Standard Guidelines for the Health Workers on Management of Complication of Abortion

Reproductive Health
Public Health Department
FOREWORD

Abortion is the process of termination of pregnancy before 180 days (25 weeks and three days) of pregnancy. About 10 - 15% of all pregnancy outcome is abortion. Only 25% of abortion are clinically recognised and 75% are not noticed. Therefore, it is unrealistic to gather and rely on data regarding abortion prevalence.

Some of these abortion are spontaneous (occurring without any interference) and other are induced, which can be legal or clandestine depending upon availability of legal code and modern facilities available for the procedure. Available evidence strongly suggest that nearly every where women of all background resort to abortion to some extent regardless of legal codes, religion sanctions or personal dangers.

Abortion as such is self-limiting and the women recover fully within a short period of time including the return of fertility unless complications develops. This complication can be life threatening to some women and can also cause irreversible health effect in some women. Complications are greater in women resorting to unsafe abortion. In the years 2001 -2002 cut of 35 investigated maternal deaths in the country 2 deaths (5.7%) were because of Abortion complicated (incomplete abortion septicamie) Abortion complication is one of the most common obstetric morbidity with a case mortality rate of 1.4%.

Study of abortion is incomplete unless the complementary relationship between abortion and contraception evolving over time is understood. The relative roles of contraception and abortion vary within and between countries.

In some countries abortion is the primary means of fertility control, in other increased use of contraception lowers the incidence of abortion. However, it is observed that greater reliance on contraception decreases the abortion related maternal deaths, the neonatal and infant death rate and the birth rate to a significant extent.

The booklet "Training Manual on Post Abortion Care" deals mainly on these issues and recommended appropriate care for complications of abortion. Post abortion and contraception is discussed in detail that will facilitate increase use of contraceptives by women in immediate post abortion period.

I hope Health Care providers at all level will be immensely benefit by the manual as an working guideline and reference material.

Dr. Jigmi Singye
MINISTER
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INTRODUCTION:

Any sexually active women of reproductive age group may have an induced or a spontaneous abortion at some part of her lifetime. When a woman has abortion, either spontaneous or induced, complications may develop. And both can be unsafe depending on the subsequent events and the care a woman receives.

Women’s reproductive health rights state that a woman has a right to knowledge, right to accessibility to contraception, and right to safe abortion care. Further, women with abortions need proper treatment for the complications that may arise and at the same time need accurate information and proper counselling for family planning before she leaves a health centre. She may not come back later unlike women who give birth to live children.

Women may have unwanted pregnancy and may sometimes resort to unsafe abortions. In Bhutan, abortion is illegal and women seek services outside the country, which is not always safe. When these women develop complications and seek treatment, it is important that they are treated with same respect, and unbiased attitude like any other client. Unlike a woman in her postpartum period, she also may lack social support from her family. On one hand, she had a bad experience and on the other, she is liable to have another unwanted pregnancy. That has to be borne in the minds of people who treat her.

At present, a woman may receive treatment for abortion complications, but no uniform mechanism exists for providing family planning services before she leaves the Health Center. In a hospital setting, she is treated in a ward by one set of providers, whereas family planning is provided in the RH Unit by another set of providers as an OPD activity. A linkage has to be created where these women come in contact with the family planning providers. There must be some sort of co-ordination between the two sets of providers. Who should start the counselling? When should it be done? Where should it be done: in the ward or in the RH clinic? Every health worker should know that this group of women needs family planning services immediately, as they may become pregnant within one month.

A proper guideline for all the health care settings must be in place to ensure that these women receive the care they need so that they can continue to have good reproductive and sexual health.
ABORTIONS

Abortion: Ending of a pregnancy before 180 days (25 weeks and 5 days). Babies born before this period do not survive (WHO guidelines).

Spontaneous Abortion:

Stages:

1. Complete where foetus and placenta are expelled completely.
2. Incomplete where there is retention of products of conception (POC).
3. Missed/external abortion where foetus and placenta are retained. Blighted ovum also falls under this group.
4. Threatened abortion where there is a possibility of carrying on the pregnancy. The embryo or foetus is alive.
5. Inevitable abortion where there is no possibility of saving the pregnancy.
6. Active abortion where the POC is on the process of expulsion through the cervix.
7. Septic abortion - infection with or without the POC.
8. Repeated/habitual abortion where a woman has three or more consecutive abortions.

Abortion occurs for 2 reasons; either there is improper implantation or there is an abnormal embryo. 75% of abortions go unnoticed; only 25% are clinically recognized. Out of 100 women with documented pregnancy, 25% will have threatened abortion out of which half will evolve into normal pregnancy and half will end. Therefore, spontaneous abortion is seen in 10 to 15 women out of a 100 with documented pregnancy. Risk of abortion is more if a woman already had one in the past. Possibility of abortion is highest up to 8 weeks of pregnancy.

