she and her husband have decide that they do not want to have any more children and she would like to be sterilized. When you check her medical chart you see that she has just been treated for abortion and that when she came to the hospital she had a uterine size of 15 weeks. You tell her that you cannot do the operation today because of the size and position of her uterus and she begins to cry because she lives so far from the hospital and does not know when she will be able to come back.

Case 9: A 28 year old woman treated for incomplete abortion tells you that this is the third time she lost pregnancy in the last five years. She asks you how to make sure that her next pregnancy is not lost.

Case 10: A 26 year old married woman was treated for incomplete abortion without complications. She said that she was taking injections before she became pregnant but has stopped because it took so long to walk to the nearest clinic for injections and when she was able to go, the clinic has run out of supplies. Besides, she really couldn’t afford the shots.
• **When can I resume sexual activity?**
  Three days after your bleeding has stopped.

• **How soon can I become pregnant?**
  Almost immediately - even before your next period.

• **How can I avoid becoming pregnant again?**
  Start using a family planning method now.

• **Which method can I use right away?**
  Ask your family planning counsellor which methods may be right for you. The family planning methods that can be safely used immediately after abortion include:
  - Condoms
  - Oral Contraceptives ("The Pill")
  - Injectables
  - Implants
  - Spermicidal foams, jellies, tablets, sponge, or film
  - Diaphragm or cervical cap
  - IUD*
  - Female or male sterilisation

• **Which methods protect against STDs?**
  Only **Condoms** and **Ablstinence** offer STD protection.

---

If you have intercourse without using a family planning method, ask your provider about emergency contraception. If you take a special dose of birth control pills within 72 hours (three days) after intercourse, you have much lower chance of becoming pregnant.

---

*The IUD should not be inserted following possible infection, injury to genital track, or severe bleeding with anaemia.
“Free and informed choice means that the client/family planning client chooses a contraceptive method voluntarily, and without pressure or coercion. It is based on a clear understanding of the benefits and limitations of the methods that are available. The client should understand that almost all methods can be used safely and effectively immediately after treatment of an incomplete abortion and that she can choose another method later if she wishes to change”. (except in the case of sterilisation)

Postabortion Care Consortium (1995)

“Remember:
Acceptance of contraception or of a particular method should never be a prerequisite for obtaining emergency Postabortion care”

World Health Organization (1995)

“The provision of emergency abortion care of elective abortion procedures must not be made conditional on the acceptance of family planning in general, or of specific method of contraception. Clients need information on a wide range of contraceptive methods in order to make their own selection, in consultation with clinic staff. Managers can ensure that coercion is not being used in method selection by monitoring trends in contraceptive distribution to clients after abortion.”


“Service providers should establish mechanisms to assure clients the opportunity to make informed, voluntary choices about Postabortion family planning use. Provision of abortion care should never be contingent on acceptance of a family planning method, and a client should never be given a method to which she does not consent. Furthermore no client should leave a service setting without all the information necessary to enable her to continue or discontinue use of the method she has chosen. Adherence to these principles is particularly important where long-term or provider-dependant methods are concerned and in the crisis context of emergency care settings”
### Individual Factors for Family Planning Counselling During Postabortion Care

**Handout 12.3**

**Please Note:**
(more than one may apply)

<table>
<thead>
<tr>
<th>If the client.....</th>
<th>Recommendations</th>
<th>Rationales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not want to be pregnant soon</td>
<td>♦ Consider all temporary methods.</td>
<td>♦ Seeking treatment for abortion complications suggest that the client does not want to be pregnant.</td>
</tr>
<tr>
<td>Is under stress or in pain</td>
<td>♦ Consider all temporary methods. Do not encourage use of permanent methods at this time. ♦ Provide referral for continued contraceptive care.</td>
<td>♦ Stress and pain interfere with making free, informed decisions. ♦ The time of treatment for abortion complications is not a good time for a client to make a permanent decision.</td>
</tr>
<tr>
<td>Was using a contraceptive method when she became pregnant</td>
<td>♦ Assess why contraceptive failed and what problems the client might have had using the method effectively. ♦ Help the client choose a method that she will be able to use effectively. ♦ Make sure that she understands how to use the method, get follow-up care and re-supply, discontinue use, and change methods.</td>
<td>♦ Method failure, unacceptability, ineffective use, or lack of access to supplies may have led to the unwanted pregnancy. ♦ These factors may still be present and may lead to another unwanted pregnancy.</td>
</tr>
<tr>
<td>Had stopped using a method</td>
<td>♦ Assess why the client stopped using contraception (e.g., side effects, lack of access to re-supply, etc.) ♦ Help the client choose a method that she will be able to use effectively. ♦ Make sure she understands how to use the method, get follow-up care and re-supply, discontinue use, and change methods.</td>
<td>♦ Unacceptability or lack of access may have led to the unwanted pregnancy. ♦ These factors may still be present and may lead to another unwanted pregnancy.</td>
</tr>
<tr>
<td>Has a partner who is unwilling to use condoms</td>
<td>♦ If the woman wishes, include her partner in counselling ♦ Protect the woman’s</td>
<td>♦ In some instances, involving the male in counselling will lead to his use of and</td>
</tr>
<tr>
<td>If the client.....</td>
<td>Recommendations</td>
<td>Rationales</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------</td>
<td>------------</td>
</tr>
<tr>
<td>or will prevent use of another method</td>
<td>confidentiality (even if she does not involve her partner) • Discuss methods that the woman can use without her partner’s knowledge (e.g., injectables). • Do not recommend methods that the woman will not be able to use effectively</td>
<td>support of contraception; however, if the woman, for whatever reasons, does not want to involve a partner, her wishes should be respected.</td>
</tr>
<tr>
<td>Wants to become pregnant soon</td>
<td>• Do not try to persuade her to accept a method • Provide information or a referral if the woman needs other reproductive health services.</td>
<td>• If the woman has had repeated spontaneous abortions, she may need to be referred for infertility treatment.</td>
</tr>
</tbody>
</table>

**Adapted from:** Leonard and Ladipo, 1994
### Guidelines for Contraceptive Use by Clinical Condition

<table>
<thead>
<tr>
<th>Clinical Condition</th>
<th>Precautions</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| **No complications** after treatment of incomplete abortion | ♦ **Natural Family Planning:** do not recommend until a regular menstrual pattern returns  
♦ **Female voluntary sterilization:** the time of treatment for incomplete abortion usually is not the best time for clients to make decisions about methods that are permanent  
♦ **Diaphragm or cervical cap:** should be refit after a second-trimester incomplete abortion | Consider all temporary methods  
♦ **Norplant implants:** can begin use immediately  
♦ **Injectables (DMPA, NET-EN):** can begin use immediately  
♦ **IUD:** can begin use immediately  
♦ **Oral contraceptive (combined or progestin-only):** can begin use immediately  
♦ **Condoms (male/female):** can be used when sexual activity is resumed  
♦ **Spermicidal foams, jellies, tablets, sponge or film:** can be used when sexual activity is resumed |
| **Confirmed or presumptive diagnosis of infection** | ♦ **Female voluntary sterilization:** do not perform procedure until risk of infection is ruled out or infection is fully resolved (approximately 3 months)  
♦ **IUD:** do not insert until risk of infection ruled out or infection fully resolved | ♦ **Norplant implants:** can begin use immediately  
♦ **Injectables (DMPA, NET-EN):** can begin use immediately  
♦ **Oral contraceptives (combined or progestin-only):** can begin use immediately  
♦ **Condoms (male/female) can be used when sexual activity is resumed**  
♦ **Spermicidal foams, jellies, tablets, sponge or film:** can be used when sexual activity is resumed |
<table>
<thead>
<tr>
<th>Clinical Condition</th>
<th>Precautions</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury to genital tract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Terine perforation (with or without bowel injury)</td>
<td>♦ <strong>Female voluntary sterilization:</strong> do not perform procedure until serious injury healed</td>
<td>♦ <strong>Norplant implants:</strong> can begin use immediately</td>
</tr>
<tr>
<td>• Serious vaginal or cervical injury, including chemical burns</td>
<td>♦ <strong>IUD:</strong> do not insert until serious injury healed</td>
<td>♦ <strong>Injectables (DMPA, NET-EN):</strong> can begin use immediately</td>
</tr>
<tr>
<td>• Spermicidal foams, jellies, tablets, sponge or film: do not begin use until vaginal or cervical injury healed</td>
<td>♦ <strong>Diaphragm or cervical cap:</strong> do not begin use until vaginal or cervical</td>
<td>♦ <strong>Oral contraceptive (combined or progestin-only):</strong> can begin use immediately.</td>
</tr>
<tr>
<td>Severe bleeding (haemorrhage) and related severe anaemia (Hb &lt;7 gm/dl or Hct&lt;20)</td>
<td>♦ <strong>Female voluntary sterilization:</strong> do not perform procedure until the cause of severe haemorrhage or anaemia resolved</td>
<td>♦ <strong>Condoms (male/female):</strong> can be used when sexual activity is resumed.</td>
</tr>
<tr>
<td>• Progestin-only pills: use with caution until acute anaemia improves</td>
<td>♦ <strong>Norplant implants:</strong> delay</td>
<td>♦ <strong>Spermicidal foams, jellies, tablets, sponge or film:</strong> can be used when sexual activity is resumed.</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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**National Postabortion Care Curriculum for Service Providers**  
Trainees Manual  
12-11
<table>
<thead>
<tr>
<th>Clinical Condition</th>
<th>Precautions</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| inserted until acute anaemia improves.   | - **IUD (inert or copper-bearing):** delay insertion until acute anaemia improves. | - **Diaphragm or cervical cap:** can be used when sexual activity is resumed.  
- “Some experts recommend starting using COCs exactly 1 week postabortion, as there is suggestion of a slight increase in coagulation factors measurable in the first few days after first trimester abortion, in women starting COCs immediately. If started later than 1 week, COCs may not be immediately effective because the ovary resumes follicular development as soon as 1 week after first trimester abortion.” |
| Second-trimester incomplete abortion     | - **Female voluntary sterilization:** Advisable to delay procedure until uterus returns to pregnancy size (4 to 6 weeks). If this is not possible, use minilap technique.  
- **IUD:** size of uterus requires skilled, experienced provider for high fundal placement. If this is not possible, delay insertion for 4 to 6 weeks.  
- **Diaphragm or cervical cap:** should be refit when uterus returns to pre-pregnancy size (4 to 6 weeks) | - **Norplant implants:** can begin use immediately  
- **Injectables (DMPA, NET-EN):** can begin use immediately  
- **Oral contraceptives (combined or progestin-only):** can begin use immediately.  
- **Condoms** (male/female) can be used when sexual activity is resumed  
- **Spermicidal foams, jellies, tablets, sponge or film:** can be used when sexual activity is resumed |
## Guidelines for Selection of Contraception by Method

<table>
<thead>
<tr>
<th>Method</th>
<th>Timing Postabortion</th>
<th>Advantages</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non - Fitted Barriers;</strong></td>
<td><strong>May be used as soon as sexual intercourse is resumed</strong></td>
<td>• Inexpensive</td>
<td>• Less effective than IUD or hormonal methods</td>
</tr>
<tr>
<td>(Latex and vinyl male/female condoms; vaginal sponge and suppositories (foaming tablets, jelly, or film)</td>
<td></td>
<td>• Good interim method if initiation of another method must be postpone</td>
<td>• Requires use with each episode of intercourse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No medical supervision required</td>
<td>• Requires continued motivation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Condoms (latex and vinyl) provide protection against STDs, including HIV</td>
<td>• Re supply must be available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Easily discontinued</td>
<td>• May interfere with intercourse.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Effective immediately</td>
<td></td>
</tr>
<tr>
<td><strong>Fitted Barriers used with Spermicides</strong></td>
<td>Diaphragm can be fitted immediately after first trimester abortion; after second trimester abortion, fitting should be delayed until uterus has returned to pre-pregnancy size (four to six weeks) Delay fitting cervical cap until bleeding has stopped and uterus has returned to pregnancy size (four to six weeks).</td>
<td>• Inexpensive</td>
<td>• Less effective than IUD or hormonal methods</td>
</tr>
<tr>
<td>(Diaphragm or cervical cap with foam or jelly)</td>
<td></td>
<td>• No medical supervision required for use</td>
<td>• Requires use with each episode of intercourse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Some protection against STDs, including HIV</td>
<td>• Requires continued motivation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Easily discontinued</td>
<td>• Re supply must be available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Effective immediately</td>
<td>• Associated with urinary track infections in some users</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Requires fitting by trained service provider</td>
</tr>
</tbody>
</table>
### Oral Contraceptives
(Combined and progestin-only)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Considerations</th>
</tr>
</thead>
</table>
| May begin pill use immediately, preferably on the day of treatment.     | • Highly effective  
• Can be started immediately even if infection is present  
• Can be provided by non-physicians  
• Does not interfere with intercourse  
• Requires continued motivation and daily use  
• Re supply must be available  
• Effectiveness may be lowered with long-term use of certain medications (e.g. rifampin, Dilatin, griseofulvin)  
• Condoms recommended if at risk for STDs including HIV |

### Injectable (DMPA, NET-EN)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Considerations</th>
</tr>
</thead>
</table>
| May be given immediately after incomplete abortion in the first or second trimester  
May be appropriate for use if a woman wants to delay choice of long-term method | • Highly effective  
• Can be started immediately even if infection is present  
• Can be provided by non-physicians  
• Does not interfere with intercourse  
• Not user-dependent (except for injection every 2 or 3 months)  
• No supplies needed by client  
• May cause irregular bleeding, especially amenorrhoea; excessive bleeding may occur in rare instances  
• Delayed return to fertility  
• Must receive injections every 2 or 3 months  
• Condoms recommended if at risk of GTIs and other STDs (HBV and HIV/AIDS) |

### Progestin-only implants
(Norplant/Jade II implants)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Considerations</th>
</tr>
</thead>
</table>
| May be given immediately after incomplete abortion. If adequate counselling and informed decision-making cannot be guaranteed, insertion must be delayed and an interim method provided.  
Should not be inserted until haemorrhage is controlled. | • Highly effective  
• Long-term contraception (implants effective for 5 years)  
• Immediate return to fertility on removal  
• Does not interfere with intercourse  
• No supplies needed by client  
• May cause irregular bleeding, (especially spotting) or amenorrhoea  
• Trained provider required to insert and remove  
• Cost-effectiveness depends on long-term use  
• Condoms recommended if at risk of GTIs and other STDs (HBV and HIV/AIDS) |
| IUD | • Delay insertion until serious injury is healed, haemorrhage is controlled or acute anaemia improves  
• Delay insertion until infection has been resolved (3 months)  
First-trimester  
• IUDs can be inserted if the risk or presence of infection can be ruled out. If adequate counselling and decision making cannot be guaranteed, delay insertion and provide and interim temporary method  
Second Trimester  
• Delay for 6 weeks unless equipment and expertise available for immediate postabortal insertion  
| Highly effective  
• Long-term contraception  
• Immediate return to fertility on removal  
• Does not interfere with intercourse  
• No supplies needed by client  
• Requires only monthly checking for strings (by client)  
• Only one follow up visit needed unless there are problems  
| • May increase menstrual bleeding and cramping during the first few months  
• Uterine perforation can occur during insertion  
• May increase risk of PID and subsequent infertility for women at risk of GTIs and other STDs (HBV and HIV/AIDS)  
• Trained provider required to insert and remove  |
| Female voluntary Sterilization (VSC) | • VS after first-trimester abortion is similar to an interval procedure; after a second-trimester abortion it is more similar to a postpartum procedure  
• Technically, VS procedures usually can be performed immediately after treatment of postabortion complications unless infection or severe blood loss is present  
• Do not perform until infection is fully resolved (3 months) or injury healed.  
| Permanent method  
• Most effective female method  
• Once completed, no further action required  
• Does not interfere with intercourse  
• No change in sexual function  
• No long-term side effects  
• Immediately effective  
| • Adequate counselling and fully informed consent are required before VS procedures; this is often not possible at the time of emergency care  
• Slight possibility of surgical complications  
• Requires trained staff and appropriate equipment  
• Condoms recommended if at risk for GTIs and other STDs (HBV and HIV/AIDS)  |
| Natural family planning | • Not recommended for immediate postabortion use  
• The first ovulation after an abortion will  
| No cost associated with method  
| Unreliable immediately after abortion  
• Alternative methods recommended until  |
| be difficult to predict and the method is unreliable until after a regular menstrual pattern has returned. | resumption of normal cycle  
- Requires extensive instruction and counselling  
- Condoms recommended if at risk of GTIs and other STDs (HBV and HIV/AIDS)  
- Requires continued motivation and a thorough understanding of how to use the method by the woman and her partner. |

**Service Delivery Capabilities**

A woman’s ability to use a method effectively is based in part on the resources of the community where she lives. To ensure continuity of care, health care providers must consider a woman’s family planning needs relative to the overall health care system. If a woman has travelled far from her home for treatment of postabortion complications, family planning providers need to know what services she will have access to when she returns home in order to help her choose an appropriate method. If provision of either counselling or methods is not possible on-site, refer the woman to a provider of these services in her community.
<table>
<thead>
<tr>
<th>Facility, provider and community Capability</th>
<th>Issues to consider</th>
<th>Recommendations</th>
</tr>
</thead>
</table>
| Opportunity, space and private environment for counselling | • Emergency care settings may be too crowded and hectic to ensure privacy and informed choice  
• Do not give permanent or long-acting methods (e.g., Norplant implants or injectables) without adequate counselling and assurance that the client has been able to make a well considered decision not influenced by stress, pain or other factors. | • Arrange space and time for private counselling  
• If adequate counselling is impossible, offer temporary methods and provide referrals for further counselling regarding other methods |
| Choice of contraceptive methods | • Do not limit the range of methods offered. Limiting the availability of methods will deny some women access to their preferred methods | • Make a range of methods available. Reduce provider bias for or against particular methods by educating providers about appropriate use of all methods |
| Links with family planning resources in the community | • Consider the woman’s access to follow-up care and re-supply in recommending methods | • Make sure counsellors and providers know about family planning resources throughout the area served.  
• Establish referral links among family planning resources or between postabortion care and family planning services. |
Managing Sexually Transmitted Infections (STIs)

Summary
This module provides an opportunity for PAC providers to have a common understanding about the content of the MOH STI Syndromic management flow charts and how to use them when linking comprehensive PAC client to other RH services.

