COMPREHENSIVE ABORTION CARE

MNS

Official document

NATIONAL CENTRE FOR STANDARDIZATION AND MEASUREMENT

Ulaanbaatar
2004
1. Purpose

This standard aims to reduce number of abortions and its complications through the provision of comprehensive abortion package in safe environment by specialist physicians.

2. Who may perform

This standard is required to be followed by physicians and specialists of public and other medical providers, who provide abortion services in accordance with the Health laws of Mongolia.

3. Definition

Comprehensive abortion care is the medical termination procedure of pregnancy including pre and post abortion counseling up to 23 weeks of gestation.

4. Classification

Abortion procedure is classified as early or late by duration of pregnancy.

An early abortion procedure is the medical termination of pregnancy performed up 12 weeks of gestation.
Late abortion procedure is the medical termination of pregnancy performed from 12 to 23 weeks of gestation.

5. Normative citation

- MNS 5081: 2001 Structure and functions of Inter soum hospitals
- MNS 5082: 2001 Structure and functions of Aimag general hospitals
- MNS ……: 2003 Structure and functions of RDTC
- MNS…..:2002 Structure and functions of specialised clinics and centers
- MNS 4621: 1998 Common diagnostic and treatment procedures
- MNS 11020: 2003 Ultrasound diagnosis of fetus
6. **Organization of the pregnancy termination services**

6.1 Pregnancy termination is performed by accredited hospitals providing obstetrics and gynecology care at the inter-soum and above levels.

6.2 Pregnancy termination is performed by physicians licensed to provide ObGyn care.

6.3 The facility which provides early abortion care must meet the following requirements:

6.3.1 To have met hygienic and infection prevention requirements. /Order #336, 1997 of Minister of Health and Social Welfare/.

6.3.2 Measures to prevent complications are in place and the facility should have the ability to provide necessary emergency care, especially cardiopulmonary resuscitation in case of complications.

6.4 Address of facilities (hospital, department, room) providing abortion service should be clear and easy to find.

6.5 Facilities should have enough natural and electric light and be warm.

6.6 Client’s rights, regulation of services, and timetable should be displayed in a visible place for clients.

6.7 Sufficient chairs should be available.

6.8 Surgical equipment and instruments should be sterilized and stored in separate wardrobe and shelf.

6.9 Should have a container with disinfection solutions and covered storage receptacle for used equipment and instruments.

6.10 Should have separate containers for the storing of single-use gloves, syringes, needles and dirty cotton, gauze, and other materials.

6.11 Should have enough pyjamas and slippers for clients.

6.12 Ensure privacy during examination and procedure (unable to be interfered with by someone).

6.13 Able to provide health education, information, and communication using different methods.

6.14 Should have question box or form for getting client’s comments on services.

6.15 Should serve soft drinks and cup. /drinking water, tea etc/.

6.16 Should have bed/beds for post-abortion recovery.

6.17 Counseling room should ensure privacy and have equipment and materials for counseling /books, handouts, models, contraceptives/.
6.18 Should have a bathroom for client use.

6.19 Bathroom must be equipped with disinfection substances and a container for disposals.

7. **Indications for abortion**

7.1 In early stage of pregnancy;

7.1.1 requested by pregnant woman
7.1.2 by decision of Medical Commission

7.2 In late stage of pregnancy, accordance with Order #56 of Minister of Health dated 12 of February, 2002

7.3 Indications for delaying abortion;

7.3.1 Acute inflammatory diseases or redeveloping infectious diseases
7.3.2 Acute pelvic inflammatory diseases

8. **Registration and information of abortion care**

8.1 Should have an abortion registration book. /personal client number, date, name, age, address, duration of pregnancy, name of provider/

8.2 History of abortion should be filled according to form „ESM 3А„.

8.3 The written consensus request by woman or care taker should be attached to the ESM3А, before abortion procedure.

8.4 The result of lab test should be attached to the ESM 3A, before abortion procedure.

8.5 Method of diagnosis of pregnancy should be attached to the ESM 3A. /ultrasound, pregnancy test, vaginal examination/

8.6 Counseling should be noted in the ESM 3A.

8.7 Abortion procedure, anesthesia, description of tissue of fetus, placenta and uterus should be written and approved by signature in the ESM 3A /history of abortion/.