Causes of abortion: In 50% of spontaneous abortion, foetal abnormality is found (chromosomal or structural). Following factors also play a role:

- Uterine hypoplasia (small uterus)
- Presence of septi
- Presence of fibromi especially the submucous type
- Endometrial causes like presence of inflammation
- Cervical causes like incompetence

Local maternal causes:

- Chronic/severe hypertension
- Hyper pyrexia of any cause
- Diabetes, hypo/hyperthyroidism
- Infectious diseases like syphilis, toxoplasmosis, lysteria and viral diseases
- Acute appendicitis and acute PID
- Acute chronic intoxications and smoking
- Physical/psychic trauma
- Nutritional and immunological eg. Rh incompatibility

Embryonic and foetal causes:

Placental alterations: H. mole, anomalous implantation, infection and placental tumours.

Membrane abnormality: Abnormal production of amniotic fluid, abnormal fragility, infections and inflammations.

Foetal causes: Like blighted ovum and presence of malformations incompatible with life.

Paternal causes: Chromosomal anomaly, alcoholism, intoxication and drugs.

Clinical aspects:

1. Threatened abortion: There is bleeding which is modest and dark coloured. There may be pain, which usually appears after bleeding has started. On pelvic examination, uterine size corresponds with the period of amenorrhea, cervix is closed, bleeding slight and blood is usually dark coloured.
Differential diagnosis:
- Ectopic pregnancy (pain occurs before bleeding and there is severe tenderness on pelvic examination)
- Polyp, cervicitis, carcinoma of cervix and twin pregnancy.

Put a speculum and see cervix properly. Diagnosis is confirmed after an ultrasound.

Management:
- Rest. Avoid sexual intercourse and repeated vaginal examinations.
- Beta-stimulants like Salbutamol or Ritodrine (not very helpful in first trimester)
- Progesterone in luteal phase deficiency. In the past, it was used to induce relaxation of uterus
- Cercelage if cervical incompetence is diagnosed.
- Do a blood group and Rh and Hb.

2. Inevitable abortion: Bleeding is heavier and colour is now red. Os is already opening. Pain is more severe.

Management:
- a) Wait and watch
- b) Do the blood tests.
- c) Do an evacuation if necessary.

3. Active abortion: POC is already coming out of cervix. In late second trimester, there is first rupture of membranes followed by contractions and bleeding. It may be incomplete since some part of placenta is retained.

4. Complete abortion: all POC is expelled. There is no pain and bleeding is slight.

5. Incomplete abortion: Here bleeding continues (red blood). Infection may settle in and there may be fever. This occurs after a spontaneous abortion, after evacuation of uterus or after an induced abortion. On examination, uterus is soft and bulky; cervix is usually open (may be closed sometimes). May need confirmation with USG.

Management:
- Evacuation of uterus under Oxytocin drip especially in second trimester abortions
- Antibiotics after culture sensitivity if possible or Amoxycillin and Metronidazole.
- Methylergometrine tablets (Methergin) IM or oral
- If perforation of uterus suspected (in clandestine abortion), first treat with antibiotics if no bleeding and then do an evacuation.
- If there is perforation with bleeding, needs immediate laparotomy.

6. Missed abortion:
Dead foetus is retained. Uterus is smaller than expected and does not grow on subsequent examinations after two or three weeks. Cervix is closed and there is no bleeding. Refer to higher centre. Diagnosis is by USG.

Management:
First trimester: Prostaglandin (Misoprostol or Dinoprost) intracervical or intravaginal followed by evacuation.

Second trimester: Prostaglandin and oxytocin. If placental retention suspected after expulsion, do an evacuation.

7. Habitual abortion: It's a kind of sub fertility and should be included under the management of infertility.

8. Induced abortion: Discussed under unwanted pregnancy.
UNWANTED PREGNANCY

Contraceptive technology has not reached the point at which sexual intercourse can be completely separated from becoming pregnant. All methods of contraception, including the combined pill, can fail, even when used by well-instructed and conscientious couples. Moreover, many couples have problems in using contraception because of personal reasons or lack of access to family planning education and services. As a result, this can lead to an unplanned pregnancy that is also unwanted. Unplanned pregnancies are seldom due to deliberate irresponsibility. Sexual behaviour is not easy to regulate and unplanned conception is the result of some or all of several factors (box 1).

**Box 1: FACTORS LEADING TO UNPLANNED PREGNANCY**

- Inadequate sex education
- Poor availability of contraceptive advice and supplies
- Contraceptive method failure
- Poor communication between partners
- Pressures within a relationship
- Sexual violence

With young couples, embarrassment, ignorance, and guilt may hinder communication about sex. In long-established relationships, differences may have arisen between the man and the woman so that, although they are bound to each other by common responsibilities for home and children, communication between them is poor. Sexual activity in these circumstances tends to happen unpredictably and without verbal planning.

