**Table of Contents**

**Foreword**................................................................................................................................. IV
**Acknowledgement**....................................................................................................................... V
**Abbreviations**.............................................................................................................................. VI

**CHAPTER 1**

Comprehensive Post Abortion Care Curriculum ............................................................................. 1
  1.1 Introduction to Curriculum ....................................................................................................... 1
  1.2 How to use the Curriculum ...................................................................................................... 2
  1.3 Overall /General Objectives ..................................................................................................... 4
  1.4 Specific Training Objectives .................................................................................................... 4
  1.5 Tentative Schedule cPAC Clinical Skills Training for Service Providers .......................... 5

**CHAPTER 2**

Introducing comprehensive Post Abortion Care and related services ........................................... 8
  2.1 Basic Information for Enhancing Effective Comprehensive Post Abortion Care Training .......................... 8
  2.2 Essential Drugs for Emergency Comprehensive Post Abortion Care .................................... 9
  2.3 Glossary – Operational Definitions ......................................................................................... 10
  2.4 Guiding Legal Framework of Abortion in Tanzania .................................................................. 12
  2.5 Involving the Community for Comprehensive PAC services Access and Quality ............ 13

**CHAPTER 3**

Organizing the Health Facility for Sustainable Comprehensive Abortion Services .................. 14
  3.1 Goals and Rationale for Comprehensive Post Abortion Care (cPAC) ................................. 14
  3.2 Clients’ Rights and Needs to Receive Quality cPAC Services .............................................. 15
  3.3 Providers role in provision of cPAC services ......................................................................... 16

**CHAPTER 4**

Providing cPAC Services ................................................................................................................ 17
  4.1 Threatened Abortion ................................................................................................................ 17
  4.2 Incomplete Abortion ............................................................................................................... 18
  4.3 Complete Abortion .................................................................................................................. 18
  4.4 Septic abortion ....................................................................................................................... 19
  4.5 Molar Abortion ....................................................................................................................... 19

**CHAPTER 5**

Step by Step Understand Comprehensive Post Abortion Care .................................................. 20
  5.1 Introduction to Comprehensive Post Abortion Care (cPAC) ................................................. 20
  5.2 Elements of Comprehensive Post Abortion Care ................................................................. 22
  5.3 MVA Procedure and other Procedures for cPAC ................................................................. 23
  5.4 Guide for selecting appropriate cannula size for MVA ......................................................... 25
  5.5 Step by Step in Performing MVA ......................................................................................... 26
An estimated 283,000 women worldwide die every year as a result of complications of pregnancy and childbirth and 99 percent of these deaths occur in Sub-Saharan Africa and Asia. In Tanzania, each year approximately 7,900 women and girls die due to pregnancy and delivery complications; out of which 19% are due to abortion related complications. The World Health Organization estimates that 1 out of 10 women in Tanzania are at risk of dying during pregnancy and childbirth.

Abortion complications can be prevented and when present can be treated if there is appropriate use of comprehensive Post Abortion Care (cPAC) knowledge and skills to manage them. This may effectively reduce maternal deaths by strengthening provision of one of 7-signal functions of Emergency Obstetric and Newborn Care (EmONC) which is performing Manual Vacuum Aspiration (MVA) of retained products of conception after incomplete abortion for pregnancies which are below 13-weeks.

In an effort to improve the quality and availability of obstetric care in Tanzania, the Reproductive and Child Health Section of the Ministry of Health, Community Development, Gender, Elderly and Children in collaboration with development partners reviewed cPAC Guideline to address evolution of technologies in services provision, competency capacity building and incorporating legal guidance. The cPAC Guideline is intended to serve as a training manual and reference tool to health care providers. This tool will enhance maternity care providers’ ability to diagnose, manage and refer abortion and related complications. With new developments in medical sciences, a need for revision of this document in line with the effort to improve the quality of care was created.

This Guideline may be used for training doctors, clinical officers, nurses and other health professionals responsible for providing cPAC services at the dispensary, health centre and hospital level. The guideline may be used for both pre- and in-service training.

I recommend the cPAC Guideline to be used as a standard tool for training service providers’ at all public, voluntary agency and private health facilities to ensure uniformity in providing quality services.

Dr. Mpoki M. Ulisubisya

PERMANENT SECRETARY
The Ministry of Health, Community Development, Gender, Elderly and Children wishes to acknowledge with sincere gratitude all those who in one way or another contributed to the development and production of this comprehensive Post Abortion Care (cPAC) Guideline. The Ministry would like to convey special thanks to Population Services International (PSI) Tanzania for the financial, technical and logistical support throughout the review process. The Ministry is also grateful to the following organizations for their contribution towards finalization of this manual: The Reproductive and Child Health Section of MoHCDGEC for guiding the process of review to the final stage, as well as Muhimbili University of Health and Allied Sciences (MUHAS), Association of Gynaecologists and Obstetricians Tanzania (AGOTA), Tanzania Midwives Association (TAMA), Morogoro Regional Referral Hospital, Dodoma Regional Referral Hospital, Muhimbili National Hospital, PSI, Marie Stopes, EngenderHealth and Pathfinder for providing technical assistance.

The Ministry would like to thank the following for their commitment and participation in the review of this guideline: Dr. Koheleth Winani – Coordinator, Safe Motherhood, Dr. Ahmad Makuwani – for leading the review (EAC), Ms. Ennegrace Nkya, Dr. Maurice Hiza, Ms. Patricia Maganga – for providing legal framework, Mr. Deogratias Mapunda, Ms. Martha Rimoy, Ms. Mary J. Chuwa, Prof. Andrea Pembe, Dr. Ali Said (AGOTA), Dr. Belinda Balandya (AGOTA), Ms. Joy Bategereza (PSI), Ms. Furaha Mafuru (PSI), Ms. Melissa Megbie (PSI), Dr. Khadija Suleiman Said (PSI), Dr. Joseph Mashafi (PSI), Dr. Emmanuel Rwamshaija (VSI), Dr. Mzee Masumbuko (Dodoma Regional Referral Hospital), Dr. Rita Lyamuya (Morogoro Regional Referral Hospital), Dr. Jeremiah Makula (Marie Stopes), Dr. Berno Mwambe (Marie Stopes), Dr. Leopold Tibyehabwa (Engenderhealth), Dr Joseph Obadiel Obure (Pathfinder), Ms. Joyce Samson Kondoro (Shinyanga), Dr. Della Sagwa (Simiyu), Ms. Eveline Zuguma (Singida) and Ms. Amina Athumani (Bagamoyo Nursing School).