Objectives
At the end of this session, participants will be able to:

1. Define STI, HIV/AIDS.
2. Explain why Postabortion clients may need information on STIs, HIV/AIDS.
3. List the essential information that all Postabortion clients must have about STIs before they leave the health facility.
4. Explain why it’s important to promote gender sensitivity in reproductive health.
5. Diagnose, treat syndromically and follow up clients with STIs.
6. Describe the management of HIV/AIDS clients.

13.1 Trainee Materials
- Flowchart on syndromic management of sexually transmitted infections (STIs)
- Guidelines on national AIDS/STD control programme (NASCOP)
- Ministry of Health, Kenya handout on STD and syndromic management Hatcher et al
- Essentials of contraceptive technology, Hatcher et al
- Handout 13.1 - 13.9
What are STDs?

- The term sexually transmitted disease refers to an infection that is passed from person to person by sexual contact. STDs are part of a broader group of infections known as reproductive tract infections. Some RTIs are not caused by sexual contact, but may be the result of an overgrowth of the bacteria and other organisms that normally live in the vagina. While some RTIs may cause only mild discomfort, others can be very serious. The presence of any infection that causes irritation of the skin in and around the vagina increases possibility of infection with HIV, the virus that causes AIDS. Viruses can enter the body through damaged skin more easily than through healthy skin. For client comfort and safety, all infections should be treated.

- When a client states that she or he has reproductive tract symptoms (pain, itching, swelling, sores, or discharge), the counsellor should remember that not all infections of the genitals or reproductive tract are the result of sexual contact. Telling a client he or she has a sexually transmitted disease can have serious negative consequences for the client and his or her sexual partners. Before doing so, the counsellor must be sure of the diagnosis.

What are the Symptoms of STDs?

- Symptoms are things happening in your body that may tell you when something is wrong. The following are common symptoms that someone who has an STD may experience. However, many people who have STDs, especially women, have no symptoms. A woman might only find out that she has an STD if her partner tells her that he has one and that she should get checked.

<table>
<thead>
<tr>
<th>Symptoms in Women</th>
<th>Symptoms in Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sores or bumps inside the vagina or around the entrance to the vagina or anus</td>
<td>• Sores on or around the penis or anus</td>
</tr>
<tr>
<td>• Pain during urination</td>
<td>• Discharge (fluid) from the penis</td>
</tr>
<tr>
<td>• Pain during sexual intercourse</td>
<td>• Pain during urination</td>
</tr>
<tr>
<td>• Unusual discharge (fluid) from the vagina that is:</td>
<td></td>
</tr>
<tr>
<td>• Bad-smelling</td>
<td></td>
</tr>
<tr>
<td>• Unusual looking (green or yellow colour, or foamy)</td>
<td></td>
</tr>
<tr>
<td>• Much more than normal</td>
<td></td>
</tr>
<tr>
<td>• Irregular vaginal bleeding</td>
<td></td>
</tr>
<tr>
<td>• Vaginal itching</td>
<td></td>
</tr>
</tbody>
</table>
• Having one of these symptoms does not necessarily mean that you have an STD, but if you do have symptoms then you should get checked at a clinic or hospital.

• STDs include:
  - Chlamydia;
  - Gonorrhoea;
  - Hepatitis B;
  - Syphilis;
  - Herpes;
  - Chancroid;
  - HIV/AIDS;
  - Human Papilloma Virus (HPV).

• What are the long-term effects of STDs?
  *(Use female and male reproductive system diagrams with explanation)*

**PID:**

• If an STD such as chlamydia or gonorrhoea is not treated in a woman, the infection can spread and lead to pelvic inflammatory disease (PID). In addition to infertility, PID can lead to chronic pain and to ectopic pregnancy, which can have serious complications.

• The symptoms of PID may include:
  - Pain or tenderness on the lower abdomen.
  - Fever.
  - Increased pain during menstruation.
  - Pain or bleeding during sexual intercourse.
  - Unusual discharge from the vagina.

**Infertility:**

• STDs such as chlamydia and gonorrhoea generally start, for women, in the cervix (between the vagina and the uterus) and, for the men such infections start in the penis (urethra). If not treated, the infection can spread into the uterus and fallopian tubes (women), or into the epididymis, testicles, and vas deferens (men) causing scar tissue, leaving the woman unable to become pregnant or the man unable to make a woman pregnant.
Illness in a baby:

- Some STDs can be passed from mother to baby, either during pregnancy or during delivery. This can cause serious illness for the baby.
- Some STDs are associated with serious illness or death, from PID to cervical cancer. Syphilis and HIV/AIDS can lead to many complications and death. Also, someone who already has an STD is at higher risk of passing or getting another STD (such as HIV/AIDS) to or from a partner.

*Discharge is not necessarily an indicator of an STD.*

GONORRHEA

- The bacteria that causes gonorrhoea grow in the warm, moist parts of the body, such as the urethra, the cervix, the rectum, and the throat (throat infection can occur following oral-genital sex with an infected partner).

**Symptoms:**

- In women, symptoms include unusual vaginal discharge, or dysuria. About 50% of them have no noticeable signs or symptoms. Untreated gonorrhoea may lead to pelvic infection with symptoms that include abdominal or lower back pain, pain during intercourse, bleeding between periods and fever. Pelvic infection can be a very serious condition and requires immediate medical care.
- In men, the symptoms of gonorrhoea are a cloudy or pus-like discharge from the penis, pain or burning with urination, or swollen and tender testicles. Some men have no symptoms.
- Gonorrhoea infections in the rectum often have no symptoms, but gonorrhoea in the throat may cause a sore throat.

**Risks:**

- In women, gonorrhoea can spread into the pelvic area and infect the uterus, fallopian tubes, and ovaries. This may cause enough damage to the women’s Reproductive organs that she can become sterile.
- In men, gonorrhoea can infect the epididymis, a structure where sperms are stored. The resultant epididymitis can lead to infertility.
- Gonorrhoea can be passed from mother to baby during birth, to the extent of causing blindness. Without prompt treatment, the infant’s eyes can be seriously damaged.
**CHLAMYDIA**

**Symptoms:**
- Women with Chlamydia often have no symptoms of infection. Some women notice an unusual vaginal discharge or bleeding after intercourse or between menstrual periods. Untreated Chlamydia may lead to pelvic infection with symptoms that include abdominal or lower back pain, pain during intercourse, bleeding between periods, and fever. Pelvic infection can be a very serious condition and requires immediate medical care.
- Symptoms in men usually include a clear discharge from the penis and burning with urination or swollen and tender testicles. Many men have no symptoms.
- The same bacteria that cause these symptoms (Chlamydia Trachomatis) can also cause another infection called LGV (lymphogranuloma venereum). The symptoms in LGV include genital sores (ulcers) and swollen lymph nodes (bubos).

**Risks:**
- In female clients, Chlamydia can spread into the pelvic area and infect the uterus, fallopian tubes, and ovaries. This may cause enough damage to the woman’s reproductive organs that she can become sterile.
- In men, chlamydia can affect the testicles and also cause sterility.
- Chlamydia can be passed from mother to baby during birth, infecting the baby’s eyes. Without prompt treatment, the infant’s eyes can be seriously damaged. Chlamydia trachomatis can also cause eye infections in children or adults, although this is not necessarily by sexual transmission.

**SYPHILLIS**
- It is caused by Treponema pallidum.

**Symptoms:**
- The first symptom of syphilis infection is usually a small painless sore in the area of sexual contact (penis, vagina, rectum, or mouth), which appears about three weeks after exposure and disappears within a few days. Shortly after the sore disappears, a rash, swollen lymph nodes, fever, or tiredness may be noticed, but these symptoms also disappear within a few weeks.

**Risks:**
- Syphilis is a very serious disease for both men and women. It spreads through the whole body. Without the proper antibiotic treatment, the disease can cause mental illness, blindness, heart disease, and death.
- Syphilis can be passed from mother to infant before birth, and an infected newborn may suffer from blindness, other severe organ damage, or death. Syphilis may cause abortion or premature delivery.

**TRICHOMONAS VAGINALIS**

- Trichomonas is a microscopic organism that can be sexually transmitted from person to person.

  **Symptoms:**
  - Both men and women may be infected with Trichomonas, yet have no symptoms. Some people may carry the organism for months or years with no symptoms at all, or they may have had symptoms that have gone away.
  - Women who have symptoms may notice an unusual vaginal discharge or odor, and itching or soreness of the vulva.
  - Men who have symptoms may observe a discharge from the penis and burning with urination.

  **Risks:**
  - Trichomonas itself is not known to lead to serious complications. However, recent evidence indicates that Trichomonas may be associated with early delivery in pregnant women. In addition, Trichomonas can cause irritation of the skin in and around the vagina, and the presence of damaged skin can increase the risk of HIV transmission.

**PELVIC INFLAMMATORY DISEASE**

- Pelvic inflammatory disease (PID) is an infection of the internal female organs, usually affecting the uterus, one or both fallopian tubes, the ovaries, and surrounding pelvic tissues. These tissues became inflamed, irritated, and swollen. PID is caused by several types of bacteria and other microorganisms. Nearly half of all cases of PID are caused by Chlamydia; Gonorrhoea is the other cause of a large percentage of PID cases. Both gonorrhoea and Chlamydia are sexually transmitted.

  **Symptoms:**
  - The primary symptom of PID is lower abdominal or pelvic pain. In mild cases, there may be only slight cramping, while in severe cases the pain may be intense. Physical activity, especially sexual intercourse, may greatly increase the pain. Abnormal vaginal bleeding (extremely heavy menstrual periods or bleeding or spotting between periods) is a very common symptom. Abnormal vaginal discharge and fever may also be present.
Risks:

- The complications following PID can be very serious. They include:

1. Repeat PID:
   Women who have had PID in the past are very likely to get it again.

2. Pelvic Abscess:
   This local collection of pus in the pelvis is formed by the breakdown of tissues. It is found in severe cases of PID. Pelvic abscess requires hospitalization and intravenous antibiotic treatment; it often requires surgery.

3. Infertility:
   When PID heals, scar tissue can form around the pelvic organs. This scar tissue can cause blockage and distortion of the fallopian tubes. The result is that the egg cannot get through the tube and into the uterus. After one episode of PID, a woman has an estimated 15% chance of infertility. After two episodes, the risk of infertility increases to approximately 35%, and after three, the risk is nearly 75%.

4. Chronic Pelvic Pain:
   Besides causing infertility, the scar tissue associated with PID may produce chronic pelvic pain or discomfort because of the distortion of the pelvic organs. Surgery may be required in severe cases.

5. Ectopic Pregnancy:
   An ectopic pregnancy occurs outside the uterus, most commonly in the fallopian tubes. Because PID can cause partial blocking or distortion of the fallopian tubes, the chances of an ectopic pregnancy are greatly increased in a woman who has had PID. An ectopic pregnancy is a very serious condition and must be surgically removed.

OTHER STDs

- There are many other infections that are sexually transmitted. Sores, growths, ulcers, or swollen lymph nodes in the genital area, and pain, burning or vaginal irritation are common signs and symptoms of STDs and other RTIs and should be evaluated by a clinician. When clients complain of these symptoms, they may or may not have an STD, but they should see a clinician for evaluation as soon as possible.
RTIs THAT ARE NOT CONSIDERED STDs

1. Bacterial Vaginosis

Bacterial vaginosis has been referred to by a number of different names (such as Gardnerella and Hemophilus). It is an overgrowth of a variety of normally occurring bacteria in the vagina, but the actual cause is unclear. Studies indicate that a woman with bacterial vaginosis has an increased chance of having a variety of other reproductive tract problems, so diagnosis and treatment are important.

**Symptoms:**

- Bacterial vaginosis usually causes a vaginal discharge that is grey in colour and has an unpleasant or fish-like odour. The discharge may or may not be accompanied by itching or irritation. Some women have no symptoms.

- Men usually do not have symptoms of this infection. It is unclear if they carry the bacteria and if bacterial vaginosis is sexually transmitted.

**Risks:**

- Bacterial vaginosis may increase a woman’s chance of having other reproductive tract problems, such as other types of infections. It has also been associated with early delivery in pregnant women and low birth weight in newborns.

2. Candidiasis (moniliasis)

Other names used for moniliasis include yeast and yeast infection. Moniliasis is caused by an overgrowth of organisms that are often present in low numbers in the vagina. Pregnancy and taking antibiotics are among things that can cause an overgrowth of these organisms, leading to irritation or itching in and around the outside of the vagina. Frequent exposure to semen over a short period of time can also cause moniliasis. Sometimes, but rarely, moniliasis can be passed sexually from person to person.

**Symptoms:**

- In women, symptoms of moniliasis include vaginal itching, irritation, burning, and sometimes a white, thick discharge.

- In men, moniliasis can appear as an itchy rash on the genitals.
Risks:

- Moniliasis does not infect the uterus or fallopian tubes and does not affect a woman’s ability to become pregnant. It may cause severe irritation, and because it damages the skin bothersome and do not require treatment.

CAN STDs BE TREATED?

• Most STDs can be treated and many can be cured. Treatment varies depending on the particular disease. Regardless of the type of medication given for treatment, it must be taken for the entire time it is prescribed, even if the symptoms go away. If not, remaining germs may multiply and spread, causing the symptoms to re-occur.

• If a client is diagnosed with an STD, his or her partner(s) probably has it too, whether or not the partner(s) has symptoms. They should both be treated for the STD, and any other partners should also be treated. If not, the untreated partner can pass the disease back to the treated one or to other partners. Both partners should complete the prescribed treatment before they have sex to be sure that none of the germs are passed from one to the other.

• There is no cure for herpes, HIV/AIDS, Hepatitis B, or HPV; but treatment may be possible for some symptoms and conditions (for example, herpes sores can be treated).

• How can I protect myself from getting an STD?

• The best way to lower your risk of getting an STD is to use condoms correctly every time you have sex. The only way to completely prevent getting an STD is to completely avoid sex and sexual contact. Having sex with one partner who is not infected and who has no other partners can also protect you against STDs. But if your partner has sex with others and becomes infected, then you can become infected through your partner.

How do STDs relate to family planning?