8.8 Abortion report should be written based on ESM 3A and reported monthly to the Aimag and City Health Department Statistical unit.

8.9 Health Department will compile reports and send to the Health Statistics Department of Directorate of Medical Services.

9. **Counseling**

9.1 Provide information clients on abortion procedure its techniques, options, risks, possibilities, consequences and will help to assist the woman in making the decision.
9.2 Information on complications and trauma must include the following aspects: bleeding, uterine perforation, trauma, persistent pregnancy, postabortion infection, later reproductive capacity, psychological trauma.

9.3 Information on contraception must be provided to all patients undergoing a pregnancy termination procedure.

9.4 Doctor’s must counsel the women in clear, polite language and using a minimum of specialised terminology.

9.5 All women undergoing pregnancy termination in public or private medical units must sign an Informed Consent before undergoing the procedure, including her statement that she understands the procedure, the existing alternatives, potential risks, benefits and complications and that the decision is un coerced and that she is ready for pregnancy termination.

9.6 If client is not yet reach to legal age of adult, should be taken permission of legal care taker or parents and documented.

9.7 If the patient’s age is below that of legal consent (18) the parent’s or the legal guardian’s approval to terminate pregnancy must be documented.

9.8 Voluntary counseling must be private and confidential.

9.9 The personnel providing voluntary counseling must be trained in counseling methods.

9.10 All service providers involved in providing abortion services, taking all reasonable precautions, must keep the information confidential.

10. Pre-abortion diagnostic procedures

10.1 Bacteriological testing of the vaginal content for each client.

10.2 Determination of hematocrit and of hemoglobin must be performed in women with a history or with symptoms of significant anemia.

10.3 An ultrasonographic examination of pelvic organs should be preformed to verified gestational age.

10.4 If an ectopic pregnancy is suspected, diagnosis must be verified before the decision is made to perform an abortion.

10.5 A client suspected having reproductive or other health problems, should be given other necessary tests.

11. Use of peri-operative antibiotics

11.1 During the pregnancy termination procedure through aspiration or curettage, patients should be given prophylactic antibiotics. Metronidazole 1g, rectally at abortion time.
12. Pain management

12.1 The following things required to provide this service

12.1.1 Local Anesthetic preparations: lidocain, novocain, bupivacain
12.1.2 General Anesthetic preparations: ketamin, teopental, prophopol
12.1.3 Narcotic pain killers: phentanil, pentazocin, morphine
12.1.4 Non-steroid anti-inflammatory preparations: paracetamol (acetaminophen), ibuprophen, diclodenk
12.1.5 Sedative preparations: Diasepam, midazolam
12.1.6 Oxygen supply
12.1.7 Equipment for the delivery of oxygen
12.1.8 Pulse oxymetry (Il-lll level hospitals)
12.1.9 Ambu bag
12.1.10 Medications for emergency care: adrenalin, ephedrin, calcium chloride, uterus contraction preparations
12.1.11 Intravenous liquids: 0.9% natrium chloride, Ringer lactate, dextran

12.2 Personnel and monitoring

12.2.1 Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthesia, paracervical anesthesia and monitored anesthesia care and the patient’s oxygenation, ventilation, circulation, temperature and effects on respiratory, cardiovascular and neurological system must be continually monitored.

12.2.2 When conscious sedation or local anesthesia is used, there should be an available practitioner responsible for the treatment of the patient and/or the administration of drugs for sedation.

12.2.3 When conscious sedation, deep sedation, or general anesthesia is used, there must be documentation that the patient or accompanied people have been warned of possible transient mental impairment.