Prof. Muhammad B. Kambi

Chief Medical Officer
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABCD</td>
<td>Airway; Breathing; Circulation; Disability</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>AMO</td>
<td>Assistant Medical Officer</td>
</tr>
<tr>
<td>AVPU</td>
<td>Alert; Verbal; Pain; Unconscious</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>CHMT</td>
<td>Council Health Management Team</td>
</tr>
<tr>
<td>cPAC</td>
<td>Comprehensive Post Abortion Care</td>
</tr>
<tr>
<td>CRH</td>
<td>Comprehensive reproductive health</td>
</tr>
<tr>
<td>CHW</td>
<td>Community health workers</td>
</tr>
<tr>
<td>CO</td>
<td>Clinical Officer</td>
</tr>
<tr>
<td>COPE</td>
<td>Client Oriented Provider Efficiency</td>
</tr>
<tr>
<td>EN</td>
<td>Enrolled Nurse</td>
</tr>
<tr>
<td>EmOC</td>
<td>Emergency Obstetric Care</td>
</tr>
<tr>
<td>FeFol</td>
<td>Ferrous Sulphate and Folic acid</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>hCG</td>
<td>Human Chorion Gonatrophin</td>
</tr>
<tr>
<td>Hgb</td>
<td>Haemoglobin</td>
</tr>
<tr>
<td>HiMS</td>
<td>Health Information Management System</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference for Population and Development</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education &amp; Communication</td>
</tr>
<tr>
<td>IM</td>
<td>Intramuscular</td>
</tr>
<tr>
<td>IPC</td>
<td>Infection Prevention and Control</td>
</tr>
<tr>
<td>IU</td>
<td>International Unit</td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>LNMP</td>
<td>Last Normal Menstrual Period</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal &amp; Child Health</td>
</tr>
<tr>
<td>MoHCDGEC</td>
<td>Ministry of Health, Community Development, Gender, Elderly and Children</td>
</tr>
<tr>
<td>MO</td>
<td>Medical Officer</td>
</tr>
<tr>
<td>MVA</td>
<td>Manual Vacuum Aspiration</td>
</tr>
<tr>
<td>NA</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Government Organization</td>
</tr>
<tr>
<td>NS</td>
<td>Normal Saline</td>
</tr>
<tr>
<td>OB/GYNE</td>
<td>Obstetrician/Gynaecologist</td>
</tr>
<tr>
<td>OJT</td>
<td>On the Job Training</td>
</tr>
<tr>
<td>PAC</td>
<td>Post Abortion Care</td>
</tr>
<tr>
<td>PHNB</td>
<td>Public Health Nurse (B)</td>
</tr>
<tr>
<td>PHN</td>
<td>Public Health Nurse</td>
</tr>
<tr>
<td>POC</td>
<td>Products of Conception</td>
</tr>
<tr>
<td>PV</td>
<td>Per Vagina</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>RCH</td>
<td>Reproductive and Child Health</td>
</tr>
<tr>
<td>RL</td>
<td>Ringers Lactate</td>
</tr>
<tr>
<td>RMNCH</td>
<td>Reproductive Maternal Newborn &amp; Child Health</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual &amp; Reproductive Health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>UPT</td>
<td>Urine for Pregnancy Test</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>TOT</td>
<td>Training of trainees</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Chapter 1

Comprehensive Post Abortion Care Curriculum

1.1 Introduction to Curriculum

This competency–based curriculum is based on five elements of comprehensive Post Abortion Care (cPAC), National Policy Guidelines, Program Components and Service Standards for Family Planning and Safe Motherhood.

In 2002 when this curriculum was launched, the focus was to manage incomplete abortion and its related complications hence was named cPAC. In this review the curriculum has expanded to include other conditions of abortion such as threatened abortion, inevitable abortion, missed abortion, aborted/un-aborted Hydatidiform mole and legal related needs of abortion as stipulated in Penal Code Cap 16 section 230.

Partnering with the community and community based agents (eg. Community Health Workers-CHW) enhance identification of challenges, analysis of causes and effects of abortion and coming up with appropriate solutions/strategies in addressing unwanted pregnancies and unsafe abortion.

Mobilization of resources is important in helping young girls/women receive appropriate and timely care for abortion related complications and ensuring that health services reflect and meet community expectations and needs.

Emergency treatment of complications from spontaneous or induced abortion is of paramount importance in life saving; therefore linkages to access comprehensive reproductive health (CRH) care such as counselling, family planning and services are essential.

The curriculum contributes to enhance the knowledge skills and changing attitudes of health workers in order for them to:

- Display ethical, non-judgmental and caring attitude to young girls/women in need of cPAC services.
- Be proactive in assisting young girls/women to prevent repeated abortion and related health consequences.
- Reflect on clients rights.
Programmatically, the implementation of the curriculum will help the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) and Council Health Management Teams (CHMTs) to decentralize cPAC from hospitals to health centres and dispensaries. A pool of cPAC graduates will ensure access and coverage of wide range of cPAC services through multi skilling and task sharing.

The cPAC service provider will use integrated approach to link and provide other services such as counselling and testing of STIs/HIV/AIDS, Family Planning, cervical cancer screening etc.

The curriculum can be adapted or adopted for a variety of structured training approaches depending on training needs, setting of the training and availability of resources, such as:

- Short centralized or group training.
- Distant learning.
- On the Job training.
- Whole sites training.

For each training approach, participants will be assisted to link or transfer knowledge and skills, and provide mentorship to others.

### 1.2 How to use the Curriculum

The curriculum is composed of facilitators guide and trainees’ manual which is presented in 5 interrelated modules with 27 sessions as listed in the table of contents. Training methodology, monitoring and evaluation method are included in the facilitators guide. However, this manual does not replace the use of other recommended references to enrich knowledge and skills for cPAC.

In addition, there is a schedule which introduces clinical practices, scenarios, workshops and skill stations. These new approaches allow more time for practice and easy understanding of participants.

**Primary users:**

The Primary users of this curriculum are cPAC trainees and trainers.

**Secondary users:**

- Mentors and supportive supervisors of the health facilities
- CHMT have to ensure trained staff receives maximum support needed to provide CPAC services.

The curriculum is presented in a modular form for easy selection of modules to meet training needs of service providers with different entry knowledge and skills.

- The users of the curriculum will require at least two planning days before starting the training.
- During these two days the trainers should review the whole curriculum for familiarization.
- The trainer should assemble and familiarize themselves in the use of available equipment, go through the suggested reference to update the content presented. Visit sites for practicum to ensure that the training sessions do not interfere with section practices/operations.
- Review registers and other forms used for recording cPAC activities and relevant MTUHA documents before starting the training.
Conducting the training

Use the session plan and other materials developed during the planning phase.