Male and female condoms can help prevent STDs as well as pregnancy, but other family planning methods do not offer good STD protection. It can be dangerous to get an IUD if you have chlamydia or gonorrhoea, even if there are no symptoms.
### Symptoms and Likely Diagnosis of Common STDs and Other Genital Infections:

#### Infections That Cause Painful Urination or Unusual Genital Discharge

<table>
<thead>
<tr>
<th>Likely diagnosis</th>
<th>Typical Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Woman</strong></td>
<td><strong>Man</strong></td>
</tr>
<tr>
<td><strong>Gonorrhoea and/or Chlamydia</strong></td>
<td></td>
</tr>
<tr>
<td>Difficult to diagnose.</td>
<td></td>
</tr>
<tr>
<td>• Unusual vaginal discharge.</td>
<td>• Painful urination</td>
</tr>
<tr>
<td>• Unusual vaginal bleeding.</td>
<td>• Drops of pus from his penis</td>
</tr>
<tr>
<td>• Lower abdominal pain.</td>
<td>• In men symptoms usually appear soon after infection.</td>
</tr>
<tr>
<td>• A woman can have gonorrhoea or</td>
<td>Without treatment, gonorrhoea and chlamydial infection</td>
</tr>
<tr>
<td>chlamydial infection for several</td>
<td>can cause sterility. If an infected woman gives birth,</td>
</tr>
<tr>
<td>months without symptoms.</td>
<td>her baby could get infected and go blind unless treated.</td>
</tr>
<tr>
<td>• Painful urination</td>
<td></td>
</tr>
<tr>
<td>• Ddrops of pus from his penis</td>
<td></td>
</tr>
</tbody>
</table>

| **Trichomoniasis**                |                                                          |
|                                   |                                                          |
| • Vaginal burning and itching.    | • Watery, white fluid from the penis.                    |
| • Foamy, green-yellow fluid with  | • Pain or burning when urinating.                       |
| a bad smell from the vagina.      |                                                          |
| • Pain or burning when urinating. |                                                          |

| **Bacterial vaginosis**           |                                                          |
| A common infection, not           |                                                          |
| sexually transmitted. Can come    |                                                          |
| from douching, pregnancy, or      |                                                          |
| antibiotics.                      |                                                          |
| • Gray sticky fluid from the     |                                                          |
| vagina (with a fishy smell       |                                                          |
| especially after sex.            |                                                          |

<p>| <strong>Candidiasis</strong>                   |                                                          |
| Rarely sexually transmitted. A   |                                                          |
| very common genital infection.    |                                                          |
| • Intense, vaginal burning and    |                                                          |
| itching.                          |                                                          |
| • Clumpy white fluid in and      |                                                          |
| around the vagina.                |                                                          |</p>
<table>
<thead>
<tr>
<th>Likely diagnosis</th>
<th>Typical Symptoms</th>
<th>Woman</th>
<th>Man</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Syphilis</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| An inexpensive screening test for syphilis is widely available | - Painless sore on the vagina or anus.  
- Sore may last only a few days, usually goes away without treatment.  
- Women may not notice it.  
- But the disease keeps spreading throughout the body.  
- Weeks or months later, the person may have:  
  - Sore throat,  
  - Skin rashes, and/or  
  - Mild fever.  
- All these symptoms may disappear.  
- Without treatment, however, syphilis causes heart disease, paralysis, insanity, and even death.  
- A pregnant woman can pass syphilis to her foetus before birth. |       | - Itchiness of the genitals.  
- White fluid under the foreskin (if uncircumcised).  
- Painless sore on the penis or anus.  
- Sore may last only a few days, usually goes away without treatment. But the disease keeps spreading throughout the body.  
- Weeks or months later, the person may have:  
  - Sore throat,  
  - Skin rashes, and/or  
  - Mild fever.  
- All these symptoms may disappear.  
- Without treatment, however, syphilis causes heart disease, paralysis, insanity, and even death. |
| **Chancroid**           |                          |       |             |
|                         | - Soft, painful sore on vagina or anus.  
- Swollen lymph nodes in the groin that contains pus.  
- These may open and drain pus, and scar up. |       | - Soft, painful sore on penis or anus.  
- Swollen lymph nodes in the groin that contains pus.  
- These may open and drain pus, and scar up. |
| **Lymphogranuloma venereum** | - In women, symptoms may not appear or may be difficult to notice.  
- Early symptoms:  
  - Swollen lymph nodes in the groin that may open and drain pus.  
  - Less common in women.  
- Late symptoms:  
  - Enlarged genitals,  
  - Abscesses around the anus,  
  - Narrowed rectum and anal fistula. |       | - In women, symptoms may not appear or may be difficult to notice.  
- Early symptoms:  
  - Swollen lymph nodes in the groin that may open and drain pus.  
  - Very common in men.  
- Late symptoms:  
  - Enlarged genitals,  
  - Abscesses around the anus,  
  - Narrowed rectum and anal fistula. |
<table>
<thead>
<tr>
<th>Likely diagnosis</th>
<th>Typical Symptoms</th>
<th>Woman</th>
<th>Man</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genital herpes</td>
<td>• One of more very painful blisters around the vagina or around the anus.</td>
<td>• One of more very painful blisters around the penis or around the anus.</td>
<td>• Blisters burst open and dry up to become scabs.</td>
</tr>
<tr>
<td></td>
<td>• Blisters burst open and dry up to become scabs.</td>
<td></td>
<td>• Sores can last for 3 weeks or more with first infection then disappear.</td>
</tr>
<tr>
<td></td>
<td>• Sores can last for 3 weeks or more with first infection then disappear.</td>
<td></td>
<td>• New blisters usually appear from time to time because the virus stays in the body.</td>
</tr>
<tr>
<td></td>
<td>• New blisters usually appear from time to time because the virus stays in the body.</td>
<td>• Blisters last a shorter time than on first infection.</td>
<td>• Blisters last a shorter time than on first infection.</td>
</tr>
<tr>
<td>Granuloma inguinale (donovanosis)</td>
<td>• Lumps under the skin in the genital area, most often between the labia and vagina.</td>
<td>• Lumps under the skin in the genital area, most often between the scrotum and thighs on men.</td>
<td>• Lumps grow, then break down into beefy, red ulcers.</td>
</tr>
<tr>
<td></td>
<td>• Lumps grow, then break down into beefy, red ulcers.</td>
<td></td>
<td>• Ulcers are painless but bleed when touched.</td>
</tr>
<tr>
<td></td>
<td>• Ulcers are painless but bleed when touched.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genital Human Papilloma virus (HPV)</td>
<td>If not treated, can lead to destruction of the genital organs.</td>
<td>If not treated, can lead to destruction of the genital organs.</td>
<td>Warts on or near penis or anus. Warts may not appear or may be difficult to notice.</td>
</tr>
<tr>
<td></td>
<td>• Warts on or near vagina or anus. Warts may not appear or may be difficult to notice.</td>
<td>Warts on or near vagina or anus. Warts may not appear or may be difficult to notice.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Client Screening:

History Taking:

- The first step in screening female clients is to do an STI screening history. It should include at least the following questions:
  - Are you having a vaginal discharge?
  - Have you had increased or irregular vaginal bleeding during the last few menstrual cycles?
  - In the past, have you had a genital tract problem such as a vaginal discharge or ulcers or skin lesions in your genital area?
  - Has your sex partner (spouse) been treated for genital tract problem, such as discharge (drip) from the penis, an ulcer or swollen groin glands in the last 3 months?
  - Does your sex partner (spouse) have other sex partners that you know of?
  - Have you had more than one sex partner in the last 2 months?
  - Do you think that you might have a genital tract infection?
- If the client answers “yes” to any of the above questions, she should undergo further evaluation for a possible STI. In addition, she should be counselled concerning the risks of transmission and the possible consequences of untreated, STIs, such as infertility.

Remember:
Because some of these questions are very sensitive, it may not be possible to ask them in a direct way; the service provider should obtain this information in a respectful and culturally sensitive manner. **Confidentiality must be assured for all clients.**

Client Screening:

Careful Abdominal and Pelvic Examinations

- The second step in screening a female client for possible STIs is to perform careful abdominal and pelvic examinations.
- In women it is important to check for:
  - Lower abdominal pain or tenderness;
  - Genital ulcers, sores or swellings (buboes) in the groin;
- Presence of a purulent (containing mucopus) discharge, friable (easily bleeding) cervix or unrecognized vaginal discharge;
- Pain on cervical motion;
- Suprapubic, adnexa or pelvic mass.

**Use Appropriate STI Flow-Chart:**

- Vaginal Discharges: Flow Chart 1.
- Genital Ulcers: Flow Chart 3.

**Use of the 4 C’s:**

1. Compliance.
2. Condoms.
3. Counselling/Education.
4. Contact Tracing.

1. **Compliance**

   Compliance includes taking all the drugs required for the full time and in the right dosage. Clients with STIs often stop taking their medicine when the symptoms decrease or go away. They need to understand the importance of continuing to take the drugs so the infection is fully cured.

   Compliance also includes returning to the clinic for follow up if the signs and symptoms do not improve. Compliance can be increased if clients understand the instructions and the reasons for them. To check if your client understands, ask her/him to repeat back the instructions before leaving.

2. **Condoms**

   Condoms can prevent the spread of STIs and HIV if used properly. Clients who continue with risky sexual behaviour needs to know how to use condoms properly. Health workers should be prepared to discuss and demonstrate use of condoms to clients. The service provider must demonstrate how to:

   a) Ensure that the condom is not expired
   b) Ensure that the package/condom is not punctured
   c) Properly open the package
   d) Pinch the “tit” to remove residual air and create reservoir for semen
   e) Ensure proper placement of the outer side and inner side before wearing a condom
   f) Properly roll the condom on erect penis
g) Safely remove the condom without self contamination
h) Safely dispose the used condom

You will need to feel comfortable talking about condoms and showing how they are used.

3. Counselling

Counselling includes giving health education messages. Listening to what clients say and how they say it can help you to give them the information they need. Although each encounter with a client is short, it is important to get across to every client with a STI the fact that they are at risk for HIV/AIDS. Every client with an STI needs to think about her/his sexual behaviour. (For more information about counselling, refer to Module 11).

4. Contact Tracing

Contact tracing requires health worker to establish a good relationship with the client. Clients need to understand the importance of advising their partners about the risk and encouraging them to seek treatment. Known contacts should be treated for the STI even if they have no symptoms themselves. Health workers can increase the number of contacts who come for treatment by giving clients appointments for their contacts, offering to discuss the risk with them and their contacts, streamlining care for contacts in their clinics so they are not kept waiting and having clients think about how they plan to tell their contacts.

**Give Return Visit and Follow-up Care:**

Follow return visit guidelines in appropriate flowchart.
Treatments for Common STDs and Other Genital Infections

These treatments are based largely on 1998 recommendations of the US Centres for Disease Control and Prevention.

IMPORTANT:

Various treatments are listed below. For the appropriate likely diagnosis, choose ONE treatment from the list. Choose a treatment known to be effective in your area. Consult supervisors if you are not sure. You can place an X or √ in a box to mark the appropriate treatment for your area.

a. Gonorrhoea and/or chlamydial infection

If possible, test, or refer patient to a convenient place for test and treatment. (Gonorrhoea test alone is useful because it may rule out that disease.) If not possible to test, both gonorrhoea and chlamydial infection can be treated at the same time. Give ONE treatment from EACH group.

Gonorrhoea treatments (choose ONE)

- Ciprofloxacin, 500mg tablet by mouth as a single dose. (Do NOT give to pregnant or breastfeeding women.)
- Ceftriaxone, 125mg intramuscular injection as a single dose.
- Cefixime, 400mg by mouth as a single dose.
- Ofloxacin, 400mg by mouth as a single dose AND azithromycin, 1g by mouth as a single dose. (Do NOT give ofloxacin to pregnant or breastfeeding women.)
- Spectinomycin, 2g intramuscular injection as a single dose.

Treatments that may be useful in countries where the disease is not commonly resistant to these medications:

- Kanamycin, 2g intramuscular injection as a single dose.
- Trimethoprim, 80 mg/sulphamethoxazole, 400 mg; 10 tablets by mouth daily for 3 days. (Do NOT give to pregnant or breastfeeding women.)

In most areas of the world, penicillin and tetracycline are no longer effective against gonorrhoea.

Tell patient to avoid sex until treatment is completed and symptoms are gone. Urge that sex partners(s) get treated.
Treatments for chlamydial infection (choose ONE)
- Azithromycin, 1g by mouth as a single dose.
- Doxycycline, 100mg by mouth 2 times daily for 7 days. *(Do NOT give to pregnant or breastfeeding women.)*
- Tetracycline, 500mg by mouth 4 times daily for 7 days. *(Do Not give to pregnant or breastfeeding women.)*

Treatment for pregnant or breastfeeding women:
- Amoxicillin, 500mg by mouth 3 times daily for 7 days.
- Erythromycin, 500mg by mouth 4 times daily for 7 days.

Tell patient to avoid sex for 7 days after treatment starts. Urge that sex partner(s) get treated.

b. Trichomoniasis/Bacterial vaginosis treatments (choose ONE)
- Metronidazole, 2g by mouth as a single dose.
- Metronidazole, 500mg by mouth 2 times daily for 7 days.
*(Do NOT give metronidazole to pregnant women before the fourth month of pregnancy.)*

Tell patient not to drink alcohol while taking metronidazole. It may cause nausea and vomiting. Urge that sex partner(s) get treated. Tell patient to avoid sex until treatment is completed and symptoms are gone in both partners.

c. Pelvic Inflammatory Disease Treatment
Treat for gonorrhoea, chlamydia, and trichomomas — all 3.

d. Candidiasis Treatments (Choose ONE):
*For Women:*
- Nystantin, 100,000 unit tablet inserted in vagina once daily for 14 days.
- Miconazole, 200 mg suppository inserted in vagina once daily for 3 days; or 100 mg suppository inserted in vagina once daily for 7 days.
- Clotrimazole, 500 mg tablet inserted in vagina as a single dose; or 100 mg tablet once daily for 7 days; or two 100 mg tablets once daily for 3 days.
For Men:

- Nystatin, miconazole, or clotrimazole cream or ointment, applied to infected area 2 times a day for 7 days.

**c. Syphilis Treatments**

For early disease—primary, secondary, or latent syphilis of 2 years or less (choose ONE)

*For anyone without penicillin allergy:*

- Benzathine penicillin C, 2.4 million units total, in 2 intramuscular injections during 1 clinic visit; give 1 injection in each buttock.
- Aqueous procaine penicillin G, 1.2 million units in 1 intramuscular injection once daily for 10 days.

*Allergic to penicillin* *(men and non-pregnant women only):*

- Doxycycline, 100mg by mouth 2 times daily for 14 days.
- Tetracycline 500mg by mouth 4 times daily for 14 days.

*Allergic to penicillin (pregnant women only):*

- Erythromycin, 500mg by mouth 4 times daily for 14 days. Not highly effective. Urge these women to bring their babies within 7 days after birth for treatment for congenital syphilis.

_Urge client to ensure that their sex partner(s) also get treated._

**Late Latent Syphilis or Latent Syphilis of Unknown Duration**

*For anyone without penicillin allergy:*

- Benzathine penicillin G, 7.2 million units total, administered as intramuscular injections in 3 doses of 2.4 million units each at 1-week intervals.

*Allergic to penicillin (men and non-pregnant women only):*

- Same as for early disease but treat for 4 weeks rather than 14 days.

*Allergic to penicillin (pregnant women only):*

- Same as for early disease but treat for 4 weeks rather than 14 days.
**Congenital Syphilis (Choose ONE)**

- Procaine penicillin G, 50,000 unit per kg of body weight, as one intramuscular injection daily for 10 days.
- Aqueous crystalline penicillin C, 100,000 to 150,000 U per kg of body weight per day, given as 50,000 units/kg intravenously every 12 hours for the first 7 days of life and every 8 hours thereafter for the next 3 days.

*If more than 1 day of treatment is missed, the entire course should be restarted.*

Typical symptoms of true allergy to penicillin are the symptoms of anaphylaxis, including severe facial swelling, widespread itching and hives, difficulty breathing and swallowing, sudden drop in blood pressure, weak and rapid pulse, nausea, vomiting, abdominal cramps, diarrhoea, confusion, dizziness, and possible loss of consciousness. Symptoms occur within 20 minutes after penicillin injection. In general, treatment involves maintaining an airway and giving oxygen and epinephrine.

d. **Chancroid Treatment (Choose ONE)**

- Azithromycin, 1g by mouth as a single dose.
- Ceftriaxone, 250mg intramuscular, injection as a single dose.
- Erythromycin, 500mg by mouth 4 times daily for 7 days.
- Ciprofloxin, 500mg by mouth 2 times daily for 3 days.

*(Do NOT give to pregnant or breastfeeding women or people under age 18.)*

- Trimethoprim, 80mg/sulphamethoxazole, 400mg; 2 tablets by mouth 2 times daily for 7 days. (Use only in area where it has been proved effective against chancroid and its effectiveness can be regularly monitored. Do NOT give to pregnant or breastfeeding women.)
- Re-examine in 3 to 7 days. Sex partner(s)—even those with no symptoms—should be treated if they had sex with patient within 10 days before patient’s symptoms started or since symptoms started.

e. **Lymphogranuloma Venereum Treatment (Choose ONE)**

- Doxycycline, 100mg by mouth 2 times a day for 21 days. (Do NOT give to pregnant or breastfeeding women.)
- Erythromycin, 500mg by mouth 4 times a day for 21 days.
- Tetracycline, 500mg by mouth 4 times a day for 14 days. (Do NOT give to pregnant or breastfeeding women.)
Urge client to ensure that their sex partner(s) also get tested and treated.

**Note:**
Clients should not have sex when blisters are present—not even with a condom. Herpes can be spread even when no blisters are present, but a condom may provide some protection.

**f. Genital Herpes Treatment**

- No cure available. The client should keep the infected area clean and try not to touch the sores. Antibiotic ointments may help.
- Duration of symptoms can be shortened if treatment begins early in an outbreak. If not started early, treatment may be ineffective.
- For first outbreak give acyclovir, 200mg by mouth 5 times a day for 7 to 10 days or 400mg 3 times a day for 7 to 10 days.
- For recurrences of blisters, give acyclovir, 200 mg by mouth 5 times a day for 5 days. If the client has outbreaks more than 6 times a year, treat with acyclovir, 400mg by mouth 2 times a day for 1 year and then reassess.

Urge that sex partners be evaluated and counseled and, if they have symptoms, treated.

**Note:**
A woman with herpes can infect her baby during childbirth. This is very dangerous for the baby and requires medical attention.

**g. Granuloma inguinale (donovanosis) Treatment (Choose ONE)**

- Trimethoprim, 80 mg/sulfamethoxazole, 400 mg, 2 tablets by mouth twice daily for at least 21 days or until sores heal. (Do NOT give to pregnant or breastfeeding women.)
- Tetracycline, 500 mg by mouth 4 times a day for at least 14 days or until sores heal. (Do NOT give to pregnant or breastfeeding women.)
- Doxycycline, 100 mg by mouth 2 times a day for at least 21 days or until sores heal. (Do NOT give to pregnant or breastfeeding women.)
- Erythromycin, 500 mg by mouth 4 times a day for 21 days, or until sores heal.
h. Human Papilloma Virus (HPV) Treatment

No cure available. Can be treated chemically or surgically for cosmetic purposes. If warts grow rapidly, check for HIV infection.