12.3 Anesthesia

12.3.1 Choosing appropriate method of anesthesia.
12.3.1.1 Verbal sedation
12.3.1.2 Using drugs: (Showed in table)
12.3.1.2.1 Using local anesthetic substances – T.1
12.3.1.2.2 Using pain killers – T.2, T.3, T.4, T.5, T.6
12.3.1.2.3 Using sedative preparations – T.7, T.8
12.3.1.2.4 Intravenous anesthesia – T.9
12.3.1.2.5 Spinal anesthesia
12.3.1.2.6 General anesthesia
12.3.3 If need general or zonal anesthesia, anesthesian have to decide drug type.
<table>
<thead>
<tr>
<th>Type of drug</th>
<th>Drug name /Generic/</th>
<th>Usual dose and timing</th>
<th>Half-life/Duration of effect</th>
<th>Common side effects</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>T.1 Local anesthetics</td>
<td>Lidocain (Xylocaine)</td>
<td>10-20ml of 0.5-1% solution in paracervical block Should not exceed 4 mg/kg.</td>
<td>60-90 min</td>
<td>Buzzing in ears, dizziness, numbness of lips, mouth and tongue, metallic taste, seizures</td>
<td>Aspirate before injecting to avoid vascular administration. Mild reaction (itching, rash, hives): treat with 25-50 mg diphenhydramine IM or IV. Intense reaction or respiratory distress: obtain IV access immediately. Treat with epinephrine 0.4mg subcutaneously and diazepam 5 mg IV (pushed slowly), and support respiration with oxygen and ventilating bag. If wheezing is present, an inhaler may be useful. Allergic reaction is very rare. Reactions that do occur are most likely due to methylparaben preservative in multidose vials. Preservative-free lidocaine allergy is extremely rare.</td>
</tr>
<tr>
<td>T.2 Analgesic /Narcotic</td>
<td>Demerol/meperidine</td>
<td>PO: 100-150mg 30-60min prior to procedure IM: 50-125mg 15-30min prior to procedure IV: 25-50mg 5-15min prior to procedure</td>
<td>2 hours</td>
<td>Drowsiness, light-headedness, weakness, nausea and vomiting, CNS and respiratory depression, hypotension, seizures</td>
<td>Stop effect when inject 0.4 mg naloxone IV. If respiration is compromised: assist with breathing (oxygen, Ambu bag). Meperidine oral use effect is weaker than use IV.</td>
</tr>
<tr>
<td>T.3 Analgesic /Narcotic</td>
<td>Sublimaze/fentanyl</td>
<td>IV: 50-100mcg 5-15min prior to procedure /may repeat every 10-15min, not to exceed 250mcg/</td>
<td>30-60 min</td>
<td>Drowsiness, light-headedness, weakness, bradycardia, CNS and respiratory depression</td>
<td>Stop effect when inject 0.4 mg naloxone IV. If respiration is compromised: assist with breathing (oxygen, Ambu bag). 100mcg fentanyl =10mg of morphine Onset of action: 2-7min when given IV</td>
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<tr>
<td><strong>T.4</strong> Narcotic combination</td>
<td>Tylenol with codeine (300mg acetaminophen with 30mg codeine)</td>
<td>PO: 1-2 tablets 1 hour prior to procedure</td>
<td>3-6 hours</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Drowsiness, light-headedness, weakness,</td>
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<td></td>
<td></td>
<td></td>
<td>Liver and kidney toxicity especially in the presence of pre-existing disease</td>
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<td></td>
</tr>
<tr>
<td><strong>T.5</strong> Analgesic/NSAID</td>
<td>(Ibuprofen) or (naproxen)</td>
<td>PO: 400-800mg PO: 550mg 1 hour before procedure</td>
<td>4-6 hours</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Possible gastro-intestinal upset</td>
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<td></td>
<td></td>
<td></td>
<td>Do not use in women with active peptic ulcer disease or renal failure. Allergic reaction may occur in patients with nasal polyps, asthma or sensitivity to NSAIDs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>T.6</strong> Analgesic</td>
<td>Tylenol (acetaminophen)</td>
<td>PO: 500-1000mg 30-60 min before procedure</td>
<td>4-6 hours</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Liver toxicity from overdose. Do not use in the presence of renal compromise.</td>
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<td></td>
</tr>
<tr>
<td><strong>T.7</strong> Anxiolytic/Amnestic</td>
<td>Valium (diazepam)</td>
<td>PO: 10 mg 1 hour prior to procedure IV: 2-5 mg 60 minutes prior to procedure.</td>
<td>21-37 hours</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Blurred vision, dizziness, disorientation, pain and redness on injection</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>If respiration is compromised: assist with breathing (oxygen, Ambu bag) and reverse with flumazenil. Has a mild amnestic effect. Onset of action: 2-10 minutes when given IV.</td>
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</tr>
<tr>
<td><strong>T.8</strong> Anxiolytic/Amnestic</td>
<td>Versed (midazolam)</td>
<td>IM: 0.07-0.08 mg/kg or about 5 ig (using 5 ig/ml dilution) IV: 1-2 ig initially, then 0.5-1.0 ig IV every 5 minutes as needed, not to exceed 5 mg.</td>
<td>1-4 hours</td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td>Blurred vision, dizziness, disorientation, (significantly less pain on injection than diazepam due to water solubility of midazolam)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>If respiration is compromised: assist with breathing (oxygen, Ambu bag) and reverse with flumazenil. 2.5 mg midazolam = 10 mg diazepam Stronger amnestic effect than diazepam. Onset of action: 1-5 minutes when given IV; 15-30 minutes when given IM</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>T.9</strong> General anesthesia</td>
<td>Ketamin</td>
<td>IV: 1 mg/kg 2-3 minutes prior to procedure IV 2/3 of first dose as needed.</td>
<td>10-15 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Blurred vision, dizziness, disorientation, hallucination</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Onset of action: 1-3 minutes and lasts 10-15 minutes. To reduce hallucination effect combine with diazepam.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
12.4. Paracervical blockade used alone or in combination of non-steroid anti-inflammatory drugs.