Monitor knowledge and skills acquisition as described below:

- Demonstrate all cPAC procedures and allow trainees a return demonstration through simulation and/or models before practicing into actual patient.
- Review and modify training methods and materials during training if the trainee’s skills acquisitions pace does not match with the process and time suggested.
- Use standard Power Point Presentation.
- Provide one-to-one guidance to trainees during the centralized training practicum.
- Ensure that each trainee practices MVA procedures using mannequins and at least 2 clients and following a competency based check list appropriately.
- Encourage trainees to document the changes/applications learnt that they intend to make at their work sites.

Outcomes of monitoring the training contributes to end of training recommendations for certifying participants:

- Use the cPAC related manuals such as FP Procedure Manuals, STIs Syndromic Management Flow Charts, Competency based Checklists and steps of providing cPAC, including Infection Prevention Procedures to monitor skills acquisition.
- Encourage individual trainees/trainer consultations or guidance.
- Observe whether the trainee can link theory into practice through identifying opportunities during actual client care.
- Remind the trainees that they will be monitored at their work sites based on their back home application plan using cPAC related manuals.

Monitoring the training

Evaluation of the training to be conducted jointly by the trainer and trainee:

- Administer the Pre/Post knowledge training Questionnaire and share results with individual trainees during the first and last day of training.
- Use the checklists/skills assessment tools, the cPAC related manuals and STIs syndromic Management Flow Charts to document the status of each trainee’s competence.
- Administer Participant Course Evaluation Form to evaluate the whole training.

By the end of the training participants are expected to have achieved the following:
- Acquire/update their knowledge on FP, STIs/HIV, counselling skills, treatment, MVA and Infection Prevention and control (IPC).
- Update their skills in documenting findings of client assessment and management of abortion complications and referrals where appropriate.
- Update their skills in community mobilization and involvement.
- Acquire skills in advocating for cPAC.
- Conduct on-job training for other health workers.

Expectations of trainee competence at the end of training
The one week training enables the graduate to achieve acceptable exit level competence. Proficiency is expected to occur once the newly trained person is deployed as a cPAC provider. However, as a newly qualified cPAC service provider, one-to-one guidance at the work site would contribute to maintaining the skills acquired. The on-site supervisor should be encouraged to provide an atmosphere for self-directed learning. It is hoped that the Hospital and CHMTs will make this possible.

The trainee to continue with learning through using job aids provided during the training and various procedures on cPAC counselling, FP/PAC/STIs/HIV/AIDS. The source of these job aids includes the FP Manual leaflets and posters.

If the participant has completed one week training and in that time has demonstrated acquisition of all cPAC skills according to set standards, then the trainer shall issue certificate.

### 1.3 Overall /General Objectives

**By the end of one week training the participants will be able to:**

- To provide cPAC services including management of abortion complications

### 1.4 Specific Training Objectives

- **Provide Emergency Care**
  - Assess the client for shock and other life threatening complications
  - Initiate resuscitative measures and treatment of life threatening complications
  - Assess the client to ascertain the diagnosis and plan the management
  - Manage pain associated with cPAC complications and treatment

- Perform uterine evacuation using MVA
  - Give antibiotics
  - Identify clients with complications that need referral to a higher health facility.

- **Offer Family Planning and other Reproductive Health Services**
  - Provide family planning methods including dual methods use and emergency contraception to girls/women who had abortion
  - Provide selected STIs/HIV/AIDS care and treatment during cPAC service delivery using syndromic management chart

- **Advocate for cPAC services**
  - Create an enabling environment for access to cPAC services at health facility.
  - Solicit the support of all stakeholders at facility level in improving the quality of and access to cPAC services.
  - Link with the community health workers for community mobilization and participation

- **Counsel cPAC Clients**
  - Provide emotional support to clients during comprehensive abortion care.
  - Counsel clients on other reproductive, medical and psychosocial (e.g. rape, wife battering) issues that may have contributed to the abortion.
- Organize cPAC/RH services
  - Apply universal precautions for reducing infection during cPAC and other health services.
  - Maintain a mechanism for assuring timely availability of supplies, equipment and other necessary materials.
  - Use records to evaluate and improve the quality of cPAC services.
  - Ensure all post abortion clients receive contraceptive methods.
  - Conduct On-Job Training (OJT) for other health workers according to their functions and cPAC service requirements.

### 1.5 Tentative Schedule cPAC Clinical Skills Training for Service Providers

**DATE:** From.................................to........................................20..........

**VENUE:** .............................................................................................................................

Generic training programme

#### DAY ONE

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>0730</td>
<td>Registration of training participants</td>
<td></td>
</tr>
<tr>
<td>0800</td>
<td>Introducing participants</td>
<td></td>
</tr>
<tr>
<td>0830</td>
<td>Opening remark</td>
<td>Guest of Honour &lt; &gt;</td>
</tr>
<tr>
<td>0900</td>
<td>Introduction of the cPAC course</td>
<td>Course director &lt; &gt;</td>
</tr>
<tr>
<td>0930</td>
<td>Pre knowledge assessment</td>
<td>Course assessor &lt; &gt;</td>
</tr>
<tr>
<td>1030</td>
<td>Tea Break</td>
<td></td>
</tr>
</tbody>
</table>

#### 1100 Lecture 1: Legal and community consideration of abortion < >

<table>
<thead>
<tr>
<th>Time</th>
<th>Station 1</th>
<th>Station 2</th>
<th>Station 3</th>
<th>Station 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>How do society view abortion</td>
<td>Legal guidance in provision of cPAC</td>
<td>Human right guidance to access cPAC</td>
<td>Need for supporting society in cPAC</td>
</tr>
<tr>
<td>1120</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>1150</td>
<td>D</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>1220</td>
<td>C</td>
<td>D</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>1250</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>1320</td>
<td>Lunch</td>
<td></td>
<td></td>
<td>All</td>
</tr>
</tbody>
</table>

#### 1400 Lecture 2: Management of critically ill and unconscious patient < >

<table>
<thead>
<tr>
<th>Time</th>
<th>Station 1</th>
<th>Station 2</th>
<th>Station 3</th>
<th>Station 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ABCD approach</td>
<td>Airway management</td>
<td>CPR</td>
<td>Manage circulation</td>
</tr>
<tr>
<td>1430</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>1500</td>
<td>D</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>1530</td>
<td>C</td>
<td>D</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>1600</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>A</td>
</tr>
</tbody>
</table>