**REACTION TO AN UNWANTED PREGNANCY**

For a woman, the discovery that she is pregnant leads to mixed feelings: surprise; pleasure in being fertile; fear of foetal abnormality; fear of child birth; happy anticipation of becoming a mother; and, sometimes, distress at probable consequences (social, educational, economic, or emotional) of having a baby. Many unplanned pregnancies are welcomed, although only after a few days of anxiety and uncertainty. Some women who had no immediate intention of having a baby may find, after moderate readjustment, that they will be able to care for the child. Others become increasingly distressed as they contemplate the disruption of their long-term plans, or they are aware that they lack the physical or emotional resources necessary to be an adequate parent. Many women feel obliged to continue an unwanted pregnancy, even if this will result in hardship, but some reluctantly decide to have an abortion. Women may feel guilt in requesting an abortion, and the pressures that lead to this decision should be understood. If safe legal abortion is unavailable, women are often prepared to risk death from a clandestine procedure rather than continue the pregnancy to term.

The conflicting emotions experienced by a woman about unplanned pregnancy and about the option of abortion are felt by the doctors, midwives, and nurses she consults. Health professionals, who understand the problems of personal regulation of sexual behaviour, are in a strong position to provide sympathetic support and counselling. Censorious comments by health professionals aggravate rather than lessen the woman’s distress.

**OPTIONS (BOX 3)**

Most women with an unwanted pregnancy have made a decision about the their pregnancy by the time they consult a health professional. A few are uncertain about what to do.

**KEEPING THE BABY**

Cultural attitude to sexuality, contraception, abortion, motherhood, and the place of women in society are crucial. A woman who feels guilty about her “poor control” over sexual behaviour, who considers motherhood a woman’s main function, and who believes that abortion is wrong is likely to decide to continue the pregnancy, even if this results in considerable hardship to herself and her family. Much depends on the quality of woman’s relationship with her partner and the extent to which she would receive support from him or from members of her family. Sometimes the woman is entitled to receive support from the state of which she may not always be aware, or there may be charities that can assist with problems relating to poverty or inadequate housing. The young single woman who continues her pregnancy may be rejected by her family and, for her, support from the state or from charities specializing in the care of unmarried pregnant women is essential. This kind of situation is seen in the developed countries. In Bhutan, girls in rural Bhutan invariably continue the pregnancy despite odds since abortion is not accessible to her. Her family or her partner is forced to accept her pregnancy in time.

Women who reluctantly continue unplanned pregnancies often live in substandard conditions which, in turn, make them more liable to antenatal complications such as anaemia and preterm labour. They are also unlikely to attend antenatal care or seek timely treatment in the event of pregnancy complications, due to shame.
INDUCED ABORTION:

There are 50 million induced abortions a year, out of which 20 million are unsafe leading to 70,000 maternal deaths a year. Besides, 15 million teenagers become mothers. Abortion is considered unsafe when unskilled persons using inadequate instruments under improper aseptic conditions induce it. It is safer if legally done in hospitals by competent people. Maternal mortality is high where abortions are illegal.

Unsafe abortion is sought if abortion is illegal, safe procedures are difficult to access or afford or the woman is ashamed to seek care because she is unmarried or victim of sexual abuse. In almost every country there are legal indications for induced abortions. These indications vary widely. Some countries restrict legal induced abortions to situations where it is necessary to save the life of the women. Other countries allow induced abortion in pregnancy resulting from rape or incest, and for probable presence of foetal abnormalities. In Bhutan at present, medical termination of pregnancy is allowed only where maternal health is in danger or there is foetal abnormality.

Methods used:
- Pharmacological induction with Mifepristone and Prostaglandin
- Vacuum aspiration
- Dilatation and curettage after pretreating cervix with prostaglandin
- vaginally or intracervically.

Complications of induced abortions
- Sepsis
- Severe haemorrhage
- Uterine injury
- Genital injury
- Renal failure
- Coma
- Death

When complications develop, these women must receive immediate and proper care or referral to a higher level.

**TABLE 1: Treatment of abortion complications at various levels of health care:**

<table>
<thead>
<tr>
<th>Level</th>
<th>Possible staff</th>
<th>Care activities</th>
</tr>
</thead>
</table>
| Community VHW       | Community residents with basic health training, traditional healers. | Recognition of signs and symptoms of abortion and complications.
| BHU 11              | HA/ANM AN/BHW                                       | Timely referral to the health center (BHU or hospital).                          |
| BHU - I and Hospitals | Nurses, midwives and Specialists in OB/Gyn.         | All of the above plus:
|                     |                                                    | - Simple physical and pelvic examination
|                     |                                                    | - Diagnosis of the stages of abortion
|                     |                                                    | - Resuscitation and preparation for treatment and transfer
|                     |                                                    | - Hb and blood grouping
|                     |                                                    | - Referral if needed
|                     |                                                    | If the trained staff and the appropriate equipment are available, the following additional activities can be performed at the BHU 11:
|                     |                                                    | 1) Initiation of essential treatment including antibiotic therapy, IV fluids and Oxytocin.
|                     |                                                    | 2) Basic pain control
| Regional Referral hospital | Nurses, midwives, general practitioners and specialist in Obs/Gyn, medicine and surgery | All of the above plus:
|                     |                                                    | - Uterine evacuation as indicated
|                     |                                                    | - Treatment of severe complications like bowel injury, tetanus, renal failure, gas gangrene and severe sepsis
|                     |                                                    | - Treatment of coagulopathy.                                                      |
SEPTIC ABORTION

Infection can occur after a spontaneous or an induced abortion. This is the most important complication of abortion. If not treated in time or properly, it may lead to death or many serious consequences.