5. Preventing and Curing Sexually Transmitted Diseases (STDs)

First, prevent STDs.

- **Some STDs cannot be cured.** This includes HIV/AIDS.
- **Remember—ABC prevents STDs:**
  - Abstain from sex.
  - Be faithful. Stay with just one sex partner.
  - Consistently use Condoms.
- **Protect yourself against AIDS.** Other STDs increase your risk of getting HIV/AIDS.
- If you have an STD:
  - Seek care quickly if you think you might have an STD—even if you do not have symptoms.
  - Do not spread STDs: If you think you might have an STD, avoid sex or at least use condoms with every sex partner. If you are told you have an STD and given medicine, avoid sex until 3 days after you have taken all of your medicine and you have no more symptoms.
  - **Cure your infection:** Take all your medicine as directed even if symptoms go away or you feel better.
  - **Help your sex partners get treatment:** Tell them to come for treatment or else bring them in.
  - **Come back to make sure you are cured:** If you still have symptoms, you can get more medicine to cure your infection.
  - **Protect your baby:** Go (or help your wife go) to an antenatal clinic within the first 3 months of pregnancy for a physical exam and syphilis test.
Syndromic Approach in STI Management

Rationale:
- Health care providers lack time to diagnose and treat.
- Health care providers lack equipment to diagnose STIs using laboratory tests.
- Clients need relief of symptoms as some may abscond
- Many clients may not return for test results.
- Providers often diagnose based on clinical judgment, and often they are wrong.
- A person may have mixed infections.

Success Depends On:
- A reliable drug supply.
- Referral clinics.
- A structure to support STI services in primary health centres.
- Epidemiologic surveillance to identify the most cost effective antibiotics.
- Condoms readily and cheaply available and promoted to the public.
- Main media communication to alert people to STIs, encouraging them to seek treatment, promote condoms and support mutual monogamy.
- Contact tracing and treatment.

Types of STIs:
- Gonorrhoea.
- NGU - Non-gonococcal urethritis.
- Genital ulcer disease and buboes:
  - Syphilis;
  - Chancroid;
  - L.G.V. ;
  - Herpetic Ulcers;
  - Granuloma Inguinale.
- Other STI syndromes:
  - Viral hepatitis;
  - Venereal warts;
  - Molluscum contagiosum;
  - H.I.V;
  - Ectoparasites.
**Managing STIs:**

- Obtain Information:
  - About client’s health and sexual activity, about the sexual partner.
  - It gives an opportunity to explain STI transmission and prevention and to begin counselling.
  - Perform a Physical Examination:
    - Confirm the symptoms described by clients.
    - Allows providers to check for signs of STIs.
  - Levels of Physical Examination:
    - Symptoms only.
    - Simply observe and see, if with gloves can be more thorough.
  - Symptoms plus signs from:
    - A physical exam;
    - abdominal exam;
    - penile exam;
    - groin exam;
    - pelvic exam;
    - bimanual etc.
  - Symptoms plus signs plus simple tests, microscopy, acidity, ph of discharge, take specimens.
  - Symptoms plus signs plus simple tests plus culture done at STI referral centres.
  - Diagnosis and Treatment.

**Approaches of Diagnosing STI:**

1. **Etiologic Diagnosis:**
   - Identify organism with microscope or laboratory tests.
   - Expensive/time consuming
   - Require – 1 - 6 days for incubation and c/s
   - Require - needles, syringes, centrifuge etc.
2. **Clinical Diagnosis:**
   - Identify the STI causing symptoms based on clinical experience. Even experienced STI service providers, however can misdiagnose STIs when relying only on their clinical experience, and also mixed infections do occur.
3. **The syndromic Diagnosis:**
   - Diagrams and management on the basis of groups of symptoms or syndromes rather than for specific STIs.

**Advantages of Syndromic STI Management**
- Improves clinical diagnosis by avoiding wrong diagnosis and ineffective treatment.
- Can be learned by primary health workers, clinical officers, medical assistants, nurses, or nurse/midwives.
- Allows treatment of symptomatic clients in one visit.

**Disadvantages of Syndromic STI Management**
- Not adequately treating those with no symptoms.
- Women take up to 2 weeks to show symptoms.
- Wasting of drugs which are scarce in developing countries.

**Common STI Symptoms:**
- The 4 most common syndromes caused by STIs are:
  1. Genital ulcer in a man or woman.
  2. Urethral discharge on a man.
  3. Vaginal discharge.
  4. Lower abdominal pain in a woman.
- For a baby under one month old, swollen, infected eyes, or swollen vagina and cervix. The microorganism can be:
  1. Sexually transmitted.
  3. Iatrogenically introduced.

**Factors in Susceptibility to Infection:**
- Alteration in host immune system (AIDS).
- Disruption of normal ecological interaction with other flora by broad spectrum antibiotic.
- Dislocation of normal flora from one area of the body to other tissues which they never colonize under normal circumstances.

**Factors Affecting Occurrence of PID:**
- Cervical mucus plug;
• Cervical ectopy;
• IUD use;
• Sex – (sperm migration -microbes-stick on them.)

**Risk Factors For PID:**
• Age;
• Sexual activity;
• Contraceptives;
• Instrumentation: D&C, tubal insufflation, IUD insertion, legal abortion;
• Low socioeconomic status;
• Previous episode of PID.

**Infertility:**
• Definition - cohabitation and exposure to pregnancy without conception for a period of 2 years.
• Constitute 2/3 Gynae Consultations.
• In Africa 26-32% of couples are infertile.
• In Africa the main cause is STIs and pregnancy-related: (postpartum and postabortal infections).

**Causes of Infertility:**

<table>
<thead>
<tr>
<th>Causes</th>
<th>In Female</th>
<th>In Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>No course noted</td>
<td>16%</td>
<td>46%</td>
</tr>
<tr>
<td>Sperm defect</td>
<td>-</td>
<td>13%</td>
</tr>
<tr>
<td>Tubal factor</td>
<td>85%</td>
<td>20% varicocele</td>
</tr>
<tr>
<td>Ovarian factor</td>
<td>26%</td>
<td>11% accessory gland defect</td>
</tr>
<tr>
<td>Endometriosis</td>
<td>1%</td>
<td>-</td>
</tr>
</tbody>
</table>

**Prevention of infertility:**
• Improved diagnosis, treatment and control of STIs.
• Public education about STIs for both sexes.
• Expanded family planning services for men as well as women.
• Stressing barrier methods and the pill.
• Improved delivery and maternal health Care.
STD/HIV and Other Reproductive Health Problems:
- While HIV/AIDS occupy the headlines, other STDS create devastation of their own.

In Women STIs Can Lead To:
- PID:
  - Life long pain
  - Infertility.
  - Ectopic pregnancy
- Beatings and Divorce.
  Or
- Abandonment of infertile women.
- Death, through spontaneous abortion, ectopic pregnancy and cervical cancer.

STIs in Men Can Lead To:
- Urethritis.
- Urethral strictures.
- Epididyorchitis leading to fistulae and/or infertility.

In Children STIs Can Lead To:
- Eye infections (Ophthalmia Neonatorum) which can cause blindness
- Pneumonia
- Congenital Syphilis

Other Sequelae of STIs:
- Advanced stage syphilis.
- Facilitate transmission of HIV by nine-fold.

Statistics:
- Over 250 million new cases each year World Wide.
- 1 to 2 women in MCH clinics out of 10 may be infected with STI.
Kenyan Situation:
- PID:
  - 2nd most common reason for admission to the Gynae wards (Abortion being 1st);
  - 2/3 of gynae consultations are due to tubal infertility - mainly resulting from PID.
  - Estimated incidence 360/100,000 population.

C.F: Uganda:
- 30% Gynae admission are due to PID

C.F: Zimbabwe:
- 44%

Aetiology of PID
Chlamydia 50-65%
Gonorrhoea 15-30%
Polymicrobial The rest
- In Kenya - majority PID cases are due to gonococcal or chlamydial infections.

Normal Flora in the Vagina

<table>
<thead>
<tr>
<th></th>
<th>Aerobes</th>
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<tbody>
<tr>
<td>1</td>
<td>gram negative rods</td>
<td></td>
</tr>
<tr>
<td></td>
<td>gram positive cocci</td>
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<tr>
<td></td>
<td>gram negative cocci</td>
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<tr>
<td>2</td>
<td>gram positive rods</td>
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<tr>
<td></td>
<td>gram negative cocci</td>
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<tr>
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<th>Yeasts</th>
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<tr>
<td>3</td>
<td>Candida</td>
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<tr>
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<th>Mollicutes</th>
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<tr>
<td>4</td>
<td>Mycoplasma,</td>
</tr>
<tr>
<td></td>
<td>ureaplasma</td>
</tr>
</tbody>
</table>

Normal Flora Causing Infection by:
- Following childbirth or abortion through the placental bed.
- Hematogenous TB, pelvic peritonitis.
Syndromic STI Management Flow Chart

Handout 13.5
• **What is HIV?**
  - HIV is *human immunodeficiency virus*, the organism that causes AIDS. A person can be infected with HIV and not know it. HIV is found in the body fluids (particularly blood, semen, and vaginal secretions) of infected persons. It is believed that most people infected with HIV will develop AIDS. HIV can be transmitted whether symptoms of AIDS are present or not. There are tests that tell people if they have been exposed to the virus. They do not tell people if or when they will get AIDS.

• **What is AIDS?**
  - AIDS is *acquired immunodeficiency syndrome*, a condition caused by HIV that attacks the immune system and makes it unable to fight disease and infection. A person can be infected with HIV and not know it. The symptoms of AIDS are listed on the next page. Even if the symptoms of AIDS subside for a while, the virus that causes them is still present, and the infected person can still transmit the disease. AIDS is usually fatal. At present, there is no cure for AIDS. People with HIV/AIDS get sick easily with pneumonia, tuberculosis, diarrhoea, skin diseases and carcinoma and these diseases are the ones which kill them.

• **How is HIV Contracted?**
  - HIV is contracted:
    - Through sexual contact (vaginal, anal, or oral intercourse) with an infected person. During intercourse, semen or vaginal fluids and sometimes blood come into contact with the penis, the thin lining of the vagina, the rectum, or the mouth. HIV in these fluids can then get into the blood stream. HIV can enter the blood through the vagina, penis, anus, open genital or oral pores, or cuts.
    - Through transfusions or treatments with infected blood products.
    - Through skin-piercing instruments that have been in contact with
infected blood or body fluids and have not been properly disinfected (for example, needles, syringes, razor blades, or circumcision instruments used before on another client who was HIV positive).

♦ In infants, from an infected mother during pregnancy or childbirth. If the mother is infected with HIV, there appears to be a 15% to 30% chance that the newborn child will be infected. According to recent evidence, a breastfeeding child may have a higher risk of HIV infection through breast milk if the child’s mother is initially infected with HIV while she is breastfeeding. There is also some risk of HIV transmission in breast milk if the woman has been infected before beginning breastfeeding. However, the risk of HIV infection of the child must be weighed against the risk of the child dying from other causes if it is not breastfed. Diarrhoeal disease in young children, which can be fatal, is often attributed to lack of breastfeeding. If a woman is HIV positive, or suspects she is, and wishes to breastfeed, she should be encouraged to consult a doctor or nurse for advice.

• How is HIV NOT Contracted?
  - HIV is not contracted through any of the following:

  ♦ ordinary social contact;
  ♦ sharing clothes;
  ♦ touching shared food or dishes;
  ♦ kissing and hugging or shaking hands;
  ♦ toilet seats;
  ♦ insect bites;
  ♦ tears;
  ♦ saliva;
  ♦ sweat;
  ♦ living with an infected person.

What are The Symptoms of HIV Infection and AIDS?
  - Persons infected with HIV may be asymptomatic. It can take eight years or more between HIV infection and the diagnosis of AIDS. Once symptoms begin to develop, they may include:
• an unexplained 10% loss of body weight within one month;
• diarrhoea for one month or more;
• a white coating on the tongue;
• enlarged or sore glands in the neck and/or armpit;
• a cough that persists for more than one month;
• persistent fever of unknown origin;
• persistent symptoms of vaginitis.

Being well with no signs/symptoms (asymptomatic)

To having some signs and

To having some severe (symptoms)

And finally

Note:
Since these symptoms characterize other diseases (a persistent cough may be a symptom of tuberculosis; diarrhoea may indicate an intestinal illness), a blood test must be done to confirm the presence of HIV.

Who is at Risk?

- Anyone can become infected with HIV but only through the means described above. Clients who are at high risk include:

  • Commercial sex workers
  • Persons who have multiple sexual partners or whose sexual partners have had sexual relations with others,
  • Users of intravenous drugs,
  • Persons who have received unscreened blood products.
  • Health care workers who have direct contact with infected blood are at high risk.
Can HIV Infection and AIDS be Prevented?

- Though AIDS cannot be cured, HIV infection and AIDS cap be prevented by avoiding high-risk behaviour. The only way to be absolutely certain of avoiding HIV infection through sex is to abstain from sex. But, in general, the best advice to give clients is as follows:
  - Keep one faithful sexual partner and remain faithful to her or him. (In polygamous marriages, the husband and his spouses should remain mutually faithful.)
  - Use latex condoms. (Unless the couple has had a mutually faithful relationship for many years, or both partners have tested negative for HIV at least six months after their last possible exposure, HIV infection may be present.) Latex condoms are a wise choice for avoiding HIV infection and other STDs. They also prevent pregnancy.
  - Avoid sharing needles or using any skin-piercing instrument that has not been disinfected.
  - Remember ABC:
    - A means abstinence.
    - B means be faithful.
    - C means use condoms.
    - Avoid sharing needles or using any skin-piercing instruments.

Note:
Other STDs increase HIV/AIDS infection - STDs patients require immediate and effective treatment and counselling on HIV/AIDS.

REMEMBER:
HIV/AIDS
- HIV positive persons normally look as healthy as any other person. A fat person can be HIV positive and will pass on the virus before she/he becomes thin.
- Use of condoms will protect your partner from STIs apart from HIV.
Distribution of HIV/AIDS
More than 90% of all infected people with HIV/AIDS live in Sub-Saharan Africa and Asia.

Cure
In the absence of cure and or vaccine preventive measures are the main weapon in this struggle to contain HIV/AIDS epidemic:
- Behavioural change.
- Reduction in the number of sexual partner.
- Faithfulness.
- Abstinence.
- Condom use.

To Effect Behavioural Change
- Programs must be linked to a network of services which work together to develop talents and build self esteem.
- Offer Information that enables responsible decision making.
- Provide motivation to take a healthy action.
- Provide appropriate services and support.
- Include an element of empowerment.
- Incentives and rewards bring out the best in young people and keep them motivated.
- Programs must work to find out what adolescents actually want and like their most pressing needs.
- Young people want skills and knowledge to take control over and feel positive about their lives.

Building self-esteem:
Goals:
- Change health behaviour;
- Nurtured leadership skills;
- Linked information to services;
- Be proactive;
- Responsible decision making, for example;
  - Abstaining from sex before marriage.
  - Using condoms.
  - Resisting Peer Pressure.
Special Counselling Tips:
- Encourage and praise behaviour that lessens the risk of infection.
- Assist the client in finding alternatives to high-risk behaviour.
- Be non-judgemental.
- Explain risks and dispel myths in an objective manner.
- If the client shows any signs of HIV infection or AIDS or is at high risk of contracting HIV infection, refer her or him for testing, if it is available in your area.
HIV/AIDS:

- HIV positive persons normally look as healthy as any other person. A fat person can be HIV positive and will pass on the virus before she/he becomes thin.
- Use of condoms will protect your partner from STIs apart from HIV.

Distribution of HIV/AIDS:

- More than 90% of all infected people with HIV/AIDS live in Sub-Saharan Africa and Asia.

Cure:

- In the absence of cure and or vaccine preventive measures are the main weapon in this struggle to contain HIV/AIDS epidemic. Some of the preventative measures are:
  - Behavioural change;
  - Reduction in the number of sexual partner;
  - Faithfulness;
  - Abstinence;
  - Condom use.

To Effect Behavioural Change:

- Programs must be linked to a network of services which work together to develop talents and build self esteem.
- Offer Information that enables responsible decision making.
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- Programs must work to find out what adolescents actually want and like their most pressing needs.
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Building Self-Esteem:

Goals:

- Change health behaviour;
- Nurtured leadership skills;
- Linked information to services;
- Be proactive;
• Responsible decision making e.g.:
  - Abstaining from sex before marriage;
  - Using condoms;
  - Resisting Peer Pressure.

**Relationship between Sexually Transmitted Infections and HIV/AIDS Care:**

1. **High-risk Sexual Behaviour:**
   - High-risk sexual behaviour is a predisposing factor to getting an STI, including HIV. Having multiple partners and changing partners often are risky and expose people to STIs. People who have one STI are likely to get another STI. Talking to people with an STI and getting them to think about their high-risk sexual behaviour may help them to change their sexual behaviour and avoid getting another STI.
   - Having certain STIs such as genital ulcers also seems to increase the chance of getting AIDS. When a person has an HIV infection, s/he may not have taken the medication, but also that s/he may be resistant to the drug, may have been re-infected or s/he may have AIDS.

**Risk Behaviour and Groups at Risk of Contracting STI, HBV, HIV/AIDS:**

**Risk Behaviours**

- **Indiscriminate sex:**
  - Having many sexual partners.