Day Off-Faculty meeting
### DAY TWO

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>0730</td>
<td>Registration</td>
<td>Secretary</td>
</tr>
<tr>
<td>0800</td>
<td>Recap</td>
<td>&lt; &gt;</td>
</tr>
<tr>
<td>0830</td>
<td><strong>Lecture 1: Classification and Management of abortion</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Facilitator</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Management of incomplete abortion</td>
<td>Management of haemorrhage in abortion</td>
</tr>
<tr>
<td></td>
<td>Management of septic abortion</td>
<td>Management of peritonitis and suspected perforation</td>
</tr>
<tr>
<td>0850</td>
<td>A, B, C, D</td>
<td></td>
</tr>
<tr>
<td>0920</td>
<td>C, D, A, B</td>
<td></td>
</tr>
<tr>
<td>0950</td>
<td>B, C, A, D</td>
<td></td>
</tr>
<tr>
<td>1010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1040</td>
<td>Tea Break</td>
<td></td>
</tr>
<tr>
<td>1130</td>
<td><strong>Lecture 2: Counselling for PAC client</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Facilitator</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Counselling for PAC clients</td>
<td>Pre-procedure counselling (Role play)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FP counselling (Role play)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post procedure counselling (Role play)</td>
</tr>
<tr>
<td>1130</td>
<td>A, B, C, D</td>
<td></td>
</tr>
<tr>
<td>1230</td>
<td>D, A, B, C</td>
<td></td>
</tr>
<tr>
<td>1300</td>
<td>C, D, A, B</td>
<td></td>
</tr>
<tr>
<td>1330</td>
<td>B, C, D, A</td>
<td></td>
</tr>
<tr>
<td>1400</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>1440</td>
<td><strong>Lecture 3: Organizing cPAC services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Facilitator</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establish MVA room</td>
<td>Introduction and care of MVA equipment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Perform MVA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IPC</td>
</tr>
<tr>
<td>1500</td>
<td>A, B, C, D</td>
<td></td>
</tr>
<tr>
<td>1530</td>
<td>D, A, B, C</td>
<td></td>
</tr>
<tr>
<td>1600</td>
<td>C, D, A, B</td>
<td></td>
</tr>
<tr>
<td>1630</td>
<td>B, C, D, A</td>
<td></td>
</tr>
<tr>
<td>1700</td>
<td>Break off and faculty meeting</td>
<td></td>
</tr>
</tbody>
</table>

### DAY THREE

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>0730</td>
<td>Registration</td>
<td>&lt; Secretary&gt;</td>
</tr>
<tr>
<td>0800</td>
<td>Recap</td>
<td>&lt; &gt;</td>
</tr>
<tr>
<td>0815</td>
<td><strong>Lecture &amp; video Performing MVA</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Facilitator</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performing MVA</td>
<td>Performing MVA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Performing MVA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Performing MVA</td>
</tr>
</tbody>
</table>

Trainees Manual, comprehensive Post Abortion Care
Trainees Manual, comprehensive Post Abortion Care

<table>
<thead>
<tr>
<th>Time</th>
<th>Station 1</th>
<th>Station 2</th>
<th>Station 3</th>
<th>Station 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>0845</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>0930</td>
<td>D</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>1015</td>
<td>C</td>
<td>D</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>1100</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>1100</td>
<td>Tea</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Station 1</th>
<th>Station 2</th>
<th>Station 3</th>
<th>Station 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitators</td>
<td>Performing MVA</td>
<td>Performing MVA</td>
<td>Performing MVA</td>
</tr>
<tr>
<td>1130</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>1215</td>
<td>D</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>1300</td>
<td>C</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>1345</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>1430</td>
<td>Lunch Break</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>Station 1</th>
<th>Station 2</th>
<th>Station 3</th>
<th>Station 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1530</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>1615</td>
<td>D</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>1700</td>
<td>C</td>
<td>D</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>1745</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>A</td>
</tr>
</tbody>
</table>

Break off and faculty meeting

**DAY FOUR**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>0730</td>
<td>Registration</td>
<td>&lt;Secretary&gt;</td>
</tr>
<tr>
<td>0800</td>
<td>Recap</td>
<td>&lt; &gt;</td>
</tr>
<tr>
<td>0815</td>
<td>Lecture: Integration of cPAC and other RH services</td>
<td>&lt; &gt;</td>
</tr>
<tr>
<td>0830</td>
<td>Facilitator</td>
<td></td>
</tr>
<tr>
<td>0930</td>
<td>Cervical cancer</td>
<td></td>
</tr>
<tr>
<td>0900</td>
<td>Breast cancer</td>
<td></td>
</tr>
<tr>
<td>1000</td>
<td>GBV</td>
<td></td>
</tr>
<tr>
<td>1030</td>
<td>Tools of M&amp;E</td>
<td></td>
</tr>
<tr>
<td>1030</td>
<td>Tea Break</td>
<td>All</td>
</tr>
<tr>
<td>1100</td>
<td>M &amp; E</td>
<td></td>
</tr>
<tr>
<td>1200</td>
<td>Action Plan</td>
<td>All</td>
</tr>
<tr>
<td>1300</td>
<td>Post knowledge test</td>
<td>All</td>
</tr>
<tr>
<td>1345</td>
<td>Photography</td>
<td>All</td>
</tr>
</tbody>
</table>

**DAY FIVE**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800</td>
<td>Report writing</td>
<td>All Facilitators</td>
</tr>
<tr>
<td></td>
<td>Participants to practicum site</td>
<td>All trainees</td>
</tr>
<tr>
<td>1500</td>
<td>Participant feedback</td>
<td>All Facilitators</td>
</tr>
<tr>
<td>1630</td>
<td>Training closure</td>
<td></td>
</tr>
</tbody>
</table>
Chapter 2

Introducing comprehensive Post Abortion Care and related services

2.1 Basic Information for Enhancing Effective Comprehensive Post Abortion Care Training

Selection Criteria for Trainers, Trainees and Practicum Sites for the Training

The cPAC Trainer

A cPAC trainer can either be a Clinical Officer (CO), Assistant Medical Officer (AMO), Medical Officer (MO), Obstetrician/Gynecologist (OBGYN), Enrolled Nurse (EN)/Registered Nurse (RN) or Public Health Nurse (PHN)

A person will be recognized by MOHCDGEC and other bodies as cPAC Trainer if he/she has attended cPAC Training of Trainers (TOT) and mentorship.

- Health care workers i.e. OBGYN, MO, AMO, CO, EN, RN, PHN
- Should be deployed for cPAC services and willing to train other staff members for the continuity of cPAC services.
- Should be working in a health care facility that provides maternal health services.