12.4.1 After determination of allergic reaction against local anesthetics and related drugs, aspirate 10-20ml of a 0.5-1.0% lidocain solution without adrenaline.

12.4.2 Local anesthetics administered by 22-25G needle. Inject 1-2ml of anesthetic at the cite where tenaculum will be placed usually 6 or 12 o’clock.

12.4.3 Place tenaculum at the anesthetized site. Use slight traction to move the cervix and define the transition of smooth cervical epithelium to vaginal tissue. This reflection marks the site of further injections around the cervix. Compared to cervical tissue, vaginal mucosa is more elastic and appears folded.

12.4.4 After inserting the needle under epithelium, draw back plunger and to make sure that the needle is not penetrating a blood vessel.

12.4.5 Inject 2-2.5 ml lidocaine into each injection site at 3, 5, 7 and 9 o’clock. Inject slowly to decrease pain of injection.

12.4.6 Inject to a depth of 1 inch.

12.5 Post abortion anesthesia

12.5.1 After early abortion and late abortion, except in a pregnancy termination by Cesarian section, use oral non-steroid anti-inflammatory drugs if necessary.

12.5.2 If pregnancy was terminated by Cesarian section in the late stage, paracervical blockade or narcotic anesthesia is to be used with non-steroid anti-inflammatory drugs.

13. Pre-abortion preparation

13.1.1 Provider has to meet with client and introduce her/himself.

13.1.2 Provider should explain every procedure to the client before examination.

13.2 Pre-procedure examination

13.2.1 Vital signs (blood pressure, pulse and temperature) and physical exam should be noted in medical history (ESM3A).

13.2.2 Placing a clean material under the client before vaginal examination.

13.2.3 Provider has to ask the client to empty her bladder before a vaginal examination.

13.2.4 Provider has to help the client lay on the examination bed.
13.2.5 Provider has to wear gloves.

13.2.6 Provider should note pelvic examination in the ESM 3À.

13.2.7 Provider has to give information and help the client to choose a type of procedure after determining gestational age.