- **Sharing intravenous needles:**
  - There is direct transmission through blood.

- **Drug addiction:**
  - Some drugs impair normal judgment and inhibitions, making an individual a target of sexual victimization. Drugs like cocaine increase libido and can be used to facilitate sexual arousal, while other drugs, (e.g., marijuana) are used to increase sexual sensitivity and perception of sexual experience. Drugs that are highly rewarding (users often feel good), like cocaine, can result in compulsive drug seeking behaviour in which sex may be used to obtain drugs.

- **Multiple sexual partners:**
  - Sex with many partners increase the risk of acquiring an STI and HIV because the probability of having sex with an infected person increases correspondingly

- **Commercial sex workers:**
  - They have multiple sexual partners and if one is infected, others in the pipeline have a greater chance of infection.
  - Clients of commercial sex workers and their partners are also vulnerable.
- **Health workers:**
  - They are at risk to the nature of their job, but if they practice infection prevention measures the risks are greatly reduced.

- **Recipients of blood and blood products:**
  - Transfusion of contaminated blood and blood products has been an important source of HIV, HBV and STI transmission for both men and women.

- **Not using condoms:**
  - Not using condoms to protect self if not in a mutually monogamous relationship.

### Groups at Risk
- Health workers.
- Long-distance truck drivers.
- Commercial sex workers.
- Homosexuals.
- Multiple sex partners.
- Blood transfusion recipients (HIV).
- Drug addicts.
- People with history of STIs.
- Youth.
- Clients of commercial sex workers.
- Partners of clients of commercial sex workers.

### Risk Reduction Behaviours That Can Be Used To Minimize Changes of Contracting STI, HIV/AIDS/HBV:
- Infection prevention measures should be taken by health workers to protect themselves and others.
- Limit number of sexual partners.
- Avoid commercial sex work and workers.
- Always use a latex condom for intercourse.
- Maintain one mutually monogamous sexual relationship. This reduces the risk of STIs. It may be necessary at the beginning of a new relationship for both partners to be tested to ensure that no STI is present.
- Abstinence is the best method of prevention of STIs, HBV, HIV/AIDS.
- Practice safe sex.
- Seek early and effective treatment if you suspect an STI and notify your sexual partner(s).
- Client Education/Counselling.
• Mode of transmission.
• Use of condoms.
• Have a single partner.
• Compliance with treatment and follow up.
• Complication of STIs.
• Where to go for counselling and services.

Assisting the Client with History of STI, HBV, HIV/AIDS to Choose an Appropriate FP Method:

<table>
<thead>
<tr>
<th>Method</th>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom/Spermicide</td>
<td>Good choice</td>
</tr>
<tr>
<td>Diaphragm/Spermicide</td>
<td>Good choice with condoms</td>
</tr>
<tr>
<td>COC</td>
<td>With condom</td>
</tr>
<tr>
<td>Injectable</td>
<td>With condom</td>
</tr>
<tr>
<td>Implants</td>
<td>With condom</td>
</tr>
<tr>
<td>IUCD</td>
<td>Not a good choice</td>
</tr>
</tbody>
</table>
Suspected (asymptomatic) HIV infection (HIV test available [A])

Asymptomatic client desires HIV test

Pre-test counselling

HIV test

Positive

HIV test

Post-test counselling

Post-test counselling

HIV infection highly likely

Repeat the screening test or carry out (or refer for) confirmatory test and further evaluation

Negative

Post-test counselling

Risk Assessment [B]

HIV infection unlikely

Advising to return for reassessment, as appropriate [B]

[A] ELISA or rapid test. If a test is not available, the client should be referred for testing, as HIV infection can be diagnosed only by means of a serological test. If the patient has symptoms and/or signs of HIV infection, use the appropriate algorithm.

[B] The presence of one or more of the following risk factors should alert the clinician to the possibility of HIV infection, the risk increasing with the number of risk factors:

1. Sex with a person with AIDS, HIV infection or known epidemiological risk factor or from an HIV-endemic region.
2. Anal sex between men
3. Multiple sex partners (e.g. more than 3 sex partners within the last 6 months)
4. Recent history of genital ulcer
5. History of transfusion of blood or blood products in the last 10 years
6. Intravenous drug use
7. History of injections, tattooing or undergoing medical or surgical procedures with nonsterile instruments (includes needle pricks in health personnel)

(Management of clients with sexually transmitted diseases, report of a WHO study Group – WHO 1991)
Guidelines to making a diagnosis of HIV infection

a.) Pre-test and Post-test Counselling

All patients undergoing an HIV test should do so after adequate pre-test counselling where they are informed of the nature of the test and the meaning and consequences of a positive test. Post-test counselling should form an integral part of the process of giving back HIV test results.

b.) Clinical Staging

All clients identified to be HIV seropositive should be given the opportunity for on-going counselling and support. For purposes of clinical management, all individuals diagnosed, as HIV+ should be classified according to disease stage as follows:
- Acute seroconversion syndrome
- Asymptomatic HIV infection
- Symptomatic HIV disease

Laboratory diagnosis of HIV infection

Laboratory testing for the diagnosis of HIV can be divided into four main categories:
- Antibody detection
- Antigen detection
- Testing for viral nucleic acid (RNA or PRO DNA)
- Culturing for the virus.

ELISA antibody detection is serological screening test used often to detect HIV infection.

Third generation ELISA’s which use recombinant antigens, are highly specific and highly sensitive. It is therefore recommended that for laboratory diagnosis of HIV infection, two ELISA’s for antibody detection should be done, one for screening and the other for confirmation. The two have to be positive for one to make a laboratory diagnosis of HIV-1 infection. In the event that one ELISA is positive and another negative, testing for viral nucleic acid (polymerase chain reaction – PCR) can be used for confirmation of the serostatus or Western blot assays.

Goals of HIV therapy and tools to achieve them.

Goals of therapy
- Maximal and durable suppression of viral load
- Restoration and/or preservation of immunologic function
- Improvement of quality of life
- Reduction of HIV related morbidity and mortality
**Tools to Achieve Goals of Therapy**
- Maximum adherence to the antiretroviral regimen
- Rational sequencing of drugs
- Preserving future treatment options
- Use of resistance testing in selected clinical settings where possible

**When to start therapy**
The decision to start therapy should be made after considering the client’s acceptance or readiness and the probability of adherence. The strength of the recommendation is dependant on the prognosis as determined by clinical state, CD4 cell count and viral burden.

**Table showing when to start therapy**

**Indication for the Initiation of Antiretroviral Therapy in the Chronically HIV-1 Infected Patient**

<table>
<thead>
<tr>
<th>Clinical Category</th>
<th>CD4+ Cell Count</th>
<th>Plasma HIV RNA</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic (AIDS, Severe symptoms)</td>
<td>Any Value</td>
<td>Any Value</td>
<td>Treat</td>
</tr>
<tr>
<td>Asymptomatic AIDS</td>
<td>CD4+ Cells&lt;200/mm³</td>
<td>Any Value</td>
<td>Treat</td>
</tr>
<tr>
<td>Asymptomatic</td>
<td>CD4+ Cells&gt;200/mm³ but &lt; 350/mm³</td>
<td>Any Value</td>
<td>Treatment should generally be offered, though controversy exists</td>
</tr>
<tr>
<td>Asymptomatic</td>
<td>CD4+ T cells &gt;350/mm³</td>
<td>&gt;30,000(bDNA) or &gt;55,000(RT-PCR)</td>
<td>Some experts would recommend initiating therapy, recognizing that the 3 year risk of developing AIDS in untreated patient is &gt;30%. In the absence of very high levels of plasma HIV RNA, some would defer therapy and monitor the CD4+ cell count and level of plasma HIV RNA more frequently. Clinical outcomes data after initiating therapy are lacking.</td>
</tr>
</tbody>
</table>
In resource poor setting, initiation for symptomatic patients can be started even when CD4 or viral load assessment tools are absent. The two assessments tests are, however, useful for monitoring therapy.

**Initiation Therapy in established HIV infection**

Before initiating therapy in any individual the following basic evaluation should be performed.

- Complete history and physical examination
- Total blood count, Urea and electrolytes and liver function tests
- CD4 (T-lymphocyte count)
- Viral load (Plasma HIV RNA)

Additional investigations should be targeted towards establishing factors leading to symptomatology including common opportunistic infections such as Tuberculosis, Cryptococcal Meningitis and Atypical pneumonia’s. It may also be advantageous to follow lipid profiles in most patients on antiretroviral therapy.

**Initiating Therapy in Patients with Asymptomatic HIV infection**

This is still controversial. A few facts however are well known:

- If the CD4 count falls below 200 then one is bound to suffer increasing incidences of opportunistic infections
- Although there is theoretical benefit to antiretroviral therapy for patients with CD4T cell counts greater than 200 cells/m3, no studies have been conducted to compare immediate against delayed potent therapy
- The optimal time to initiate antiretroviral therapy is not known

One should therefore weigh the risks and benefits of delayed and early therapy and discuss them fully with the client before initiating therapy. These risks and benefits are as outlined in the table, “Risks and benefits of delayed initiation of therapy and of early therapy in the asymptomatic HIV-Infected client”.
Risks and benefits of early therapy

Benefits of early therapy
- Control of viral replication easier to achieve and maintain
- Delay or prevention of immune system compromise
- Lower risk of resistance with complete viral suppression
- Possible decreased risk of HIV transmission

Risks of early therapy
- Greater cumulative drug-related adverse effects
- Earlier development of drug resistance, if viral suppression is suboptimal
- Limitation of future antiretroviral treatment options.

Risks and benefits of delayed therapy

Benefits of delayed therapy
- Avoid negative effects on quality of life (i.e., inconvenience)
- Avoid drug-related adverse effects
- Delay in development of drug resistance
- Preserve maximum number of available and future drug options when HIV disease risk is highest

Risks of delayed therapy
- Possible risk of irreversible immune system depletion
- Possible greater difficulty in suppressing viral replication
- Possible increased risk of HIV transmission

It is important to note that the risk of viral transmission still exists, and antiretroviral therapy cannot substitute for primary HIV prevention measures (e.g., abstinence, faithfulness, condoms and safer sex practices).

Antiretroviral profile
The gold standard of anti-retroviral therapy is HAART.

What is HAART?
Highly Active Anti-Retroviral therapy is a combination of three or more antiretroviral drugs in the treatment of HIV infection. These antiretroviral drugs fall in three different classes and work at different sites on the HIV virus.
Standardized Anti-Retroviral Regimen for Kenya

The ministry of Health has come up with a standardized regimen on antiretroviral regimen. The process of formulating the regimen took in account efficacy, cost tolerability and opportunities for second line (in case of resistance, side effects and treatment failure). These drugs are to be included in the Kenya Essential Drug list.

Justification

In view of the proposition to scale ARV therapy countrywide, the need of a simple guide on ARV regimen has been realized. The regimen will assist in standardizing care while making it possible for first line health workers such as clinical officers and nurses to participate in active management of clients. The regimens proposed herein have been deliberated on in several meetings by members of the ARV task force which draws representation from a number of multi-sectoral partners.

First Line

1. Stavudine (D4T)/Lamivudine (3TC)/Efavirenz (EFV)
2. D4T/3TC/Nevirapine (NVP) in pregnant women

This combination is associated with better tolerability, is cost effective and efficacious. D4T was selected because of being cost effective and is not associated with bone marrow suppression as is AZT. Secondly anaemia is a common presentation in our population, whether it is due to nutritional deficiencies, disease or as a result of HIV/AIDS.

EFV and Nevirapine (NVP) compare favourably cost wise. EFV has been shown to be efficacious, is better tolerated and pill burden is absent as compared to NVP. Thirdly, NVP is associated with liver damage unlike EFV. However, in pregnant women or women likely to become pregnant, NVP was preferred to EFV because the latter has been shown to be teratogenic in animal studies.

ARV therapy in clients with TB

D4T + 3TC+EFV (800mg/day)

The committee recommended that ARV therapy should be withheld during the intensive phase of TB therapy to allow close monitoring of client response to anti-TB drugs. Secondly, the clients will be excused from a heavy pill burden. It was emphasized that protease inhibitors should not be combined with Rifampicin due to drug interaction.

Adults and Adolescents

1st line

D4T+3TC+EFV
D4T+3TC+NVP in pregnant women or women likely to become pregnant.
2nd Line
AZT+DDI+Lopinavir+Ritonavir (Lopinavir and Ritonavir can be substituted by Nelfinavir).

Children under 13 years

1st Line
D4T+3TC+NVP

Prevention of Mother to Child Transmission

1st Line
Nevirapine if mother is not symptomatic
D4T+3TC+NVP in symptomatic disease

Patients with Tuberculosis
- Avoid ARVs during intensive phase
- D4T+3TC+EFV (800 gm/day)

Post Exposure Prophylaxis
Low risk exposure – AZT+3TC
High-risk exposure – AZT+3TC+Indinavir
Gender Equality in Reproductive Health

a. Why is Male Involvement Important for Reproductive Health?
   - There is general consensus that initiatives aimed exclusively either at men or at women are not desirable. To achieve reproductive health there must be full communication, participation, and partnership between men and women.
   - Couple communication has the strongest positive influence on the current contraception use, and couple communication increases if men are involved.

   - A study in Kenya has shown that men reacted positively to the promotion and introduction of vasectomy services.
   - Men’s sexual choices and behaviours can affect their reproductive health as well as that of their partners.
   - Previous exclusion of men from family planning programmes has also meant exclusion from education and counselling on the prevention of pregnancy and STIs/HIV.
   - Men and women’s needs should be dealt with together, since most sexual, family planning, and child-bearing decisions should ideally be a joint affair.
   - Men and women may negotiate about fertility and reproductive health matters, but their behaviour is strongly influenced by social norms.
   - Reproductive outcomes and contraceptive use correlated more closely to men’s preferences than to women’s.
   - Most decisions about reproductive health are made by men.
   - Many men feel that women should take responsibility for contraception, but that men should control the decision-making.
   - Norms that subordinate women’s role in sexual decision-making often discourage them from acting to promote their own reproductive health needs.
• Studies have shown that between one-quarter to two-thirds of African husbands who do not want more children are not practicing family planning.
c. **How Can Service Providers Involve Men in Reproductive Health Programmes?**

   - Provider bias and ridicule has been a major obstacle to male involvement. To promote male involvement:
     - Providers should not assume that men are not interested in contraception or reproductive health.
     - If the female client is agreeable, providers should encourage and facilitate the inclusion of male partners when providing reproductive health services.
     - At each visit, the service provider should ask the client if s/he would like his/her partner to be present at the next visit.
     - Providers should work with couples to improve their communication skills.
     - Channel IEC messages and campaigns aimed at men through the workplace, male recreational settings, and mass media.
     - When providing IEC, target couples rather than individuals.
     - Include male partners when conducting home visits.
Module Summary:
Documenting and maintaining client’s service and clinic records is important. It contributes towards guiding the service provider monitor and evaluates services provided, make realistic planning including use of resources (personnel, monetary, equipment and supplies) at sites, modify practices that hinder clients from seeking the service, prepare and submit appropriate service data to the DHMT. Service data is relevant for monitoring RH programs, meeting the needs of the clients at minimum cost and time, including assessing the extent that the district RH services addresses health needs and goals.

General Objectives:
At the end of this session, the participants will be able to:
1. Explain the purpose of record keeping.
2. Describe vital PAC information for documentation.
3. Demonstrate the ability to enter correct data and maintain PAC records.
4. Explain the use of records, presentation, storage and retrieval of records.
5. Demonstrate the ability to analyse and use data from records at site.
6. List the types of records and reports used in RH service.

14.1 Trainee Materials
- Handouts 14.1 -14.6
- Kenya Postabortion Care Performance Standards.
Procedure for submitting records

All records are submitted to the district, provincial and headquarters using:

- Tally sheets and quarterly returns
- Monthly consolidated morbidity forms
- Death record forms
- Forms for notifiable diseases
- Staff returns

Ensure that the participants recognize the importance of internal reports, i.e., from unit to head of department.

Participants should only address or be acquainted with the ones relevant to postabortion care. They will review those included in handouts. The following flowchart summarizes the procedure of submitting reports.