The cPAC Trainee

In order to provide effective practicum, the site must meet the following criteria:

- The facility should be providing quality cPAC services according to national standards.
- Should have the client caseload that will enable trainees to learn.
- The facility must have adequate running water supply to maintain Infection Prevention (IP) standards.
- The facility should be one that has good support services.
- The facility have a dedicated MVA room

The cPAC Practicum sites

Equipment, Supplies and Medicine for Quality cPAC Services
Basic equipment and supplies for MVA

- Bi Valve speculum (small, medium or large).
- Tenaculum or volsellum forceps.
- Sponge holding forceps (2).
- MVA Kit:
  - MVA syringe
  - Cannulae of different sizes
- Reliable Light source
- Sterile gauze
- Antiseptic solution (povidone iodine)
- Gloves sterile
- Heavy duty gloves
- Kidney dish for tissue inspection
- Gall pot
- Contraceptive methods
- Examination table with stirrups
- Seat or stool for provider performing the clinical procedure
- Plastic buckets (at least 3) for decontamination process (1 bucket with chlorine solution 0.5%, 2nd with soap water and 3rd with clean water)
- Cleaning brush (e.g. toothbrush)
- Safety box
- Leak - proof container for disposal of infectious waste
- Drip stand, IV cannulae and giving set
- Plastic container for MVA kit storage

For High Level Disinfection (HDL) or sterilization of Instrument

These items should be available for processing instruments:
- Plastic containers with lids for HLD
- Sterile water Chlorine solution 0.5% or other High level disinfectants or sterilization agents; e.g. gluteraldehyde (cidex)
- Autoclave (steam) or convection oven (dry heat) for metal instruments and NOT FOR PLASTIC EQUIPMENT

Items for Emergency Resuscitation

These items are seldom required in uterine evacuation cases but are needed for possible emergency use:
- Adrenaline
- IV infusion equipments and fluid (Ringers Lactate and normal saline)
- Suction apparatus electric or manual and suction tubes
- Ambubag
- Oxygen giving apparatus (tank with flow meter) with oxygen when available.
- Oral airways

2.2 Essential Drugs for Emergency Comprehensive Post Abortion Care

Antiseptics

- Povidone
  These include:
  - Paracetamol
  - Diclofenac
  - Pethidine (or suitable substitute)

Recommended solutions are as follows:
- 0.5% chlorine solution
- Gluteraldehyde 2% (Cidex)
Antibiotics

- Ampicillin
- Amoxylline
- Benzylpenincillin
- Metronidazole
- Erythromycin
- Oxytocin injection
- Ergometrine injection
- Misoprostol tablets

Uterotonics

- Water for injection
- Sodium Lactate (Ringers)
- Normal saline
- Capability for blood transfusion or access blood transfusion services.

Blood Products

- Should be available at all secondary or referral facilities.

2.3 Glossary – Operational Definitions: A Reference and Job Aid for the cPAC/RH Service Provider

Maternal death

Death of a woman while pregnant or within 42 days of the termination of pregnancy, irrespective of the site and duration of the pregnancy from any cause related to and/or aggravated by pregnancy or its management but not from accidental or incidental causes (WHO definition).

It is estimated that 19% of maternal death are due to abortion complications (One plan 2008-2015).

Emergency Obstetric and Newborn Care (EmONC)

There are 9 signal functions of EmONC and of them is Manual removal of products of conceptions.

Human rights approach in reproductive health services

In gender dimension young girls and women in developing countries remain to be a group which is socioeconomically isolated and culturally alienated from decision making. More critical is the fact that these countries have high burdens of diseases and restricted resources. However, there is a gap of service provision between HAVES and the DON’T HAVE, and between rural and urban.

Comprehensive post Abortion Care (cPAC)

These are interventions which reduce maternal morbidity and mortality through providing care to young girls/women who suffer complication from spontaneous, unsafely induced abortions, missed abortion, molar pregnancy and termination of pregnancy on medical grounds.

Gender empowerment

Refers to the ongoing practice of enhancing a young girl/woman or man’s capacity to make responsible decisions and act on them.

Essentials of safe Motherhood

These include; antenatal care, clean, safe delivery, newborn care, postpartum care, family planning and EmONC.

Domestic violence against women

These are physical, verbal or sexual violence that are inflicted on a woman by a close relative.
| **Advocacy** | Advocacy is defined as the effort to influence actions through various forms of persuasive communication. |
| **Quality** | A measure of value in comparison to set standards. |
| **Standards** | Agreed expected service levels. |
| **Policy** | A written statement that provides a broad framework within which issues of quality service practice and control must be closely addressed and monitored. |
| **Access to services** | The proportion of the people in a catchment area who are able to use the various components of services. |
| **Continuity of service** | Services provided to a client in a health facility for 24 hours, 7-days a week; which are available, accessible, affordable and sustainable for efficiency. |
| **Quality assurance** | A process of assessing care against set standards that have already been provided and taking action to improve it in future. |
| **Whole site training** | An approach to training that encompasses a range of strategies and methodologies designed to address the training needs that are identified at a site through supervisory assessment. |
| **Integrated RCH services** | Incorporating related RCH services to maximize resource utilization and one service taking advantage of the other e.g. cPAC services linking with HIV/STI counselling, testing, treatment and family planning services. |
| **Components of (cPAC)** |  |
|  | - Counselling and psycho-social support. |
|  | - Emergency management and removal of products of conception. |
|  | - Family planning counselling and provision of method. |
|  | - Linkage with other RH services. |
|  | - Community involvement. |
2.4 Guiding Legal Framework of Abortion in Tanzania

Tanzania has no specific legislation which governs abortion issues. However, under the Penal Code, Cap 16 R,E 2002 of the Tanzania Laws, the law which provide punishments for criminal offences, has provisions which deal with abortion issues.

Section 219 provides for a situation where a person can be guilty of an offence for child destruction. Child destruction is performed when a child is capable of being born alive as it can exist independent of its mother (at gestation age of 28 weeks or more). Further to that, Sections 150 and 151 provide for offences to any person who attempts to procure abortion or procuring own miscarriage. Section 152 goes further by creating an offence to any person who supplies drugs or instruments to procure abortion. From these provisions, it can safely be said that, performing abortion in Tanzania is illegal.

However, as a matter of law, there is no general rule without exceptions. Section 230 of the same Code, provides for situations whereby abortion can be performed. The section states that a person cannot be held 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 mother’s life if the performance of operation is reasonable having regard to the patient’s state at the time and all the circumstances of the case.

From the foregoing, it is apparent that abortion can only be performed where it is only necessary to save the life of the mother. However, experience has shown that, even though abortion is illegal in Tanzania, it is one of the methods used in averting unwanted pregnancies. Being it illegal, it is normally done in secretive manner and mostly done by unqualified personnel, outside formal health care settings, hence placing the life of the victims at risk.