Factors that predispose to infection:
- Retention of products of conception.
- Presence of clots and necrotic tissue
- Trauma (perforations, lacerations)
- Substandard aseptic practices in case of illegal abortions
- Surgical interventions like evacuations or repeated PV examinations

Microorganisms:
Mostly are endogenous ones which become virulent due to presence of necrotic tissue, trauma etc. Following are the most common organisms:
- Streptococci
- E. coli
- Bacteroides
- Staphylococci
- Proteus
- Pseudomonas
- Klebsella
- Aerobacter

Sites of infection:
Most common site is uterine cavity at the site of trophoblastic/placental insertion. The clinical course and prognosis depends upon whether the infection remains localized or spreads to other organs.

Localized infection: Infection from placental site spreads to whole of endometrial surface and deep into the muscles and blood vessels. Further spread may be blocked by vascular thrombosis, leucocytes and uterine contractions, which close up the blood vessels. Spread is more likely if pus stays collected in the cavity.

Signs and symptoms:
- There is profuse discharge, bleeding (dark coloured blood), with or without foul smell.
- Intermittent fever with chills
- Pain lower abdomen

Pelvic examination reveals a bulky, soft and tender uterus.

Management:
- Do a culture-sensitivity on sample obtained from HVS (high vaginal swab) where possible. Also do blood grouping and a routine blood examination.
- Then start antibiotics (Amoxycillin and Metronidazole orally)
- Give Methergin and mobilize patient to prevention pus collection in the uterine cavity
- Give Paracetamol/Ibuprofen for fever and pain abdomen
- If there is retention of POC, do an evacuation. Oxytocin is required in the second trimester evacuation. Do evacuation after giving blood (if anaemic) and starting antibiotics. When the cervical is open, it can be done under sedation.
- If there are perforations or lacerations in case of induced abortion, do not try to repair. It usually fails.

Infection spread outside uterus:
Infection spread beyond uterus especially in presence trauma or when there is pus collection inside uterus. It spreads via lymphatic, blood vessels and tubes causing pelvic cellules including:

1. Parametritis,
2. Thrombophlebitis,
3. Peritonitis,
4. Septicaemia and
5. Shock (septic)

Death in septic abortion is due to:
1. Peritonitis
2. Septic shock
3. Pulmonary embolism
4. Heart failure.

Sequele of septic abortion:
1. Infertility
2. Fixed uterus
3. Chronic pelvic pain not responding to any treatment
4. secondary dysmenorrhea
5. Dysparaemunia
6. Socially she cannot work, cannot have sex and this affects relations
TABLE II: SUMMARY

<table>
<thead>
<tr>
<th>Area of infection</th>
<th>Signs /symptoms</th>
<th>Management</th>
</tr>
</thead>
</table>
| Localised to Uterus | - Profuse discharge, bleeding (dark coloured) with or without foul smell  
                              - Intermittent fever with chills  
                              - Lower abdominal pain  
                              - Bulky, soft and tender uterus  
|                   | - Hb, TC, DC, BT, CT, blood group and type  
                              - Culture and sensitivity from high vaginal swab  
                              - Antibiotics (amoxycillin/metronidazole)  
                              - Metheglin  
                              - Mobilise the patient  
                              - Antipyretics (paracetamol)  
                              - Evacuation if necessary. |
| Infection spread to pelvis | - Persistent high fever  
                              - Severe tenderness on abdominal or pelvic exam.  
                              - A mass may be palpable |
|                   | - IV antibiotics: ampicillin, gentamycin and metronidazole  
                              - Drainage of pus if collection present |
| Peritonitis | - Continuous high fever  
                              - Distension of abdomen  
                              - Severe abdominal pain  
                              - Vomiting  
                              - Diarrhoea followed by paralytic ileus  
                              - Tachycardia |
|                   | - IV antibiotics in high doses  
                              - Electrolytic balance correction  
                              - Blood transfusion  
                              - NG aspiration  
                              - Laparotomy if pus in peritoneal cavity |
| Septicaemia | - Very high fever  
                              - Toxic look  
                              - Poor general condition |
|                   | - Blood culture  
                              - Same as above,  
                              - Manage the complications |

Post-Abortion Family Planning

Introduction:

Despite the increase in Contraceptive Prevalence Rate over the last few years, women still have unwanted pregnancy. Some of these women may seek induced abortion, which may be unsafe.