<table>
<thead>
<tr>
<th>Dispensary Health centre</th>
<th>District through DPHN for statistical analysis</th>
<th>Provincial level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-district</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Collecting information from client</td>
<td>Collecting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>from client</td>
</tr>
<tr>
<td></td>
<td>Proper recording of client information in the</td>
<td>Proper storage</td>
</tr>
<tr>
<td></td>
<td>relevant form/book</td>
<td>of clients’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>records</td>
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KEY:  
- Report Upwards – upper management level for future projection
- Feedback downwards – disseminate as feedback as an incentive to enhance quality
- Demand action
## Procedure Register

<table>
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<tr>
<th>Monthly No.</th>
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<th>Date (DOA)</th>
<th>Patient’s Name</th>
<th>Marital Status</th>
<th>Age</th>
<th>Uterine Size</th>
<th>Parity</th>
<th>Diagnosis</th>
<th>Evacuation Method</th>
<th>Provider</th>
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<td>Referral To:</td>
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**Summary Record**

KENYA MINISTRY OF HEALTH
QUARTERLY REPORT & REQUEST FOR CONTRACEPTIVES

Province ____________________________ District ____________________________

Full Name of SDP/Clinic ________________________________________________

Registered Number of SDP ____________________________

Facility Type: Depot □ District Store □ Other Store □ SDP/Clinic GOK: □ NGO □ Private □

Report of Quarter Beginning ___________20 ________ Ending___________20 _______

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<tr>
<th>Contraceptive</th>
<th>Beginning Balance</th>
<th>Received This Qtr</th>
<th>Dispensed/Issued</th>
<th>Withdrawn</th>
<th>Expired</th>
<th>Losses</th>
<th>Ending Balance</th>
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<tr>
<th>New Clients</th>
<th>Natural FP Counselling</th>
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<th>Sterilization</th>
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<tr>
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**Comments:** ----------------------------------------------------------

Submitted by: ___________________________  ___________________________

Name          Signature

**Designation:** ___________________________ **Date:** ___________________________
# Handout 14:3 CONSUMPTION RECORD

## DAILY ACTIVITY REGISTER (FAMILY PLANNING)

<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Client</th>
<th>Client Number</th>
<th>Client Type</th>
<th>Oral contraceptive (Cycles)</th>
<th>Injectable</th>
<th>Implants</th>
<th>IUCDs (Units)</th>
<th>Condoms (pieces)</th>
<th>Sterilization</th>
<th>Natural FP</th>
<th>Gloves</th>
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<td>Foaming tablets (tabs)</td>
<td>Done</td>
<td>Referral</td>
<td>Counselling</td>
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</table>

- **B c f**
- **Received**
- **On Hand**

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*National Post Abortion Care Curriculum for Service Providers*

*Trainee’s Manual*

14-5
## Store Keeping Records – Bin Cards

### Handout 14.5

<table>
<thead>
<tr>
<th>Reference</th>
<th>Receipt</th>
<th>Issue</th>
<th>Balance</th>
<th>Date</th>
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<th>Receipt</th>
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</table>

**DESCRIPTION OF ITEM**

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*National Post Abortion Care Curriculum for Service Providers*

*Trainee’s Manual*

*14-6*
**Transaction Record**

**Handout 14.6**

**REPUBLIC OF KENYA**

**COUNTER REQUISITION AND ISSUE VOUCHER**

Ministry .............................. Dept./Branch .............. Unit .................
To (issue point) .............................................................. please issue the stores
listed below to (point of use) .................................

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<tr>
<th>Code</th>
<th>Item Description</th>
<th>Unit of Issue</th>
<th>Quantity Required</th>
<th>Quantity Issued</th>
<th>Value</th>
<th>Remarks Purpose</th>
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Account No ............................. Date ..............
Requisitioning Officer .......... Designation .......... Signature ......
Issued by......................... Signature .................. Date ..............
Received by .......................... Designation.............. Signature.......
Community and Service Provider Partnerships

Summary:
The effectiveness of health workers in providing Postabortion care services can be improved through active involvement of the community. Health workers can help create community awareness of the need to prevent unwanted pregnancies, the dangers of abortion and the need for prompt referral and appropriate care following an unsafe abortion. When the community is aware of the problems of abortion, danger signs of incomplete abortion and the need for their help to the client, there is potential for them to establish support for the emergency PAC clients. For example, they could help provide transport to enable timely access or prevent the delay of taking the client to the health or referral site.

General Objectives:
By the end of the session, the participants will be able to:
1. Define community
2. Demonstrate ability to mobilize and involve community in PAC services.
3. Explain how to provide Postabortion health education to the community and religious leaders, policy makers, women and men groups, adolescent and other influential people within the health facility catchment areas
4. Explain how to mobilize the community and involve them in early identification and referral of clients with incomplete abortion
5. Explain how to advocate for the community to establish a health insurance scheme/self help groups to cater for clients’ transport and emergency care fee
6. Describe how to sensitize the community to own and contribute towards sustainability of quality PAC services in the health facility within their catchment area
7. Establish sustainable network for comprehensive PAC in collaboration with community-based organizations, NGOs and private (for profit) sector.
15.1 **Trainee Materials**

- Role play handout
- Case studies
- Important audiences and messages handout
- Handouts 15.1 -15.8
Community Profile Worksheet

If you don’t know how would you find out?

1. Name of community.
2. Names of local government officials.
4. Names of women’s opinion leaders.
5. Names of men’s opinion leaders.
6. Names of youth’s opinion leaders.
7. Organizations that are important.
   In the community (include names of leaders).
8. Is there a market place?
   When are market days?
9. Types of religions.
   Names of religious leaders.
10. What language(s) is spoken?
11. Main source of livelihood in the community.
12. Where do women go for abortions?
13. Where do women go for health care?
   Including post abortion care?
14. How far is it to a hospital?
15. How does the community handle emergency transport?
16. Are there other PAC Service Providers in your community?
   Who are they?
### Develop additional PAC messages if necessary

<table>
<thead>
<tr>
<th>Possible PAC messages</th>
<th>Women of reproductive age (including adolescents)</th>
<th>Family members (husbands, mothers and mother-in-law)</th>
<th>Community leaders, religious leaders, policy makers, parliamentarians, women’s groups &amp; other influential people</th>
<th>Health care providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of modern family planning methods. Any campaign to reduce the impact of unsafe abortion should include information about: what effective family planning methods, including emergency contraception, are locally available; where and how they can be obtained; how they work; how to use them correctly; and the relative risks of childbearing, contraceptive use and unsafe abortion. Also it is important to address common myths about the side effects of modern methods and to raise awareness about the relative ineffectiveness of traditional methods of family planning.</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>The symptoms of abortion complications. All community members, including traditional health care providers, should recognize the symptoms of complications from either spontaneous or induced abortion, and know when and where to seek medical care.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Dangers and ineffectiveness of traditional abortion methods. To help prevent unsafe abortion and ensure that complications are treated promptly, women and their families should fully understand the health risks associated with traditional abortion methods and unskilled practitioners.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Reasons for delaying medical treatment when experiencing complications of induced abortions and possible solutions. Those who experience complications of induced abortion often delay, or do not seek, medical treatment. Fear of being reported to the police by the clinic or hospital staff, fear of harsh treatment and exposure by nurses, and fear of reactions by parents, friends and community members are the primary reasons for avoiding medical attention.</td>
<td>✓</td>
<td>✓</td>
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</tbody>
</table>
Role Play: Talking About comprehensive PAC in the Community

Role plays: Talking about comprehensive PAC in the Community

Role Play No. 1: Talking to community elders about unsafe abortion and the availability of comprehensive PAC services.

One participant will take on the role of a PAC Service Provider while the other participants will represent community elders.

Scenario:

The comprehensive PAC Service Provider is attending a local “harambee” and is approached by a group of elders from her community. They tell her that they have heard that she is providing “abortion services” in her clinic. They want to find out if this is true, and who is coming to her clinic for this “service.”

Role play 2: Talking to a women’s group about unsafe abortion and the availability of comprehensive PAC services.

One participant will take on the role of a comprehensive PAC Service Provider while the other participants will represent members of a local women’s group.

Scenario:

The comprehensive PAC Service Provider has been asked by a local women’s group to come to one of their meetings and give a health talk. They specifically wanted her to talk about the issue of teenage pregnancy, which has been alarming the community the past few years. Utmost on their mind was the recent incident whereby a 19-year-old girl died after having an unsafe abortion.

One participant will take the role of a Comprehensive PAC Service Provider while other members will represent members of a youth group.
**Role play 3:** Service provider being an active member in a Church youth group wants to informally talk on preventing pregnancy and unsafe abortion during a weekend retreat.

One participant will take on the role of a Comprehensive PAC Service Provider while the other participants will represent members of a local women’s group.

**Scenario:**

The comprehensive PAC Service Provider is a very active member of her church and is particularly involved in the church’s youth group. She has agreed to act as a chaperone during the group’s weekend retreat, and wants to use the opportunity to talk to them, informally, about pregnancy prevention and unsafe abortion.
## Sample Community Involvement Plan

### Name of Clinic

### Period

### Name of PAC Service Provider

<table>
<thead>
<tr>
<th>Intended Action</th>
<th>What Is To Be Accomplished (Purpose Or Goals)</th>
<th>Steps To Be Taken</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>“What”</strong></td>
<td></td>
<td><strong>“How”</strong></td>
<td><strong>“When”</strong></td>
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</tbody>
</table>
| 1. Attend regular monthly meetings of Church of Kenya Women's Group. | • To be visible in my community.  
• To make women aware of my services. | • To meet with group leader to introduce myself and my services.  
• Find out venue and dates for meetings. | End of Oct. 2000 |
| 1. Introduce myself to market vendors. | • To be visible in my community.  
• To make people aware of my services. | • Talk to market master to introduce myself and obtain permission to speak with vendors.  
• Go to market on market days.  
• Prepare handouts with name of my clinic and location. | End of Nov. 2000 |
| 2. Give talk during local “harambee” about problem of unsafe. | • To reduce incidence of unsafe abortion in my community.  
• To make people aware of my services. | • Meet with village chief to help organize for talk.  
• Set venue and time.  
• Make poster to put up in community to advertise my talk.  
• Prepare talk and visual aides. | End of Feb. 2001 |
| 4. Give talk to youth group on risks of unsafe abortion. | • To reduce abortion among the youth.  
• To make youth aware of my services. | • Meet with group leader to help organize for talk.  
• Set venue and time.  
• Make posters and advertise talk.  
• Prepare talk and visual aides. | End of Mar. 2001 |
### Sample Community Involvement Action Plan

**Name of Clinic___________________________**

**Period ____________________________ To ____________________________**

**Name of PAC Service Provider___________________________**

<table>
<thead>
<tr>
<th>Intended Action</th>
<th>What Is To Be Accomplished (Purpose Or Goals)</th>
<th>Steps To Be Taken</th>
<th>Dead-Line</th>
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</thead>
<tbody>
<tr>
<td>“What”</td>
<td>“Why”</td>
<td>“How”</td>
<td>“When”</td>
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Role of the Comprehensive PAC Service Provider in the Community

- Educate men, women, adolescents, extension workers, traditional health providers (TBA, healers) and various leaders or influential people on the importance of comprehensive PAC/RH services.

- Educate the community in the need for timely and possible means of available transportation.

- Negotiate help with the community to establish transport mechanism and other means for timely referral of postabortion clients to health facilities for quality emergency care.

- Collaborate with the community-based health workers, NGOs and private sector to improve Comprehensive PAC services.
  - Follow up on the agreements; community work plan and help communities identify other emerging issues.
  - Provide needed technical assistance to trained community-based health workers and community members to improve their capacity to provide first aid care for emergencies.
  - Encourage non-emergency PAC clients to seek care after abortion e.g., physical assessment (postabortion assessment), counselling for voluntary and informed choice of FP/RH service and other identified treatment or service.
  - Help the community evaluate jointly determined activities with the community
  - Prepare report on experience and progress of community involvement and share with all stakeholders.
  - Become an active community resource all the time.

- Assist trained NGO and private sector community-based health workers to:
  - Provide comprehensive PAC education to women, men, adolescents and communities about dangers of spontaneous and unsafe abortion and the need to seek immediate care at a health facility.
  - Recognize early signs of abortion
  - Rapidly assess condition of emergency PAC clients.
  - Stabilize and refer immediately
  - Guide relatives or escorts regarding transporting clients and possible readiness for donating blood for transfusion and payment of fees on arrival at health facility.
  - Promote comprehensive PAC at work in their community consistently
Male Involvement in comprehensive PAC Services
(Adapted from Management Strategies for improving family planning services 1996, MSH)

Male leaders participate in Mrs. Kamau’s comprehensive PAC Programme

Mrs. Kamau had just returned from a special meeting with other regional nurse supervisors. The meeting had included a study tour to two successful comprehensive PAC services that were operating in the central region of the country. Mrs. Kamau had been surprised that service providers were actively working with the community members to promote the goals of comprehensive PAC. She had spent a morning talking to the manager of a local food processing factory who had been recruited by an outreach nurse of the local health centre to organize weekly talks about comprehensive PAC and other RH issues during lunch breaks. The clinic director was very exited about this new initiative because six months after this service had began, staff at the local clinic were able to clearly document that the number of postabortion clients discharged on FP increased two-fold, and the number of clients continuing use of contraception after comprehensive PAC at the FP/MCH clinic had risen. Building on the success of this experience, the clinic manager Mrs. Kamau had made plans to recruit a number of influential male community leaders to conduct similar activities in her area.

After retuning from her trip, Mrs. Kamau wondered whether involvement of local male leaders in her programme might help her meet comprehensive PAC service goals and objectives. By using male volunteers, she could solve one of her major service problems – insufficient resources to recruit, hire and train new personnel for IEC activities. In Mrs. Kamau’s area, awareness of access to comprehensive PAC services was below 50%. Women, on the other hand, were considerably more knowledgeable about comprehensive PAC and FP methods for averting unwanted pregnancies. The results of the study revealed further that men in the community preferred talking with other men about RH issues. Mrs. Kamau believed that if males in the community were more aware of the benefits of comprehensive PAC services, they would be more likely to support their partners’ during essential obstetric emergency and on use of FP. In addition, increased understanding of comprehensive PAC services among men might lead to better RH practices and prevention of STIs – a real problem in her community. She recalled that several months earlier, there had been a major public health and sanitation initiative and that the male leaders had done an excellent job in organizing men in the community to work on this project. She wondered, “Could she organize these male leaders to help support her comprehensive PAC services and to promote a micro-insurance scheme for emergency transportation within the community?”

Mrs. Kamau decided to try. Her first step in organizing the male leaders was to invite eight prominent men from the community to a meeting with two of her comprehensive PAC trained service providers. During the first meeting, she focused
the discussion on the comprehensive PAC rationale and benefits to the facility and to the community that the participation of these men might bring. This discussion generated considerable interest among the male leaders. In a second meeting, with Mrs. Kamau’s help, the group looked at the objectives of comprehensive PAC and then developed objectives for their own participation. For example, one objective was to improve timely access of comprehensive PAC services. Based on this objective, the group developed their own community participation objectives:

- To increase knowledge of comprehensive PAC, including STIs/HIV/AIDS among males.
- To reduce the time taken by clients to access comprehensive PAC services.
- To increase contraceptive use among men, women and adolescents.

In subsequent meetings, the group developed a plan to involve other men in the community. Some members were assigned the task of preparing a plan detailing the activities and training that the men would undertake to achieve the objectives which had been set. There was a lot of discussion about the role of the male leaders and their potential activities in the area of comprehensive PAC. Some thought that the male leaders should be trained to recognize and refer PAC clients. As a step in preparing the plan of activities and training, the group generated a list of the possible activities that the male leaders might undertake.

**Case discussion questions**

1. How might community male participation benefit the community?
2. How might the involvement of the community men benefit the comprehensive PAC service at the facility?
3. What activities do you think the male leaders in this case could be trained to do?
4. How might the men set up community micro insurance scheme (Mutual Health Organization - MHO) for emergency obstetric care including emergency transport?
Roles of the DHMT/DPHN in mobilizing the community

Orientation of DHMTs/DPHNs by the comprehensive PAC participant on return to the working station

On return from the training the service provider:
- Gives feedback to the supervisor about the training and its benefits to the health facility and the community.
- Shares and takes the supervisor through the back-home application plan.
- Solicits the supervisor’s support for implementation of the new skill including equipment and supplies.
- In consultation with the supervisor ascertain if it is necessary to orientate the DHMT. If necessary requests the superiors to arrange a meeting to orient the DHMT on comprehensive PAC.

Preparation of the DHMTs orientation

- Decide on the agenda:
  - Objective of the meeting
  - Expected outcome
  - Presentation of the content
- Create an agenda:
  - Date
  - Time
  - Place/Venue
  - Objective of the meeting
  - Expected outcome
  - Topics to be presented and presenters
- Present the concept of comprehensive PAC, its advantages including reduction of opportunity cost to the facility and the community
Roles of the DHMT/DPHN

- Identify individuals in the community who can actively participate in your programs, and develop a clear set of activities that these community members can undertake to actively support and sustain comprehensive PAC.

- Motivate and sustain community participation in comprehensive PAC:
  - Create bridges to the community by organizing people to promote comprehensive PAC services. This can be developed and established with some of the following types of organizations:
    - **Local NGOs**: DHMT/DPHN develops a mechanism for collaborating with other local NGOs to mobilize community members concerned with comprehensive PAC. These community organizations can carry out a variety of activities that will promote and educate members of the community about comprehensive PAC.
    - **CBOs**: DHMT/DPHN encourages service providers at facilities to collaborate with other local CBOs that provide services in areas such as literacy, education, agricultural extension and water sanitation systems. Comprehensive PAC and FP education can be incorporated into the activities of these organizations.
    - **Local governmental organizations**: DHMT/DPHN can collaborate with other local governmental organizations e.g., schools. By sharing information and resources, including government officials in local program planning, and looking for ways to promote understanding, danger signs and life-threatening complications of comprehensive PAC and how to prevent unwanted pregnancies.
    - **Clubs**: DHMT/DPHN develops a mechanism for collaborating with existing clubs for mothers, e.g., Mothers’ Unions, youth and men clubs. These clubs can address the special needs, issues and problems that club members are likely to face when encountered with abortion complications. Clubs can promote greater awareness of the benefits of FP in preventing unwanted pregnancy, link members to RH, other medical and social services and inspire recognition and identify PAC complications and make timely decision and referral to an outlet where quality comprehensive PAC services are available.
Case Study No, 15.2

Community Leaders Find Local Resources for Health Services
(Adapted from The Manager 2002, vol. II No. 2)

For three years, a clinic run by the non-governmental organization AMKENI has been delivering babies and providing prenatal and postnatal including comprehensive PAC care for women in the market town of Budalangi. The District Development Committee (DDC) has been providing the clinic with space at no cost in a little-used government building. Unfortunately, a new government water resources project is taking over the building, and the clinic must move. If the clinic closes, local women will have to travel 30 kilometres to the district capital to get the care they need in a modern health care facility.