13.2.8 Explain to client the chosen procedure and pain management.

14. **General principles of abortion procedure**

14.1. Provide pain management/ anesthesia / see step 15/

14.2. Wear sterile gloves

14.3. Wipe the vulva and vagina with cotton balls with antiseptic agent, e.g. Polyvidone iodine solution (same Betadine or Tamedine)

14.4. Insert the vaginal speculum

14.5. Wipe the vagina and cervix with antiseptic agent, e.g. Polyvidone iodine solution

14.6. Apply tenaculum forceps on the cervix

14.7. Sound the uterus by passing a uterine sound to assess the length and direction of the uterus

15. **Abortion procedure**

15.1. **Manual vacuum aspiration**

15.1.1. Select the cannula that corresponds to the gestational age (Table 1)

<table>
<thead>
<tr>
<th>#</th>
<th>Gestational age (week since last menstrual period)</th>
<th>Size of cannula</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>5-7</td>
<td>5 mm</td>
</tr>
<tr>
<td>2.</td>
<td>7-9</td>
<td>6 mm</td>
</tr>
<tr>
<td>3.</td>
<td>9-12</td>
<td>7-12 mm</td>
</tr>
</tbody>
</table>

15.1.2. After selecting the cannula, select the corresponding adapter and syringe (Table 3).

<table>
<thead>
<tr>
<th>Size of cannulae</th>
<th>Color of the adapter</th>
<th>Type of aspiration maker</th>
</tr>
</thead>
<tbody>
<tr>
<td>4,5,6 mm</td>
<td>Not use adapter</td>
<td>Single valve</td>
</tr>
<tr>
<td>4,5,6 mm</td>
<td>blue</td>
<td>Double valve</td>
</tr>
<tr>
<td>7 mm</td>
<td>yellow</td>
<td>Double valve</td>
</tr>
<tr>
<td>8 mm</td>
<td>white</td>
<td>Double valve</td>
</tr>
<tr>
<td>9 mm</td>
<td>brown</td>
<td>Double valve</td>
</tr>
<tr>
<td>10 mm</td>
<td>green</td>
<td>Double valve</td>
</tr>
<tr>
<td>12 mm</td>
<td>Not use adapter</td>
<td>Double valve</td>
</tr>
</tbody>
</table>
15.1.3. In order to create vacuum, take the syringe, close the valve(s) and pull the handle until the limit and lock.

15.1.4. After inserting the cannula into the cervix, connect it to the syringe and open the valve(s).

15.1.5. Carefully push the cannula to the uterine fundus and retract by turning it around to aspirate the uterine content. Do not extract the cannula completely until the procedure is finished. Do not detach the cannula.

15.1.6. If the syringe is filled up with the uterine content, close the valve(s), detach the syringe leaving the cannula inside, evacuate the syringe and repeat the procedure.

15.1.7. Following signs indicate the complete evacuation of the uterus:

15.1.7.1. Appearance of bright red or pink foam

15.1.7.2. Specific friction sounds and gritty sensation

15.1.7.3. Absence of blood and tissues in the cannula

15.1.8. Then close the valve(s), detach the syringe and remove the cannula

15.1.9. Inspect the evacuated tissue by filtering

15.2. Vacuum aspiration with electric pump

15.2.1. Follow the general abortion principles and select the corresponding cannula depending on gestational age (Table 4).

15.2.2. Check whether the electric pump is working.

<table>
<thead>
<tr>
<th>#</th>
<th>Gestational age (week since last menstrual period)</th>
<th>Size of cannula</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>5-7</td>
<td>5 mm</td>
</tr>
<tr>
<td>2.</td>
<td>7-9</td>
<td>6 mm</td>
</tr>
<tr>
<td>3.</td>
<td>9-12</td>
<td>7-12 mm</td>
</tr>
</tbody>
</table>

15.2.3. Carefully dilate the cervix with Hegar’s dilators in progressive manner to the required diameter (Table 5)

<table>
<thead>
<tr>
<th>#</th>
<th>Gestational age (week since last menstrual period)</th>
<th>Size of dilator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>5-7</td>
<td>5 mm</td>
</tr>
<tr>
<td>2.</td>
<td>7-9</td>
<td>6 mm</td>
</tr>
<tr>
<td>3.</td>
<td>9-12</td>
<td>7-12 mm</td>
</tr>
</tbody>
</table>
15.2.4. Insert the cannula just passing the cervical canal and connect with the pump.

15.2.5. Turn on the pump, push the cannula to the uterine and aspirated the uterine content by gently turning the cannula inside the cavity.