A woman who undergoes an induced abortion has three characteristics:

1. She is sexually active.
2. She does not want pregnancy.
3. She is likely to undergo another abortion in event of a pregnancy.

Therefore, there is a need to strengthen the family planning services to reduce unwanted pregnancy, thus avoiding unsafe (induced) abortions. Besides accurate information, proper counselling and all range of family planning methods should be made accessible and available to every woman that has undergone an abortion.

There are few factors that effect post-abortion family planning:

- Opportunity for counselling/method delivery is minimal as women may come for one visit only.
- Family planning counselling and service is not routinely provided in the set up where post abortion care is given.
- Complications from unsafe abortion may influence the choice and timing of the method.
- There may be immediate return of fertility.
- The woman may lack family and community support

There are three potential service provider groups who can give family planning advice to post abortion women:

a) Those treating abortion complications.
b) Family planning providers.
c) Induced abortion providers.
They should be able to give to the women basic information about the return of fertility and availability of safe and effective contraception. Family planning counselling and services should be available in conjunction with emergency treatment of abortion complications so that an appropriate contraceptive method can be initiated if the woman chooses to use one.

**POST-ABORTION CONTRACEPTION COUNSELLING**

While we have number of spontaneous abortions, there are evidences of induced abortions performed across the border where competence and asepsis are not necessarily taken care of. This affects the health of the woman undergoing the procedure. Most of these women are at very high risk of experiencing another abortion in near future, thus risking life and ruining her reproductive health. This shows the need of family planning services of which has been outlined already in this book.

In both cases counselling is essential. It is the responsibility of mainly those persons treating patient and family planning service provider. Counsellor must ensure that the client is given complete and clear information to allow her to make an informed choice of appropriate method so as to give opportunity and her rights to participate in maintaining her reproductive health.

**Objectives of Post-abortion counselling include:**

- To avoid further unwanted pregnancy.
- To reduce unsafe abortion
- To minimise maternal morbidity.
- To reduce maternal mortality

**Key Elements in Post-Abortion Counselling:**

Post-abortion counselling should address the topics as any other family planning counselling. However, there are additional unique points to be addressed in high quality counselling of post-abortion contraception. These include the following:

- Consideration of the patient’s physical and emotional state.
- Discussing the following with the client:
- Immediate return of fertility and possibility of another unwanted pregnancy.
- Appropriateness of methods applicable to the client.
- Any concerns that the client may have regarding sexuality, fertility, culture, social as well as religious issues.

- Provision of information on methods to reach a preferred choice based on current clinical situation of the client. Information should cover usage, effectiveness, risks and benefits, side effects and their management of each of the methods. It should also cover referral including re-supply or follow-up. For example a woman treated for abortion in a District Hospital may be given contraception service or she may be asked to report to the concerned BHU either for contraception or follow up.

- Provision of referral information about other reproductive health services. Counsellor should be alert and look for signs of high risks of reproductive health problems such as STIIHIV/AIDS. She must be informed that except for condom, any other family planning method will not protect her from STI/HIV/Aids, but only from unwanted pregnancy. Therefore, unmarried women must use condoms with new or casual partners even if she is under another type of contraceptive cover.

Significant effect of counselling depends on the quality of interactions that a counsellor makes. Clients will be more content and feel that their needs are expressed if the counsellor provides supportive environment including confidentiality.

**When to give Post-abortion Counselling:**

It may be important to find and fix a suitable time to counsel a client, particularly in a post-abortion case as the client may not be able to reach a right decision at the time. She may need counselling at different intervals depending upon post facto of the incidence, before she reaches the final decision. Counselling can be given at any place and at any time. provided she is ready to listen or when she seeks advice(s). However, privacy needs to be looked into as a necessity.

**The following need to be addressed:**

- If the woman is in stress or pain:

She may have a variety of emotions at the time of deciding to seek abortion, the abortion itself, complication and its treatment, which include fear, anxiety, and guilt. Ultimately she may have resolved from a crisis situation or she may have pain at the time of counselling. These conditions may interfere with informed voluntary decision-making; influence her interest in receiving counselling, and to use the chosen method correctly. Decisions about long-term and permanent methods are of particular concern in such situation.
When does she want to become pregnant?

Counsellor must understand the woman’s desire to become pregnant again. Woman may or may not want to use any contraceptive both short and long term particularly in case of spontaneous abortions. Others may want to delay the next pregnancy or avoid future pregnancy. It is important that the counsellor understand reproductive intentions and perspective before making any contraceptive recommendations. Following need to be considered:

- Complete and clear information on methods, fertility returns and risks;
- Use of interim methods against contraindications;
- Provision for full range of contraceptives to women not desiring pregnancy now or ever,
- Helping clarify and re-define decision to those who are unsure of their desire.

Specific Timing for Individual Contraceptives:

All family planning contraceptives have their characteristics in action and their side effects as well as protective time duration. The WHO standard on their characteristics is shown in Table III, with their indications and contraindications in particular.