It is the intention of this manual to guide health care workers on how to provide comprehensive Post Abortion Care irrespective of the nature of abortion, bearing the fact that the prime role of health care workers is to preserve the lives of patients.

Is a process of terminating pregnancy before 28 weeks of gestation. Any termination of pregnancy at 28 weeks or above is defined in the Penal Code, Cap 16 Section 219(1) as child destruction.

If it is necessary to save the woman’s life; the Penal Code Cap 16 Section 230.

Abortion must be carried out in the health facility.

A Skilled person who is convinced that an abortion would preserve life of the mother in line with Penal Code, Cap 16 section 230.

For any abortion to be carried out an informed consent must be obtained from the mother or a close relative or any known authority when patient health do not allow.
2.5 Involving the Community for Comprehensive PAC services Access and Quality

**Definition of Community**
A social group of people in a certain geographical area (e.g. village, Institution etc.) with similar interests, common culture and a "government".

**Roles of CHMT**
Should integrate cPAC services into the existing reproductive health services.

**Roles of the community in cPAC services**
Below are some of the roles carried by the community in cPAC service provision:
- Promotes common understanding of danger signs and early recognition of abortion complications
- Promotes early decision-making in seeking medical care
- Facilitates availability of transportation to a health facility
- Facilitates timely/proper treatment and care at facility level
- Encourages contraceptive use to prevent unwanted pregnancy
- Advocates for establishment of community-based cPAC services from the government
- Eliminates harmful cultural/traditional barriers that prohibit timely use of health services
- Addresses community-specific problems pertaining to cPAC services
- Creates a bridge to segments of the community that may be hard to reach through formal program channels, e.g. adolescents.
- Collaborate with community-based health workers, NGOs and private sector to improve cPAC services

**Foster community ownership of the services**
- Educate men, women, adolescents, extension workers, traditional health providers, TBA and various leaders or influential people on the importance of cPAC/RH services
- Educate the community on the need for timely referral and possible means of available transport.
- Establish transport mechanism and other means for timely referral of cPAC clients to health facilities for emergency quality of care.
- Collaborate with community-based health workers, NGOs and private sector to improve cPAC services.
  - Provide cPAC 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.
  - Recognise early signs of abortion
  - Rapidly assess condition of emergency PAC clients
  - Stabilise and refer immediately
  - Guide relatives or escorts regarding transporting clients and possible readiness for blood transfusion and payment of fees.
  - Promote cPAC at work and in their community consistently.
- 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. counselling for voluntary and informed choice of FP/RH service to avoid repeated unwanted pregnancies.
- Prepare report on experience progress of community involvement and share with all stakeholders
- Mobilization of resources to support cPAC services
Chapter 3

Organizing the Health Facility for Sustainable Comprehensive Abortion Services

3.1 Goals and Rationale for Comprehensive Post Abortion Care (cPAC)

**Goals of cPAC**
- Sustainable reduction of unwanted pregnancy by helping clients to decide on and select FP method.
- Sustainable reduction in maternal mortality by providing access to information and emergency treatment of abortion on site and at referral centres.
- Sustainable reduction in STIs and HIV transmission through discussion of sexuality issues, preventing more complications, treatment, counselling and education.

**Rationale for cPAC**
- Provision of cPAC has been shown to decrease maternal deaths.
- Helps to improve access and coverage of services to marginalized populations.
- Helps women with abortion complications to come openly to seek cPAC.
- Align the country to improve SRHR in line with international instruments such as the Maputo protocol.

**Factors that hinder cPAC services**
- Negative reaction by service provider towards abortion clients Work overload as a result of inadequacy of skilled personnel
- Inadequate essential equipment and supplies for cPAC services.
- Misconception about “abortion vs. miscarriage” by providers due to the stigma attached to “abortion” and not miscarriage.
- Restrictive professional regulations e.g. clinical officers not to provide cPAC.
- Community stigma on induced abortion.
- Inadequate primary health care awareness among the community members on the availability and accessibility of post abortion care as part of RH services.

**Factors that facilitate utilization of cPAC services**
- Integration of cPAC into other existing RH services.
- Supportive and explicit policies and service standards.
- Willingness of the community or health to establish cPAC services.
- Breaking barriers such as stigma.
3.2 Clients’ Rights and Needs to Receive Quality cPAC Services

The 1994 International Conference for Population and Development (ICPD) states that it is the rights of young girls/women and young boys/men to be informed and have access to sexual and RH services of their choices, which are safe, effective, affordable and acceptable. Clients have rights to information; express their opinion, access to services, informed choice, safety, privacy, confidentiality, dignity, comfort and continuity of care.

Contextual framework on Sexual and Reproductive Health Information

The 1994 International Conference for Population and Development (ICPD) states that it is the rights of young girls/women and young boys/men to be informed and have access to sexual and RH services of their choices, which are safe, effective, affordable and acceptable. Clients have rights to information; express their opinion, access to services, informed choice, safety, privacy, confidentiality, dignity, comfort and continuity of care.

Health care providers should provide respective care

Health care providers should respect women’s informed decision-making, autonomy, confidentiality and privacy at all times.

Provide special attention to vulnerable groups

Attention should be given to the special needs of particular populations such as adolescents and youth, women with disabilities, survivors of rape and other forms of sexual violence, poor and marginalized women.

Information

All members of the community have a right to information on the benefits of RCH 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.

Access

All members of the community have a right to receive services from RCH 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.

Choice

Below are some guidance to enable client to chose family planning method:

- Individuals and couples have the right to decide freely whether or not to practice family planning.
- When seeking RCH services clients should be given the freedom to choose which method of contraception or RCH service to use.
- Clients should be able to make informed decisions, free from discrimination. Inducement or coercion.
- Decision making should be autonomous and free of third-party involvement.

Safety

Clients have the right to safety in the practice of family planning, other reproductive or child health care.

Privacy

When a client is undergoing a physical examination it should be carried out in an environment in which her/his right to bodily privacy is respected.

Confidentiality

The client should be assured that any information she/he provides or any details of the service received will not be communicated to third parties without her/his consent.

Dignity

RCH clients have the right to be treated with courtesy, consideration, and attentiveness 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. Adolescents SRH rights should be respected alongside the provision of Youth Friendly Services.
Comfort

Clients have the right to feel comfortable when receiving services. This right of the client is intimately related to adequacy of services delivery facilities and quality of services.

Continuity

Clients have the right to receive RCH services and supply of contraceptives and other services for as long they need them

Opinion

Clients have the right to express their views on the services they receive.

3.3 Providers role in provision of cPAC services

The needs of the provider should be addressed in order to make clients’ right a reality. Without these needs being met, it becomes impossible for service providers to truly meet clients’ rights and provide quality care. The needs of the service providers can be outlined as follows:

Need for training

Service provider should have the relevant knowledge and skills needed to perform all the tasks.