15.2.6. When the signs of completion are shown, turn off the pump and remove the cannula and other instruments.

15.3. **Dilation and curetage**

15.3.1. Following the general principles of abortion technique, and progressively dilate the cervix with Hegar’s dilators as above.

15.3.2. Select the curette that corresponds to the gestational age.

15.3.3. Prepare a sponge forceps used for extracting embryonic tissue.

15.3.4. Curette the uterine walls and angles with careful and gentle movements.

15.3.5. When the signs of completion are shown, turn off the pump and remove the curette and other instruments.

15.3.6. Apply an aseptic solution (e.g. Polyvidone iodine solution) on cervix, vagina and vulva.

15.4. **Post-procedural techniques**

15.4.1. After the procedure, check:

15.4.1.1. General patient’s condition and vital signs.

15.4.1.2. Cramping of the uterus and amount of blood.

15.4.2. Prescribe Doxycillin 100 mgs twice a day for 7 days (preventive dose).

15.4.3. Clients with high risk for infection should be treated with antibiotics in therapeutical doses.

15.4.4. If the microbial agent of the infection is identified:

   - Chlamydial infection:
     - Doxycillin 100 mgs twice a day for 7 days, or
     - Acythromycin 1 mg twice a day for 7 days, or
     - Erythromycin 500 mgs twice a day for 7 days, or
     - Ophlaxacin 300 mgs twice a day for 7 days

15.4.5. If client has bacterial vaginosis:

   - Methronidazol 500 mgs twice a day for 7 days.
16. **Medical methods of abortion**

16.1. In the first trimester

16.1.1. Mifepristone and oral misoprostol can be used within the first 7 weeks of pregnancy

16.1.2. Mifepristone and vaginal misoprostol can be used within the first 9 weeks of pregnancy

16.1.3. The services should be open for 24 hrs

16.1.4. Surgical abortion facilities should be available

16.1.5. Assess whether the client presents any contraindications

16.1.6. Obtain the informed consent from the client after explaining how many times the client should visit the doctor, outcome of the treatment, side effects, especially, the risk of bleeding and possible surgical abortion procedure.

16.1.7. Provide written instructions on how to use the method and what to do in case of side effects and complications

16.1.8. The client should pay 3 visits

16.1.8.1. After the first visit, client will take 200 mgs of Mifepristone

16.1.8.2. The second visit is 36-48 hrs after the first visit, and the client will receive 400 μgs of oral Misoprostol or 800 μgs or vaginal Misoprostol depending on gestational age

16.1.8.3. The third visit is two weeks after the last visit, and client is checked whether her pregnancy has been effectively terminated

16.2. **After 12 completed weeks of pregnancy**

16.2.1. Mifepristone and misoprostol abortion

16.2.1.1. The services should be open for 24 hrs

16.2.1.2. Surgical abortion facilities should be available

16.2.1.3. Assess whether the client presents any contraindications

16.2.1.4. Obtain the informed consent from the client after explaining how many times the client should visit the doctor, outcome of the treatment, side effects, especially, the risk of bleeding and possible surgical abortion procedure.

16.2.1.5. Provide written instructions on how to use the method and what to do in case of side effects and complications
16.2.1.6. The client should pay 3 visits

16.2.1.6.1. After the first visit, client will take 200 mgs of Mifepristone

16.2.1.6.2. The second visit is 36-48 hrs after the first visit, and the client will receive 200 μgs of Misoprostol vaginally followed with 400 μgs orally every 3 hours 4 times

16.2.1.6.3. The third visit is two weeks after the last visit, and client is checked whether her pregnancy has been effectively terminated

16.2.1.6.4. Apply the following scheme depending on gestational age (Table 6)

<table>
<thead>
<tr>
<th>#</th>
<th>Gestational age</th>
<th>1st visit</th>
<th>2nd visit 36-48 hrs later</th>
<th>3rd visit 2 weeks later</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Up to 7 weeks</td>
<td>200 mgs Mifepristone orally</td>
<td>400 μgs Misoprostol orally</td>
<td>Check the success of the abortion procedure by ultrasound and pregnancy test</td>
</tr>
<tr>
<td>2.</td>
<td>Up to 9 weeks</td>
<td>200 mgs Mifepristone orally</td>
<td>800 μgs Misoprostol vaginally</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>After 12 weeks</td>
<td>200 mgs Mifepristone orally</td>
<td>200 μgs Misoprostol vaginally + 400 μgs Misoprostol orally every 3 hrs 4 times</td>
<td></td>
</tr>
</tbody>
</table>