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>Combined OCS</th>
<th>Progesterone only OCS</th>
<th>DMPA/NET EN</th>
<th>Norplant Implants</th>
<th>Female Sterilization</th>
<th>Vasectomy</th>
<th>Condoms</th>
<th>Cu-T 380A IUCD</th>
<th>Spermicides</th>
<th>Diaphragm, Cervical caps</th>
<th>Fertility awareness</th>
<th>Based methods (Periodic abstinence, coitus interruptus, safe period, rhythm method), basal body temperature method, cervical mucus method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post abortion</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>*1st trimester</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>*2nd trimester</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
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<td>2</td>
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<td>1</td>
<td>4</td>
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</tr>
<tr>
<td>*After specific abortion</td>
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<td>-</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

Table III

WHO Medical Eligibility Criteria for Postabortion Contraception method

Legend

<table>
<thead>
<tr>
<th>WHO</th>
<th>With clinical judgement</th>
<th>With limited clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Use the method in any circumstances</td>
<td>Use the method</td>
</tr>
<tr>
<td>2</td>
<td>Generally use the method (advantages generally outweighs theoretical or proven risks)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Use the method not usually recommended unless other appropriate methods are not available or acceptable</td>
<td>Do not use the method</td>
</tr>
<tr>
<td>4</td>
<td>Method not to be used</td>
<td></td>
</tr>
</tbody>
</table>

* 1ap - Can start diaphragm use after 2nd trimester abortion
* 1b - This condition may affect ovarian function and/or change fertility signs & symptoms and/or make methods difficult to learn and use.
* Conditions not listed by WHO for this method: does not affect eligibility for method use
### TABLE IV: Factors Affecting Postpartum and Post Abortion Family Planning

<table>
<thead>
<tr>
<th>Postpartum</th>
<th>Post Abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health System</strong></td>
<td><strong>Health System</strong></td>
</tr>
<tr>
<td>Opportunity for counselling/method delivery possibly increased by women’s multiple contacts with health system</td>
<td>Opportunity for counselling/method delivery minimal because women typically have one contact with health system, few return for follow-up.</td>
</tr>
<tr>
<td>Family planning care may be available in the Maternity Ward.</td>
<td>Care delivered in emergency or gynaecology ward where family planning is not offered routinely.</td>
</tr>
<tr>
<td>Easy to identify woman in Postpartum period for follow-up family planning.</td>
<td>Difficult to identify women in Postabortion period for follow-up family planning.</td>
</tr>
<tr>
<td>Preventive approach to care</td>
<td>Curative crisis oriented approach to care.</td>
</tr>
<tr>
<td>Typically supportive provider attitude towards mother</td>
<td>Often insensitive and sometimes punitive provider attitudes towards women who have undergone abortion.</td>
</tr>
<tr>
<td><strong>Clinical</strong></td>
<td><strong>Clinical</strong></td>
</tr>
<tr>
<td>Delayed resumption of menses, especially if breast feeding</td>
<td>Prompt return of ovulation and menses.</td>
</tr>
<tr>
<td>Breast feeding precludes use of some Hormonal methods.</td>
<td>Complications from unsafe abortion may influence choice or timing of method.</td>
</tr>
<tr>
<td><strong>Psychological/Cultural</strong></td>
<td><strong>Psychological/Cultural</strong></td>
</tr>
<tr>
<td>Women identifies herself as mother</td>
<td>Little known about women’s self and of the abortion experiences.</td>
</tr>
<tr>
<td>Societal support for mothers.</td>
<td>Little social support after abortion.</td>
</tr>
<tr>
<td>Some Post-partum practices postponed risk of future pregnancies.</td>
<td>Little known about practices after abortion.</td>
</tr>
<tr>
<td>Societal fertility role confirmed.</td>
<td>Societal fertility role may not be confirmed.</td>
</tr>
<tr>
<td>Women may perceive risk of subsequent pregnancy to be delayed.</td>
<td>Women may not recognise almost immediate return to fertility.</td>
</tr>
</tbody>
</table>