Need for information

Service provider needs to be abreast of current trends related to cPAC.

Need for infrastructure

Service provider needs to have the appropriate physical facilities and institutional support to provide quality cPAC services

Service provider needs sustainable supplies of commodities for cPAC services.

Need for guidance

Service provider needs clear, relevant and objective guidance through mentorship to ensure sustenance of competency for the delivery of high quality services.

Service provider needs to be reassured that whatever the level of care at which they are working, from community level to the most comprehensive clinical service sites, they are members of a larger group in which individuals or units can provide support to each other or refer.

Need for respect

Service provider needs competence and potential of service for recognition and respect.

Need for encouragement

Service provider needs stimulus in the development of his/her potential and creativity.

Need for feedback

Service provider needs feedback concerning his/her competence and attitude as judged by others.

Need for self-expression

Service provider, regardless of the level of care at which she/he is working needs to officially express his/her views concerning the quality of the programme.
Chapter 4

Providing cPAC Services

4.1 Threatened Abortion

Definition; Vaginal bleeding before 28 weeks of gestation with a closed cervix.

Symptoms and signs;
- Slight or no lower abdominal pain /cramps.
- Slight to moderate PV bleeding.
- The bleeding is not accompanied with clots.
- Stable general condition.
- Fundal height corresponds to gestational age and Uterus remains soft and non-tender.
- Cervix is closed with slight or no bleeding per cervical.

Management;
- Bed rest and avoid strenuous activities.
- Follow within 7 days.
- Should come immediately if bleeding becomes heavy, offensive discharge or severe abdominal pain.

Inevitable Abortion

Definition; refers to a stage in the abortion process when it is not possible for the pregnancy to continue.

Symptoms and signs;
- Moderate or severe per vaginal bleeding, and may be accompanied with clots.
- Severe lower abdominal pains.
- Significant draining of liquor if membranes have ruptured
- The cervix is dilated with evidence of imminent expulsion of products of conception and/or ruptured membranes.
- Fundal height may correspond with gestational age.
- Presence of uterine contractions

Management;
- Apply ABCD principles of resuscitation.
- Give IV-Ringer’s lactate or normal saline 2 Lts.
- Perform MVA if gestation age is below 12 weeks and give other cPAC services
- Augment the process of abortion by administering Oxytocin 20 IU in 500 MLs of lingers lactate at rate 40-60 drops per minute if gestation age is above 12 weeks
- Manage as incomplete abortion if after augmentation some products of conception remain in the uterus.
- Manage as complete abortion if all product of conception are expelled.
4.2 Incomplete Abortion

Definition
Definition; when some of the products of conception have been retained in the uterine cavity.

Symptoms and signs
- Expulsion of products of conception
- Slight to profuse PV bleeding accompanied with clots/products of conception
- Clots/products of conception protruding from the cervical os
- The cervix is dilated

Management
- Apply ABCD principles of resuscitation
- Give IV fluids-Ringer’s lactate or normal saline 2 litres
- Perform digital evacuation of products of conception
- Perform MVA if gestation age is below 12 weeks and give other cPAC services

4.3 Complete Abortion

Definition
Products of conception are completely expelled:

Symptoms and signs
- Expulsion of products of conception
- Minimal or no PV bleeding
- Uterus smaller than dates and often well contracted
- Cervix may or may not be closed

If patient is stable:
- Give oral antibiotics: Amoxicillin 500 mg PLUS Metronidazole 400mg orally every 8 hours for 5 days
- Give Fefol 1 tablet twice daily for 3 months and reassess after every 4 weeks
- Provide other cPAC services

If patient is in shock
- Shout for help and mobilize resources and apply ABCD principles of resuscitation
- Resuscitate with IV-Ringer’s lactate OR normal saline 3 litres. or more in the first hour
- Insert an indwelling urethral catheter and Give IV Ampicillin 2g stat
- Obtain blood for haemoglobin and X-matching

If at dispensary or health centre, REFER the patient to hospital under escort of a nurse
4.4 Septic abortion

**Definition:** An abortion complicated by infection.

- Abdominal pain following history of abortion.
- Fever with foul smelling PV discharge which may be mixed with blood
- May be in shock or/and jaundiced.
- Tender uterus and there may be rebound tenderness.
- Cervix is usually open.

**Symptoms and signs:**
- Apply ABCD principles of resuscitation.
- Give IV-Ringer’s lactate OR normal saline 3 litres in first hour using a large bore cannula.

**Management:**
- Insert an indwelling urethral catheter.
- Obtain blood for haemoglobin.
- Give Ampicillin 2gm IV or IV AND Metronidazole 500mg IV AND gentamicin 80mg IM stat then.
- Or use Ceftriaxone 2g IV and metronidazole 500mg IV stat.

Refer if at dispensary/health centre.

4.5 Molar Abortion

**Definition:** is an abnormal pregnancy characterized by abnormal proliferation of the chorionic villi leading to multiple grape-like vesicles usually in the absence of embryo or normal placental tissue

- Abdominal pain with exaggerated pregnancy symptoms.
- Fundal height usually greater than gestational age.
- Heavy PV bleeding with expulsion of vesicles/grape-like tissues
- Absence of foetal parts and the Uterus feels doughy.
- Cervix dilated.

**Symptoms and signs:**
- Apply ABCD principles of resuscitation.

**Management:**
- Give IV fluids-Ringer’s lactate or normal saline 2 litres
- Obtain blood for haemoglobin and cross matching.

REFER to hospital with an escorting nurse.
5.1 Introduction to Comprehensive Post Abortion Care (cPAC)

Complication of abortion contributes to maternal morbidity and mortality significantly:

- Globally 15% of all pregnancies end up in spontaneous abortion.
- Death and injuries from incomplete abortion are preventable.
- Addressing complications of abortion is one of critical life saving services.
- Complications of abortions are one of the six major causes of maternal mortality.

The approach goal in managing women with/without complications of abortion is to cure and not to judge whether the abortion was induced or not neither to be punitive/judgmental e.g. reporting the patient to the police.

Abortion in Sub Saharan Africa is perceived negatively.

The following global declarations have helped Africa to reposition its policies in line with the fact that abortion is a huge contributor of maternal mortality in the continent. These declarations are as follows:

- 1994-International Conference for Population and Development
- 1995-Beijing Declaration and Platform for Action: Fourth World Conference on Women
- 2000-Millennium Development Goals
- 2009-Campaign for Accelerated Reduction of Maternal Mortality in Africa.

Tanzania being part of the global community has ratified to implement almost all of these declarations.