16.2.1.7. Document the procedure and administered doses of drugs in detail in the abortion record form

16.2.1.8. If the pregnancy was continued after the procedure, opt for the surgical termination of pregnancy

16.2.1.9. If remaining placental tissue have detected, use following methods:

16.2.1.9.1. In absence of clinical contraindications, wait until abortion is completed. In majority of the cases, the repeated ultrasound scan will show completed abortion.

16.2.1.9.2. Repeat the four doses of 400 μgs Misoprostol orally every 3 hrs

16.2.1.9.3. Perform surgical uterine evacuation

16.3. Abortion procedure using 2.4% Etacridine lactate solution
16.3.1. Use this procedure after 20 completed weeks of pregnancy

16.3.2. Confirm the gestational age with ultrasound and determine the placental location and sufficiency of amniotic fluid, and check whether the bladder is empty

16.3.3. Prepare a sterile solution of 2.4% Etacridine lactate

16.3.4. Prepare a sterile 10 cms long needle and a syringe

16.3.5. Lie the client on her back and apply antiseptic solution on the anterior abdominal wall

16.3.6. Insert the needle through the abdominal wall and inject 4-6 mls of 2.4% Etacridine lactate into the amniotic fluid under the ultrasound monitoring

16.3.7. The abortion will usually start within 36-48 hrs after the procedure

16.3.8. Apply curettage of the uterus after the abortion is completed

16.3.9. Document the procedure and progress of the abortion itself in the patient’s records in detail

16.3.10. Provide the after procedure care as described in the post-abortion care standard.

17. Evaluation of evacuated uterine contents

17.1 Evacuated uterine contents must be examined before the completion of the procedure. In first trimester terminations, flotation of tissue with backlighting.

17.2 In case of hesitation of fetal tissue, send to pathological examination of evacuated uterine contents.

17.3 When insufficient tissue or incomplete products of conception are obtained, resuctioning should be considered.

17.4 When insufficient tissue or incomplete products of conception are obtained, follow-up pelvic ultrasonographic examination should be considered.

17.5 If insufficient tissue is present after complete uterine evacuation, a protocol to rule out ectopic pregnancy must be followed, and the patient must be informed of symptoms and dangers of ectopic pregnancy.

17.6 The patient must not be released from follow-up care until the diagnosis of ectopic pregnancy has been excluded. Or refer to next referral level hospital with medical record.

18. Complications
18.1.1 Because of possibilities of occurring complications during the abortion procedure, functioning equipment and current medication must be available on site to handle medical emergencies and must include: an O₂ delivery system, oral airways, uterotonics and adrenaline, iv crystalloids, iv sedation, and narcotic antagonists.

18.1.2 Protocols should be in place to ensure ongoing training of staff in the use of emergency equipment, the management of emergencies and the indications for emergency transport.

18.1.3 In case of complication, provide emergency medical care.

18.1.4 The below treatment used in the following cases:

<table>
<thead>
<tr>
<th></th>
<th>Type of Emergency</th>
<th>Prevention. Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Anaphylaxis</td>
<td>Corticosteroids, adrenaline</td>
</tr>
<tr>
<td>2</td>
<td>Allergic reactions</td>
<td>Hemisuccinate hydrocortisone, adrenaline, Romergan, calcium</td>
</tr>
<tr>
<td>3</td>
<td>Hemorrhage, shock</td>
<td>IV crystalloid (normal saline or Ringer’s Lactate), uterotonics</td>
</tr>
<tr>
<td>4</td>
<td>Respiratory arrest</td>
<td>Oxygen, suction, Ruben ambu bag, Guedel pipe, intubation</td>
</tr>
<tr>
<td>5</td>
<td>Cardiac arrest</td>
<td>CPR</td>
</tr>
<tr>
<td>6</td>
<td>Seizure</td>
<td>Diazepam, midazolam</td>
</tr>
<tr>
<td>7</td>
<td>Respiratory depression</td>
<td>Pulse oximeter</td>
</tr>
</tbody>
</table>