### TABLE V: Post-abortion Contraception

<table>
<thead>
<tr>
<th>SL #</th>
<th>Methods</th>
<th>When to start</th>
<th>Where (Hosp./BHU)</th>
<th>By Whom (Doctor/HW)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Combined OCPs</td>
<td>(i) In the first 7 days after or second miscarriage/abortion (ii) Later, any time when you are absolutely certain that she is not pregnant</td>
<td>All health centres</td>
<td>All health workers</td>
</tr>
<tr>
<td>2.</td>
<td>Progestin-only OCPs</td>
<td>(i) Immediately or in the first 7 days after either after 1st/2nd trimester abortion/miscarriage (ii) Later anytime when you are absolutely certain that she is not pregnant</td>
<td>-do-</td>
<td>-do-</td>
</tr>
<tr>
<td>3.</td>
<td>Injection DMPA/NET EN</td>
<td>-do-</td>
<td>-do-</td>
<td>-do-</td>
</tr>
<tr>
<td>4.</td>
<td>Tubal ligation</td>
<td>Immediately if indicated</td>
<td>Hospital</td>
<td>Trained Doctor</td>
</tr>
<tr>
<td>5.</td>
<td>Vasectomy</td>
<td>-do-</td>
<td>-do-</td>
<td>-do-</td>
</tr>
<tr>
<td>6.</td>
<td>Condom</td>
<td>Immediately</td>
<td>All health centres</td>
<td>All health workers</td>
</tr>
<tr>
<td>7.</td>
<td>IUCD (CuT)</td>
<td>(i) Immediately if no infection is present (ii) If infection is present, first treat and help patient to choose another effective method of FP. After 3 months if no infection remains, reinfection is not likely and she is not pregnant, then IUD can be inserted.</td>
<td>Hospital</td>
<td>Doctor</td>
</tr>
<tr>
<td>8.</td>
<td>Fertility awareness based method</td>
<td>Immediately</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
EMERGENCY CONTRACEPTION

Why does unplanned pregnancy occur among adolescents?

Most societies deny them education
Most of them have sex for extramarital reasons
They have little knowledge of contraception
They have little freedom in choosing contraceptive methods
They are not responsible for reproduction

How can we judge if a community needs emergency contraception?

Available methods at present:

1. Increased doses of combined oral contraception (tablet form)
2. Condom
3. Emergency contraception (tablets)

How to handle emergency contraception?

1. When there is an urgent need for emergency contraception
2. When there is a high risk of pregnancy
3. When there is a known pregnancy

What is emergency contraception?

Emergency contraception is a method of contraception used in emergency situations to prevent pregnancy.

What is needed in an emergency situation?

In situations where there was voluntary sexual intercourse with no protection
After sexual assault and rape
In situations where there was non-voluntary sexual intercourse

Which emergency contraceptives are available?

- Emergency contraception pills
- Condom
- Diaphragm
- IUD
- Spermicides

How is emergency contraception administered?

Emergency contraception can be administered orally, vaginally, or intramuscularly.

When is emergency contraception needed?

- In situations where there was voluntary sexual intercourse without protection
- After sexual assault or rape
- In situations where there was non-voluntary sexual intercourse

What are the benefits of emergency contraception?

- Prevents unintended pregnancies
- Reduces the need for abortions
- Prevents sexual assault

Failure to take the pill for more than three days:
- Failure to take the pill for more than three days:
- Failure to take the pill for more than three days:

Emergency contraception can thus play an important role in linking individual and couples to ongoing reproductive health care.
Methods that can be used in Bhutan:

1. Increased dose of OCP (4 pills within 72 hours, to be repeated after 12 hours).
2. CuT to be inserted within 5 days

Musts in EC:
- Providers must have clear guidelines on how and when you offer EC.
- Providers must give clear instructions to the clients to avoid incorrect use or confusion.

1. Increased dose of OCP (Yuzpe regimen):

Administration:
Give 4 pills (Microgynon in Bhutan) within 72 hours of unprotected sex followed by another 4 pills 12 hours after the first dose.

Mode of Action:
- Inhibits ovulation
- Prevents implantation of fertilized egg
- May prevent fertilization
- May prevent transport of sperm and ova

Efficacy:
- Prevent 75% of pregnancy

Side effects:
1. Nausea:
   - in 50% of clients
Advice:
Take the pills with food or at bedtime
Give prophylactic anti-emetic especially if patient has nausea with regular pills.

2. Vomiting:
   In 20% of women. If vomited within 2 hours of pills, repeat the pills again. In repeated vomiting, administer the pills vaginally.

3. Irregular uterine bleeding:
   - some have spotting
   - majority has bleeding little early or on time
   - if delay is there for more than a week, pregnancy must be suspected

4. Other side effects:
   Breast tenderness, headache, dizziness and fatigue. These do not last more than 24 hours. Give Aspirin or Paracetamol.

Contraindications:
The only contraindication is pregnancy, because treatment will not work if she is already pregnant. Contraindications associated with regular use do not apply here due to very short period of use.

Screening:
Exclude pregnancy by establishing:
- Date of LMP and whether it was normal
- Time of first and last episode of unprotected intercourse

Counselling:
While counselling:
- Be respectful towards the client
- Be responsive to her needs for information and care
- Reassure clients that all information will be kept confidential
- Have supportive attitudes
- Do counselling in a private area (ensure privacy)

What do you need to counsel on?

1. Stress:
   - Patients are stressed due to fear of pregnancy and STD
   - They are embarrassed about being sexually active
   - They are embarrassed about having failed to take effective precautions
   - Rape victims may be suffering from mental trauma

Therefore, it is essential that you have a supportive attitude while talking to these women!
1. Frequent use:

You must tell the client that EC is only for emergency and not for frequent use since there is more chance of failure. Of course there are no health risks associated.