Dr. Victoria Asiyo, the clinic’s medical officer, has invited several community leaders to meet with her to discuss the challenge of space. It is a warm, weeding season in Budalangi. The sounds of diesel trucks, cows, sheep, and children drift in the window. Fields of green maize and beans reach toward the horizon.

“I am very upset about the clinic closing!” said Mrs. Rosemary Isiaho, a retired school principal. My first daughter-in-law lost her first two babies and my second daughter-in-law almost died from miscarriage when we had no clinic nearby. Now I have a fat and healthy grandson and a lovely little granddaughter from the first daughter-in-law and two more grandchildren from the second daughter-in-law. We need this clinic to stay open. I can’t believe that the government is making us move out!”

“I am upset, too,” said Mrs. Mary Mwangi, wife of a local businessman. “Shoudn’t the government provide us with anew space to replace the one they are taking away?” “I wish that were possible”, replied Mrs. Sheila Were, a serene woman and a representative on the local government council. “The government is not obligated to provide us with a site. It is up to us to find a solution to this problem.”

“It warms our hearts to know that the community is helping us to find a solution,” said Dr. Asiyo. “We appreciate the work you and other leaders have done to encourage use of our services. Our beds are full, and we have delivered many healthy babies and saved many women from death arising from postabortion complications.” The leaders nodded to show they recognized this expression of thanks.

“AMKENI has conducted an assessment of the clinic’s needs, assuming we would have to build a new site or renovate an existing building”, continued Dr. Asiyo. “We will need building materials, a construction supervisor, labourers, funding permission to build, and a lease. Ideally, we would like to expand our operations,
which would require new equipment and beds. In any case, our first priority is a new space.” She turned to G.M Okoth, a community activist, “Have you spoken to the community-based organization (CBO), World Relief about providing space there?” “Yes. The CBO has offered the use of a building in the corner of its property”, replied Mr. Okoth. “It touches the wall and could have a separate entrance, but the roof, walls and ceilings must be repaired. The clinic may use the building if the needed repairs and renovations are done”. “This is excellent news!” beamed Dr. Asiyo. “Unfortunately, AMKENI does not have resources to pay for repairs and renovations”. She turned to Captain Thomas Sande retired from the Army. “I am sure that you will have some suggestions”.

“I know the building that Mr. Okoth is talking about,” said Captain T. Sande. “It is small, but the location is convenient. Will we be allowed to add new rooms if needed?” Mr. Okoth nodded as the Captain continued. “I have worked with a local builder. I could approach him about getting materials at a discount.”

Mrs. Isiaho frowned. “We should approach several builders if we want to get all the materials we need at a low cost - or even at no cost”.

“Captain, perhaps you would be kind enough to approach several builders about contributing to this project,” suggested Dr. Asiyo, looking at Captain Sande. He nodded at his agreement.

“We will need some labourers, also,” said Mrs. Isiaho. “What about the men who were recently laid off when the milk processing plant closed, or the final masonry and carpentry students at our local village polytechnic? They might be willing to volunteer their labour for this project while they seek new jobs or as practicals to achieve proficiency in their future trade”.

“We might get a man to volunteer as a supervisor, but I doubt that men will volunteer as labourers,” said Mrs. Were. “Let’s approach the women who are learning how to manage home building and improvement projects through a small loan program at the local polytechnic. I have observed them working on their projects. Perhaps they can help with our construction phase”.

“We will still need money for our project,” said Mrs. Isiaho, interrupting Mrs. Were. “We can’t expect to get everything done for free.”

“You are right, Mrs. Isiaho,” said Dr. Asiyo calmly. “In another village where AMKENI works, we held a raffle and raised enough money to purchase some needed equipment. Do you think Budalangi would be receptive to a raffle?”
“Yes, I think we would get a good response,” said Mrs. Mwangi. “A small generator would be popular. My husband could donate one. A radio would be suitable, also. I will consult with my husband about whom to approach about donations.”

“We have identified a building site, a material supplier, possible supervisors and labourers, and a funding source,” said Dr. Asiyo. “I am very pleased. Without your support, the clinic would have to leave this wonderful community. But we cannot start our project unless we have permission to build and a lease. We must start this paperwork right away.” She looked expectantly at Mrs. Isiaho.

“My oldest son is a lawyer in Busia town”, said Mrs. Isiaho proudly. “I will ask him what paperwork we will need to take care of. He knows how important this clinic is to me. He will help us and provide his services for free.”

Dr. Asiyo smiled at the leaders. “I must express my heartfelt thanks for your valuable support for this clinic, not just today, but over the three years since we opened”. She paused. “Perhaps it is time to think about formalizing this valuable group. I suggest that we form a Community Health Committee to oversee the construction effort and consider longer-term plans to sustain the clinic and improve the community’s health”. The leaders nodded, looking pleased. “Please come to our next meeting with ideas about other people in the community who might be willing to serve on this committee.”

**Discussion questions**

1. What resources are the local leaders thinking about besides funding?

2. What potential partners and resources have the medical officer and community leaders identified? Looking at the content if the issue and considering your own experience, what other partners and resources might be useful for a clinic of this type?

3. What strengths and weaknesses do you see in the way the group is working toward a solution to the problem?
Module 16 - Session 1

Sustainability

Module Summary

Sustainability of comprehensive PAC services is important to ensure that clients always receive quality and timely services. It’s essential for management and other health workers to support comprehensive PAC services and to be able to do so they need to understand the importance of comprehensive PAC in reducing maternal mortality and morbidity. They can assist in material, financial and human resource allocation, continuous availability of equipment and expendable supplies. Critical factors in sustainability includes, on the job training to ensure 24-hour coverage. Equally important is proper care and maintenance of equipments through cost analysis with cross subsidy, revolving fund where applicable and community involvement to ensure supportive client base.

The general purpose of this module is, therefore, to effectively sensitize the participant/comprehensive PAC provider to appreciate the importance of sustainability in PAC services and have the ability to address the critical elements as in the objectives below

Objectives

At the end of this training the participant will be able to;

1. Develop an action plan to orient all health workers on comprehensive PAC services.
2. Orient all health workers on the comprehensive PAC services.
3. Provide 24 hrs coverage at the service delivery points (SDPs) by ensuring availability of skilled service providers in comprehensive PAC.
4. Describe the rationale and the elements of cost analysis.
5. Demonstrate an understanding of how to use cost analysis to set prices for planning and cross subsidy.
6. Demonstrate the ability to carry out comprehensive PAC cost analysis.
7. Develop action plans to establish revolving fund through user fees.
8. Develop an action plan on how to acquire, and maintain equipment and supplies for comprehensive PAC services in a timely and sustainable manner.
9. Explain how to set up a revolving fund.
10. Demonstrate the ability for effective communication skills (see module 8).
11. Describe the type, number and source of equipment/supplies needed for comprehensive PAC services.

12. List and understand functions of the departments and structures for procurement, distribution of equipment and supplies for comprehensive PAC services.

13. Explain how to maintain an inventory of comprehensive PAC equipment and supplies.

14. Establish and sustain a mechanism for timely re supply and maintenance of comprehensive PAC equipment.

15. Explain how to facilitate the deployment of trained staff in appropriate departments to ensure 24-hour coverage.

16. Explain how to establish a structured comprehensive PAC OJT.

16.1 Trainee Materials

- Handouts 16.1- 16.11
Cost Analysis Tool (CAT)

Why knowing the cost of comprehensive PAC services is important
(Adapted from EngenderHealth Cost Analysis Tool - CAT)

- To establish what the actual comprehensive PAC costs for planning purposes
- To improve efficiency
- Raise funds from donors
- Charge clients realistic fees for services
- To establish realistic cross subsidy system

The limitation of this cost analysis tool (CAT) is that it does not consider indirect administrative costs such as rent, electricity, training and salaries of staff who are not in direct contact with clients.

Who to Involve
The cost analysis tool requires the cooperation of different kinds and levels of staff. Before and during data collection, it is therefore important to inform and involve all staff who have direct contact with clients receiving the services or clinical procedure being analyzed. Staff with knowledge of the costs of supplies and those with knowledge of staff salaries and benefits also need to be involved (see Step 2 below for treatment of sensitive and confidential information). Involvement of service providers with good knowledge of standards and medical practices is also important to ensure that the tool is used in a way that improves the quality of services.

What the Cost analysis Tool can do
CAT is a tool to analyze recurrent direct (program) costs of providing services and clinical procedures. These include both fixed and variable costs:

1. **Cost of the staff time spent directly providing services, including time spent preparing to provide clinical procedures and time spent cleaning up after procedures.** The cost of staff salaries is fixed because the program incurs these costs regardless of the number of procedures provided. However, the actual cost of staff time for a particular procedure can be variable because sites can change the way staff time is spent in terms of who is allowed to perform a particular procedure, what the procedure should be, or how the procedure should be carried out.

2. **Cost of commodities, expendable supplies and medications.** These costs are variable.

The site may want to reassess costs regularly, for example once a year, if staff salaries increase, or if the prices of supplies have gone up or as new services or clinical procedures are introduced.

The data obtained by using CAT can be used to:
- Set user fees for different types of clinical services (recognizing that indirect costs will have to be estimated and added on).
- Negotiate subsidies from donors or other governments.
• Evaluate the financial implications of having different types of staff perform a procedure or provide a contraceptive method. For example, the methodology can show what it costs to have a doctor versus a nurse, and obstetrician versus a general practitioner or a medical doctor versus a clinical officer provide comprehensive PAC services. **These decisions cannot be based on cost alone but must be based on good medical practice, the situation of the individual client, and so on.**

• Determine the cost of providing a service in different ways, for example, treat postabortion complications with manual vacuum aspiration (MVA) as opposed to sharp curettage (SC). **This and similar decisions cannot be based on cost alone but must be based on good medical practice, the situation of the individual client, and so on.**

The cost analysis tool helps:
1. Calculate the cost of services and clinical procedures
2. Examine if resources are used efficiently.

**Create an environment of trust.** Analyzing the process of service delivery can be threatening to staff. Trust is a precondition for obtaining an honest analysis. CAT requires examination of work processes and must not be used to blame or victimize individual staff members in any way.

**Ensure that the service/procedure reflects appropriate and safe medical practice.** It is important that all procedures and all the talks that make up each particular procedure reflect appropriate, safe medical practices. The process must allow time for staff to inform and counsel the client properly to ensure informed choice and consent; time to follow the necessary steps for infection prevention, etc.

**Cut costs by eliminating unnecessary effort, and preventing rework and waste.** Use of the cost methodology often reveals that staff time as well as supplies, and even equipment and space, can be better used. (For example, some sites have discovered that staff uses too much gauze or sutures for a given surgical procedure). Correcting inefficiencies in these areas leads to savings. **If cost cutting goes beyond this, it can be counterproductive to quality improvement,** for example, if the client-provider interaction is cut too short, or if an insufficient amount of chlorine is used for decontamination.

**How to use comprehensive PAC CAT**

**Step 1**

**You need:**
• A calculator, pencils and erasers
• Blank copies of Handouts 16.1b - 16.5 for comprehensive PAC services
• A watch that allows for measuring minutes accurately.
Step 2

- Explain CAT to participants who will be involved in the implementation at their working stations
- Ask the participants what they currently charge clients for comprehensive PAC services
- Take the participants through handouts 16.1-16.5
- Handout 16.1 is completed for each client.
- Some activities or tasks are done per clinic session but affect all clients served during the session, e.g., cleaning the room at the end of the day. For such activities at the end of the session, measure the total time spent and divide that time by the number of clients served to find the average time. *(Total time/number of clients = average time)*. Then enter the average time under the category of staff responsible for the task on Handout 16.1.
- For an activity, such as sterilizing equipment, follow the steps as describe above, but only count staff time required for cleaning up the equipment, not the time it takes the autoclave to process the equipment.
- If you do not do a client flow analysis (discussed in Step 3), you need to observe several clients, at least 5-6 clients from the starting point (registration) through discharge, in order to calculate the average time for PAC procedure.

Review Handout 16.2 – add the total staff time for each category of staff from Handout 16.1. Then enter the amount in Handout 16.2 e.g., all physician time is entered on the first line, all nurse time on the second line, and so on.

Review Handout 16.2 – Calculate cost per minute of staff time. This worksheet estimates the cost per minute of each staff member who is involved in providing direct client services. Note that information related to salary and benefits is generally very sensitive and must be kept confidential. When reviewing the worksheet, explain to the participants that you will use fictitious numbers, and that site staff with access to such information can later collect and enter the correct numbers. When they enter the correct numbers, they must follow these steps.

- Collect and enter annual salary and fringe benefits in column B
- Enter the number of working days per year in column C *(remove weekends and public holidays)*
- Divide the annual salary by the number of working days to find the cost per day for each type of staff: column B/column C = Cost per day, and enter cost per day in column D.
- Enter the number of hours each type of staff works per day in column E.
- Multiply the number of working hours per day by 60: column E x 60 = number of minutes worked per day, and enter number of working minutes per day in column F.
- Divide the cost per day by the number of working minutes per day: column I divided by column F = cost per minute.
Enter cost per minute in column G.
Review Handout 16.3 – calculate total direct cost of staff time per comprehensive PAC procedure.

- Enter the total amount of staff time for comprehensive PAC for each category of staff from handouts 16.1-16.3.
- Enter cost per minute from column G, to column B (cost per minute).
- Multiply time spent by cost per minute and enter the total cost per client for each category of staff \((\text{column A} \times \text{column B} = \text{column C})\).
- Add all the numbers in column C and enter total cost of staff time.

Review Handout 16.4 – service/clinical pre-procedure specific supplies

- Ask the participants for estimates when explaining how to use Handouts 16.4
- Explain that when staff go through this exercise, they need to carefully measure or count what they use.
- This exercise is a good opportunity to review whether correct supplies and measurements are generally used, which can help improve quality. If necessary, refer to the standards or manufacturers’ instructions.
- Add any relevant supply to the items to the list (e.g., laboratory test reagents, etc.)
- Stress that it is essential that medical staff as well as staff responsible for purchasing supplies assist in completing this section.
- Enter the amount in the unit in column A
- Enter the unit cost of the item in column B
- Enter the amount used per client in column C
- Calculate the cost per client for each item: divide amount used per client with amount in unit and then multiply by unit cost to get the cost per client for each item: \(\text{column C/\text{column A} \times \text{column B} = \text{cost per client}}\), and enter the amount in column D.
- Add all the numbers in column D and enter total cost of supplies.

Review Handout 16.5 – total direct variable costs for a clinical procedure.

- Enter total cost of staff time from Handout 16.3
- Enter total cost of supplies from Handout 16.4
- Enter any additional costs of laboratory tests, if applicable
- Enter daily in-patient costs (such as staff time, food provided, etc., if applicable). It is advisable to use CAT to calculate these rates also. Multiply the cost per day by the number of days of a client’s stay in the facility.
- Enter other costs if applicable
- Add all the costs together to find the total direct variable costs for comprehensive PAC.
Step 3

- Assist the site in deciding how to collect the data required.

There are different ways to collect the data required.

### What is Client Flow Analysis (CFA)

Client Flow Analysis (CFA) is a step by step tracking of the processes/steps the clients go through from the time the client enters the gate/door of a service delivery point/health facility to the time he/she leaves the gate/door. CFA gives the actual time the client spent at each service point (e.g., reception, consultation, laboratory, waiting, etc.) CFA also gives the actual time (to the last minute) that each service provider spent with the client and time spent on bottlenecks such as waiting areas. It is important to carry out CFA in order to get the time to enter in the CAT.

1. Conduct a client flow analysis (in which all staff record the minutes of direct contact they spend with clients) to examine direct staff contact time with clients.

2. Staffs receives thorough instructions and then measure their time spent as they provide the procedure, clean up, etc, as outlined in Handout 16.1, and the amount of supplies they used as outlined in Handout 16.4. The facilitator oversees the process and provides continuous feedback to the staff who are measuring themselves, ensuring that the information is properly timed and recorded.

3. Members from the QI team (or selected staff) can each follow a few clients from the moment they arrive at the reception desk until their discharge, measuring their contact time with staff; staff time for clean up, as outlined in Handout 16.1 and the amount of supplies used, as described in Handout 16.4. If the team choose to use this approach, it is necessary to ask the client’s permission and explain the reason for following the client.

4. The site needs to record which of these approaches they use so that if and when they use the CAT again, they use the same approach.