18.2 Bleeding

18.2.1 When there is excessive bleeding, the surgeon must institute measures to identify the etiology of the bleeding and control it. These may occur in cases of incomplete procedure, atony, fibroids, lacerations, perforations, placenta accreta, cervical or cornual pregnancy, coagulopathy and required verification and appropriate management.

18.2.2 Ultrasonography is performed to determine whether the uterus is empty and to detect occult bleeding. /Note: it cannot identify complete etiology of the bleeding/

18.2.3 When a cervical bleeding source is suspected, hemostasis may be achieved by compressing the cervix at the lateral fornices with ring forceps or placing a suture.

18.2.4 When atony is suspected, uterine massage and uterotonics may be useful (ergometrine intracervical or im, oxitocin intracervical, im or iv); prostaglandins (intracervical or im).

18.2.5 When coagulopathy is suspected, blood products or integral fresh blood may be administered with close monitoring of the coagulation – fluid balance.

18.2.6 When excessive bleeding continues, the following measures should be instituted:

18.2.7 Monitor and document blood pressure, pulse, clinical status uterotonics;

18.2.8 Establish IV access;
18.2.9 Initiate appropriate volume replacement;

18.2.10 Complete management for hemostasis.

18.3 If, in the clinician’s judgment, an instrument passes farther than expected, then uterine perforation must be considered /ultrasonography, laparoscopy/.

18.4 If a perforation occurs, even if the patient is asymptomatic, close observation and follow-up must be done in hospital or held under surveillance for 24-48 hours in in-patient care. The following treatment should be done.

18.4.1 Antibiotic treatment in order to prevent from secondary infections.

18.4.2 Uterotonics should be administered.

18.5 If a perforation occurs and the pregnancy has not been disrupted, abortion should completed under direct ultrasonography and laparoscopic visualization.

18.6 The patient must have a surgical treatment in cases of intra-abdominal viscera are detected in the uterine cavity, cervix, vagina, suction tubing, or on tissue examination; fetal parts are detected in the abdominal cavity; expanding intra-abdominal hematoma is detected; or hemodynamic instability is present.

18.7 When uterine perforation is suspected and the cannula has been inserted into the uterine cavity, suction must be released immediately before the cannula is withdrawn.

19. Post-abortion care

19.1 Patient must be observed for two hours after the procedure is completed, if there are no complications.

19.2 The following criteria must be documented prior to discharge: the patient must be ambulatory with a stable blood pressure and pulse, and bleeding and pain must be controlled.

19.3 The patient must be given instructions outlining the signs and symptoms of post-abortion complications.

19.4 When leaving the facility, all patients must be given a medical document providing the needed information on the procedure for any other physician to be able to treat any complications.

20. Post-abortion counseling

20.1 Before leaving the facility, all patients must be informed on existing birth control options and offered the selected method.

21. Instrument processing
21.1 All instruments must be processed in accordance with healthcare regulations in force, to include the following steps:

21.1.1 mechanic removal of tissue residues

21.1.2 decontamination

21.1.3 high-level disinfection or sterilization

21.2 Metal instruments must be properly sterilized in the autoclave, in accordance with the specific regulations in force.

21.3 High-level sterilization of the syringe;

21.3.1 Chlorgexidine solution or in another solution having similar properties, to be prepared according to the instructions of the producer.

21.3.2 Uterine aspiration cannulaes rinsed with sterile water

21.3.3 Leave to dry on a towel or in the open air.

21.4 Uterine aspiration cannulaes sterilized with ethylene oxide stay sterilized if the package is intact.

21.5 Sterilization equipment must be kept to optimum functioning parameters and checked regularly in accordance with the specific regulations in force.

21.6 The effectiveness of sterilization must be regularly assessed and documented, in accordance with specific regulations in force.