2. HIV/STD:

Give information on how STD/HIV can be prevented. Tell them EC will not protect them from disease, only from pregnancy. If there is fear of having contacted any STD or HIV, give them diagnostic services or refer to a higher level.

3. Regular contraceptive use:

- If a client is not already using a regular contraceptive, give her information, especially if she desires it.
- If patient is too stressed at first contact, you can talk to her later on during follow up, about using a regular contraceptive.
- If it was due to failure of a regular contraceptive method, explain the reason for failure and how it can be prevented in future.

Information for clients:

1. Tell her she still has a chance of being pregnant despite EC, but that there is no harm for the foetus.
2. Explain how to take the pills correctly.
3. Describe common side effects. This will have women to know what to expect and may tolerate better.
4. Tell her that drinking milk or eating snacks with pills may reduce nausea.
5. Help her decide when to take the first dose so that taking the second one 12 hours later is not inconvenient for her (for example, if first dose is taken at 2 PM today, she has to wake up at am in the night to take the second dose, which is definitely inconvenient!)
6. Tell her she must repeat the dose, if she vomits within 2 hours of taking the pills. In repeated vomiting, to insert the pills in the vagina.
7. If she engages in unprotected sex in the next few days, she will not be protected from pregnancy. Therefore, she must use condoms.

8. Tell her that her next menstrual bleeding may start a few days earlier or later than normal.
9. Tell her to come for regular contraception as soon as her period starts.
10. If her period is delayed for more than a week, she must have pregnancy ruled out.

If client is pregnant (EC has failed):

1. Offer her options and let her decide. Respect her decision. You may need to refer her to confirm pregnancy.
2. If she desires to keep the pregnancy, reassure her that there is no teratogenic effect.
3. In all cases of EC failure, rule out ectopic pregnancy (may be higher chances of it in EC failures than in a normal pregnant population).

11. CuT:

Insertion: To be inserted within 5 days of unprotected sexual intercourse.

Efficacy: Prevents 98% of pregnancy

Mode of action: Prevents fertilization by decreasing number of sperms reaching the Fallopian tubes. Also interferes with sperm motility.

Indications:
- Same as of OCP
- When more than 72 hours have lapsed from unprotected intercourse
- When client is already considering using CuT as regular contraceptive.
  (Not to be inserted in nullipara. OCP is better for them)

Eligibility criteria:

In case of CuT, all the contraindications for regular CuT use also apply here.

Therefore, CuT should not be used in the following situations:
- An established pregnancy
- Presence of history of puerperal or post abortion sepsis within last three months
- History of PID (current or past)
- Presence of STD (current or within 3 months)
- Purulent cervicitis
- Malgnancy of genital tract including GTN
Situation in which CuT should be used as the last choice:
1. Women who are at risk of STD (those with multiple partners). Pills are better for them, but if more than 72 hours have passed, insert CuT as EC, but advise her to switch on to another contraceptive after her next menstrual period.
2. In case of rape, use CuT only if more than 72 hours have passed. She is also at risk of contracting STD.

Counselling:
- Same as for OCP, when given as emergency contraception.
- You may suggest that she might keep CuT as regular contraception. If she does not want it, she can come for removal during or soon after her menstrual period.

Screening:
- First exclude pregnancy as with OCP. Where doubts exist you can even do a pregnancy test where possible.
- Records medical and gynaecological history
- Records present illness, including history of STD and risk factor for STD.
- Perform a pelvic examination including speculum examination of cervix.
- Perform any examination as indicated by her history.

Instruction to the client:
She must come back to the clinic if there is any of the following signs and symptoms:
- Purulent vaginal discharge
- Fever
- Pelvic Pain
- Excessive or abnormal bleeding

Follow up:
- If client does not want to keep the CuT, remove during /after next menstrual period and give her another contraceptive for regular use.
- If she wants to keep the CuT, check it to see if in place and give advice related to continue follow up.

In case of delayed menstruation, rule out pregnancy. If pregnant, remove CuT and exclude ectopic pregnancy!
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>POD</td>
<td>Out Patient Department</td>
</tr>
<tr>
<td>RHU</td>
<td>Reproductive Health Unit</td>
</tr>
<tr>
<td>POC</td>
<td>Product of concept</td>
</tr>
<tr>
<td>USG</td>
<td>Ultrasound</td>
</tr>
<tr>
<td>OCPS</td>
<td>Oral Contraceptives pills</td>
</tr>
<tr>
<td>DMPA</td>
<td>Depoprovera</td>
</tr>
<tr>
<td>IUCD</td>
<td>Inter uterine contraceptive Device</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Diseases</td>
</tr>
<tr>
<td>EC</td>
<td>Emergency Contraception</td>
</tr>
<tr>
<td>PID</td>
<td>Pelvis Inflammatory Disease</td>
</tr>
<tr>
<td>GTN</td>
<td>Gestational Tophoblatic Neoplasys</td>
</tr>
</tbody>
</table>