Keep in mind that the more staff are involved, the more ownership and commitment they will feel towards this effort.
### Part One: Steps in Service Provision

#### Service or Clinical Procedure

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<tr>
<th>Location</th>
<th>Activity</th>
<th>Individual Responsible</th>
<th>Time (min)</th>
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<tbody>
<tr>
<td>1.</td>
<td>Register Client</td>
<td>Receptionist</td>
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<td>2.</td>
<td>Collect Payment</td>
<td>Cashier</td>
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<td>3.</td>
<td>Initial assessment including taking vital signs and resuscitation</td>
<td>Nurse, Clinical Officer, Physician</td>
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<tr>
<td>4.</td>
<td>Take medical history</td>
<td>Nurse, Clinical Officer, Physician</td>
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<tr>
<td>5.</td>
<td>Conduct physical examination</td>
<td>Nurse, Clinical Officer, Physician</td>
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<td>6.</td>
<td>Provide pre procedure information and counselling</td>
<td>Nurse, Clinical Officer, Physician</td>
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<td>7.</td>
<td>Take laboratory specimens (e.g., blood of cross match)</td>
<td>Nurse, Clinical Officer, Physician</td>
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<tr>
<td>8 (a)</td>
<td>Laboratory--Conduct test(s)</td>
<td>Lab technician</td>
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<td>(b) Prepare room and client</td>
<td>Support staff, Nurse</td>
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<tr>
<td>9.</td>
<td>Provide preoperative drugs</td>
<td>Anaesthetist, Physician, Clinical Officer, Nurse</td>
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<tr>
<td></td>
<td>Repeat examination, review laboratory tests, and obtain informed consent as necessary</td>
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Surgical teams generally carry out a number of procedures in one session. The times listed should be divided by the number of procedures to obtain the time per procedure per client.
<table>
<thead>
<tr>
<th></th>
<th>Task Description</th>
<th>Role(s)</th>
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<tbody>
<tr>
<td>10.</td>
<td>Prepare equipment and materials (…….. Minutes for ……. Clients)</td>
<td>Nurse</td>
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<td>Support staff</td>
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<td>11.</td>
<td>Perform thorough hand washing (surgical team)</td>
<td>Physician</td>
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<td></td>
<td>Clinical Officer</td>
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<td></td>
<td>Nurse</td>
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<tr>
<td>12.</td>
<td>Give anaesthesia (General and/or local) including paracervical block</td>
<td>Anaesthetist</td>
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<td></td>
<td>Physician</td>
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<td></td>
<td></td>
<td>Clinical Officer</td>
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<td></td>
<td></td>
<td>Nurse</td>
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<tr>
<td>13.</td>
<td>Performs MVA/SC _____ minutes each procedure</td>
<td>Physician</td>
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<td></td>
<td></td>
<td>Nurse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinical Officer</td>
</tr>
<tr>
<td>14.</td>
<td>Clear and Prepare examination room after each client</td>
<td>Nurse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support Staff</td>
</tr>
<tr>
<td>15.</td>
<td>Provide post procedure counselling instructions and FP</td>
<td>Support staff</td>
</tr>
<tr>
<td>16.</td>
<td>Schedule follow-up visit</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Discharge client</td>
<td></td>
</tr>
</tbody>
</table>

**Daily Tasks in Procedure Room**

<table>
<thead>
<tr>
<th></th>
<th>Task Description</th>
<th>Role(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.</td>
<td>Prepare procedure room at beginning of day (_____ minutes for _____ Clients)</td>
<td>Support staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nurse</td>
</tr>
<tr>
<td>19.</td>
<td>Clean and prepare examination equipment (_____ minutes for _____ Clients)</td>
<td>Nurse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support staff</td>
</tr>
<tr>
<td>20.</td>
<td>Clean room at end of day (_____ minutes for _____ Clients)</td>
<td>Support staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nurse</td>
</tr>
<tr>
<td>21.</td>
<td>Clean up recovery room and equipment (_____ minutes daily for _____ clients)</td>
<td>Nurse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support staff</td>
</tr>
<tr>
<td>22.</td>
<td>Keeping, retrieving and maintain PAC records</td>
<td>Receptionist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nurse</td>
</tr>
<tr>
<td>23.</td>
<td>Overall staff supervision</td>
<td>Supervisor</td>
</tr>
</tbody>
</table>

* Actual involvement by a physician in this activity varies by national and local protocols.*
### Worksheet 2: Calculation of Cost Per Minute of Clinic Staff

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff Position</strong></td>
<td><strong>Annual Salary and Fringe Benefits</strong></td>
<td><strong>Number of Working Days Per Year</strong></td>
<td><strong>Cost Per Day (B/C)</strong></td>
<td><strong>Number of Working Hours Per Day</strong></td>
<td><strong>Number of Working Minutes Per Day (E x 60)</strong></td>
<td><strong>Cost Per Minute (D/F)</strong></td>
</tr>
<tr>
<td>Physician</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receptionist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Officer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaesthetist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab technician</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cashier</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Worksheet 3: Calculation of Cost per Minute of Clinic Staff Time (Cont.)**

Name of Service or Clinical Procedure: ______________________________

**Part One: Direct Cost of Staff Time**

<table>
<thead>
<tr>
<th>Staff Position</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Time Spent</td>
<td>Cost per Minute</td>
</tr>
<tr>
<td>Physician (sessional)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receptionist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Officer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaesthesia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab technician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cashier</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (2)</td>
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</tbody>
</table>

**Total Cost of Staff Time**

---

*Handout 16.3*
### Handout 16.4

#### Specific Supplies

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount in Unit</th>
<th>Unit Cost</th>
<th>Amount Used</th>
<th>Cost Per Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chromic catgut</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plain catgut</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MVA kit (syringe canulas)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cotton wool</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absorbent cotton gauze (plain)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strapping (tape)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utility gloves</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposable syringes 10 cc</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 gauge needle</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxytocic drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposable needles</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nondisposable surgeon's gloves</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposable gloves</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1% Xylocain without epinephrine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atropine injection (0.5 mg dose)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diclofenac</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buscopan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bruth/ibuprofen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paracetamol (acetaminophen)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pethidine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mefenomic Acid/Ponstan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autoclaving tape</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical spirit (methylated spirit)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antiseptic solution/Iodophore</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine dipstick</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical blades</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detergent Soap</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleach/chlorine solution/hypochlorite</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diazepam 5 mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disinfectant solution</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condoms</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Silk sutures 2.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sanitary pad</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DMPA or Net En</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implants (Norplant/Jadell)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV giving set</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drapes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV fluid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adrenaline injection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydrocortisone injection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood bag</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen gas</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus toxoid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>------------------------</td>
<td>----</td>
<td>-----</td>
<td>---------</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>Unit</td>
<td>Unit</td>
<td>Amount Used</td>
<td>Cost Per Client</td>
</tr>
<tr>
<td>Glutaraldehyde</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV ketamine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotic 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotic 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotic 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Cost of Supplies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Part Three: Total Direct Variable Costs

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cost of Staff Time</td>
<td></td>
</tr>
<tr>
<td>Total Cost of Supplies</td>
<td></td>
</tr>
<tr>
<td>Total Cost of Laboratory Tests (Add only costs that are not already included above)</td>
<td></td>
</tr>
<tr>
<td>Total Daily Inpatient Costs (Staff time, etc.) (Cost per day ________ x number of days )</td>
<td></td>
</tr>
<tr>
<td>Other (describe):</td>
<td></td>
</tr>
<tr>
<td><strong>Total Direct Variable Costs</strong></td>
<td></td>
</tr>
</tbody>
</table>
Steps in PAC Orientation

(Also refer to Module 15 Handout 15.9 – Role of DHMT/DPHN in mobilizing the community)

1. Inform the senior management about the training and the benefits of PAC services.
2. Request them to set date and time for the orientation of the management and the rest of the health workers.
3. Set the venue and invite the participants.
4. Make objectives:
   By the end of the session, the participants will be able to:-
   
   (a) Describe the global, sub-Sahara Kenya and local contribution of abortion to maternal mortality and morbidity (per day, per hour and per minute).
   (b) Discuss with the management the causes and the complications of abortion on their catchment area.
   (c) Discuss how abortion clients are handled in the facility.
   (d) Describe the concepts of comprehensive PAC and its elements.
   (e) The benefits of comprehensive PAC.
   (f) Present a proposal for sustaining PAC services in the facility and request for support.
   (g) Form a RH committee which will develop and implement action plans in the facility.

5. Minimum Staff Working in the PAC Room per Shift:
   (a) Trained PAC – (1 either nurse/RCO/Dr);
   (b) Assisting nurse/RCO/Dr;
   (c) Five shifts:
      • Morning off – 1
      • Afternoon off – 1
      • Day off – 1
      • Leave – 1
      • Night duty – 1

Note:
A minimum of 10 service providers per 24 hour shift. Alternatively have a PAC team called upon whenever there is a PAC client.
### Estimate Worksheet for MVA Syringes

This sheet will help you estimate how many syringes you need on hand each day and when to replace them; then, it will help you estimate the total single valve syringes that you will need for the year.

**STEP ONE**

Fill in the Maximum Daily procedures and the Average Monthly Procedures performed at each gestational age of both the Single Valve Syringe and the Double Valve Syringe; then sum each column:

<table>
<thead>
<tr>
<th>Caseload</th>
<th>Single Valve</th>
<th>Double Valve</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Single Valve</td>
<td>Double Valve</td>
<td></td>
</tr>
<tr>
<td>4 weeks gestation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 weeks gestation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 weeks gestation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 weeks gestation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 weeks gestation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 weeks gestation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 weeks gestation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 weeks gestation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 weeks gestation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL EACH COLUMN**
STEP TWO

Daily Syringe Needs:

Write the total maximum daily procedures for the Single Valve Syringe here

The number tells you how many Single Valve Syringes that you need on hand each day.

Write the total Maximum Daily Procedures for the Double Valve Syringe here

The number tells you how many Double Valve Syringes that you need on hand each day.

STEP THREE

Average Syringe Reuse

How many times on average do you reuse one Ipas MVA syringe?

Single Valve Syringe

Double Valve Syringe
STEP FOUR:

Replacement Rate

For both the Double and Single Valve Syringes,

1. Divide the Total Procedures per month by the Maximum Daily Procedures times the number of reuses
2. Then, divide the result into the number 30 (days per month)
3. The final result tells you in how many days your ‘set’ of syringes needs to be replaced

Single Valve Syringe Replacement Rate:

Total procedures with the Single Valve per month
Maximum daily procedures with Single Valve Syringe x Aver. Number of Single Valve Syringe Reuses

Take this number and divide it into 30 (days per month) Which will tell you in how many days you need to replace your set of Single Valve Syringes

Double Valve Syringe Replacement Rate:

Total procedures with the double Valve per month
Maximum daily procedures with Double Valve Syringe x Aver. Number of Double Valve Syringe Reuses

Take this number and divide it into 30 (days per month) Which will tell you in how many days you need to replace your set of Double Valve Syringes
**STEP FIVE**

Total procedures per month with the Single or Double Valve Syringe \( \times \) 12 (months per year) \( \div \) by the average number of uses per syringe:

\[
\text{Total} = \text{Single Valve Syringes needed per year.}
\]

Total procedures per month with the Single Valve Syringe \( \times \) 12/average number of uses for a double Valve Syringe

The result tells you how many Single Valve Syringes you need per year.

Set of syringes = enough syringes available to cover the maximum daily caseload for both the double and single valve syringes.
Basic instruments and consumable supplies needed to perform MVA include:

- Bivalve speculum (small, medium or large) – Cusco or Graves.
- Uterine atraumatic tenaculum or volsellum forceps.
- Sponge or ring forceps.
- 10-20 ml syringe and 22-gauge cervical needle (for paracervical block).
- MVA instruments;
  - MVA vacuum syringes, single or double valve;
  - Flexible cannulae of different sizes (from 3-12);
  - Adapters (if double valve syringe);
  - Silicone for lubricating MVA syringe O-ring).
- Light source (to see cervix and inspect tissue).
- Swabs/gauze.
- Antiseptic solution (preferably an iodophor such as povidone iodine).
- Gloves, sterile or high level disinfected surgical gloves or new examination gloves.
- Gloves, utility.
- Strainer (for tissue inspection) – Optional.
- Simple magnifying glass (x4-6 power) (optional).
- Clear container or basin (for tissue inspection) – Optional.
- Local anaesthetic (e.g. 1% lignocaine without epinephrine).
- Analgesics and anti-inflammatory, Ibuprofen, Ponstan, diclofenac epinephrine, Buscopan, pethidine.

Items that should be on hand, but are not required for all MVA procedures:

- Curettes, sharp.
- Tapered mechanical dilators (Pratt (metal) or Denniston (plastic).
- The essential drugs needed for emergency postabortion care that should be available at the primary and referral levels are listed in Appendix G.
**Furniture and Equipment:**
Before beginning the MVA procedure, make sure that the following equipment and supplies are in the treatment room and in working order:

- Examination table with stirrups.
- Strong light (e.g., gooseneck lamp).
- Seat or stool for clinician (optional).
- Plastic buckets for decontamination solution (.05% chlorine).
- Puncture-proof container for disposal of sharps (needles).
- Leak-proof container for disposal of infectious waste.
- Air-tight storage containers.

**For High-Level Disinfection or Sterilization**

**10 min disinfection**

**20 min high level disinfection**

- These items should be available for processing instruments:
  - Nonmetal (plastic) containers.
  - Detergent.
  - Clean running water.
  - Chlorine solution (concentrated solution or dry powder), Chlorine or glutaraldehyde (Cidex/totucide/steranios)
  - High-level disinfectant or sterilization agent (optional).
  - Large pot for boiling cannulae (Optional).
  - Autoclaved (steam) or convection oven (dry heat).

**For Emergency Resuscitation**

These items are seldom required in uterine evacuation cases but are needed for possible emergency use:

- Spirits of ammonia (ampules).
- Atropine.
- IV infusion equipment and fluid e.g., 5% dextrose and normal saline dextran - (DSW or D/S).
- Oral airways.
- Hydrocortisone.
• Adrenaline.
• Calcium gluconate.
• 50% Dextrose.
• Ergometrine and Syntocinon.
• Sodium Bicarbonate.
  • **Piriton.**
• Diazepam.
• Plasil
• Sutures and suturing equipment.
• Airways.
Before beginning the MVA procedure, make sure that the following equipment and supplies are in the treatment room and in working condition.

**Furniture and Equipment:**
- Examination table with stirrups.
- Strong light (e.g., gooseneck lamp/angle poise).  
  **For MVA procedure**
- Seat or stool for clinician (optional).
- Plastic buckets for decontamination solution (.05% chlorine).

**Instruments and Supplies:**
- Vaginal speculum.
- Tenaculum (volsellum).
- Sponge (ring) forceps.
- Swabs/gauze.
- Antiseptic solution (non-alcohol is best).
- Mechanical dilators (tapered dilators such as Pratt or Denniston are best).
- Osmotic dilators as available (such as dialapam, lamicel).
- 100 syringe and 22-gauge spinal needle (or needle extender) for paracervical block.
- Gloves: new or clean, high-level disinfected examination gloves.
- New or clean, disinfected **utility gloves**.

**Medications:**
- Analgesia medication (for example, acetaminophen, Ibuprofen, pethidine).
- Anti-anxiety medication (for example, Diazepam).
- Anaesthetic (lignocaine or chloroprocaine without epinephrine).
MVA Instruments:
- Vacuum syringes.
- Flexible cannulae of different sizes.
- Adapters.
- Silicone for lubricating syringe.

Endometrial Biopsy:
- Fixative.

For Tissue Inspection
- Receptacle as required by pathology lab.

Incomplete Abortion, First Trimester Abortion:
- Strainer (metal, plastic, or gauze).
- Clear container or basin.

For Emergency Resuscitation:
- These are seldom required in uterine evacuation cases but are needed for possible emergency use:
  - Atropine.
  - IV infusion equipment and fluid.
  - Ambu bag with oxygen.
  - Airway.

For Treatment of Complications:
- These are not needed in every treatment room but should be readily available to the clinician:
  - Broad-spectrum antibiotics.
  - Tetanus toxoid.
  - Oxytocic drugs.
For High Level Disinfection or Sterilisation of Instruments:

- Non metal containers.
- Detergent.
- Clean water.
- Chlorine solution.
- High Level disinfectant or sterilization agent.
- Large pot for boiling cannulae (optional).
Module 16 - Session II

Evaluating the training, planning for the application of the acquired knowledge and skills at the various work-sites and closure of the training

Session Summary
This module gives a guide on how to evaluate the effectiveness of the training, how to plan for the application of the acquired knowledge and skills at the various work-sites and finally the closure of the training.

Objectives
By the end of this session, participants will be able to:

1. Identify knowledge, attitudes and skills gained based on the Pre/Post Training Questionnaire.

2. Provide written comments on the Comprehensive PAC Clinical Skills Training using the Participants Reaction Form.

3. Share with peers and individual trainer’s Skills application (back home application) Plan for ensuring acquired knowledge, skills and attitudes are “transferred” to the comprehensive PAC service delivery.

4. Give personal verbal reactions on the training in a plenary.

5. Agree in one-on-one discussions with the trainers regarding:
   - Individual participants’ overall performance
   - AND document in the Skills Application Plan approaches for continuing to strengthen identified weak skills, if any.
Trainee Materials

Handouts

1. Trainer/Trainee feedback report
2. Trainee’s end of course evaluation
3. Post-course knowledge questionnaire
4. Trainee’s Journal
5. Trainee’s skills application (back-home implementation) plan