Below is an outline of global trends of maternal health in relation to women’s health and challenges of abortion:

- Global maternal deaths are 287,000 (countdown 2010).
- Globally abortion complications account for almost 9% of all maternal death (countdown 2010).
- It is a known fact that of 99% of all maternal deaths occurs in Sub Saharan Africa.
- On the other hand 62% of global maternal deaths due to abortion occur in Sub Saharan Africa.
- In Africa abortion accounts for 13% of all maternal deaths.
Tanzania is not isolated from the challenges related to abortion:

- Woog and Pembe (2003) reported that in Tanzania maternal deaths resulting from abortion was as high as 16%.
- Mswia et al, (2003) showed that maternal deaths due abortion was 12.2% (Dar), 29.1% (Hai) and 21.3% (Morogoro).
- On the other hand, HIMS data shows that abortion contribution to maternal mortality ranged between 15-19%.

When abortion is performed in unsafe condition or inadequately managed, any of the complications may be experienced:

**Immediately:**
- Haemorrhage and shock.
- Sepsis of variable degrees including shock.
- Trauma to internal organs i.e. urinary bladder, uterus and intestines.

**Long term:**
- Chronic pelvic pain.
- Pelvic Inflammatory Disease.
- Secondary infertility.
- Increased risk of ectopic pregnancy.
- Social stigma.
- Psychological stress.

To understand the drivers of abortion will help providers to counsel women for cPAC services and to care them in a non judgmental manner;

- It is important to remember there are many young girls/women with spontaneous abortions who seek care in our facilities.
- However, many complex reasons make women resort to abortion when faced with unplanned/unexpected pregnancy.

These include:

**Economic reasons:**
- Low income to care for baby.
- Lack of employment.
- Completed family.

**Social and cultural reasons:**
- Students want to finish school.
- Out of wedlock pregnancy not favoured in her community.
- Incest, rape, gender violence etc.
- Cultural and religious stigma attached to pregnancy out of wedlock and single parenting.
- Advanced reproductive age.

**Family planning related reasons:**
- Lack of access to FP services.
- Failure of FP methods.
- Lack of FP information.
- Rumours & Misconception on FP.

**Medical reasons:**
- Congenital abnormalities.
- Pregnancy adds more burdens on the health of the mother to an already existing life threatening illness.
5.2 Elements of Comprehensive Post Abortion Care

The cycle below shows elements of cPAC:

**Provide Emergency treatment**
- Apply ABCD principles of resuscitation.
- This should be given priority to manage any life threatening condition.

**Provide Integrated RH services**
- Help client to cope with emotional problems and stigma and
- Counsel the client on Family planning.
5.3 MVA Procedure and other Procedures for cPAC

This handout provides a theoretical point of view of using MVA to remove retained products of conception from the uterus after abortion.

**Purpose**

MVA will be a standard method in Tanzania mainland for management of incomplete abortion in 1st trimester

Manual Vacuum Aspiration;

- Is a simple, cost-effective procedure involving the use of aspirator to remove retained tissue and blood from the uterus through a cannula and into a syringe.

**What is MVA?**

- Is a procedure highly effective with minimal complications for uterine size of up to 12 weeks.
- Does not require a general anaesthesia and can be performed in an examination or procedure room, rather than in an operating theatre.

**Contraindications of MVA**

There are no known contraindications of MVA for treatment of incomplete abortion for uterine size below 12 weeks;

- Before performing uterine evacuation, any serious medical conditions that are present should be addressed immediately.
- These include; Shock, haemorrhage, cervical/pelvic infection, perforation or abdominal injury

If the tissue obtained on vacuum aspiration is inadequate in quantity or does not contain products of conception, it is possible that the evacuation is incomplete, that all tissue has already passed out (a completed abortion), or the woman has an ectopic pregnancy.

If ectopic pregnancy is suspected, the woman should be referred, without delay, to a facility where the necessary emergency care is available.

Using a cannula which is too small or stopping the aspiration too soon can result in retained tissue, haemorrhage, infection, and continued cramping pain. To avoid this, the provider should be careful to observe for the signs of complete evacuation of the uterus and careful examination of the tissue removed.
The figure showing double valve aspirators, adapters and cannula

- Sizes 4 – 12 mm
- Sizes 4-8 have 2 apertures
- Sizes 9-12 have 1 aperture
Preparing for the procedure

Before starting the procedure check if MVA instruments are in full working order. Ensure that the syringe will hold a vacuum:

- Check that the valve closes, if using a push valve, push the button down and forward; you should hear and feel the valve lock closed.
- If using a syringe, pull the plunger back until the arms snap outward at the end of the syringe and check that both plunger arms are fully extended and resting on the wide edge of the barrel; in this position the syringe should hold a vacuum
- Leave the valve locked and the plunger back for several minutes, then release the button to open the valve; the sound of air rushing into the syringe indicates that there was a vacuum in the syringe.

Provide moral support

A woman who seeks treatment for an incomplete abortion is often under severe emotional distress, as well as physical discomfort thus needs psychosocial support and respectful care.

Inform, examine and prepare the patient ready for MVA

Explain the procedure to the woman, keeping in mind her need for respectful, supportive care:

- Preoperative medication should be given far enough in advance of the procedure to ensure effectiveness (see pain control below).
- Regardless of the medication selected, gentle, supportive treatment throughout the procedure is essential
- Ask the woman to empty her bladder
- If possible, a midwife, nurse or other health care worker should stand by the woman’s head to reassure her during the procedure
- If the health care worker who will do the MVA did not perform the pelvic examination as part of the clinical assessment, they should do so before beginning the procedure to verify uterine size and position.

Type and route of analgesia

Administer any analgesic available in the facility 30 minutes before the procedure.

The analgesic may be through oral, intramuscular or intravenous route depending on the type of the drug available.

5.4 Guide for selecting appropriate cannula size for MVA

The size of cannula for the use of MVA is determined by assessment of uterine size in weeks since LNMP and the extent of cervical dilatation.

In general, the cannula should be large enough to allow passage of tissue expected according to gestation, but also to fit snugly into the cervix to maintain vacuum.

By counting weeks from the LNMP

When uterus is soft and palpable at the symphysis pubis indicates the pregnancy is 12 weeks gestation;

- below the symphysis pubis, below 12 weeks,
- Above it is more than 12 weeks.

Approximate Uterine Size-Weeks LNMP

<table>
<thead>
<tr>
<th>5-7 LNMP</th>
<th>5mm</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-9 LNMP</td>
<td>6mm</td>
</tr>
<tr>
<td>10-12 LNMP</td>
<td>9-12mm</td>
</tr>
</tbody>
</table>
5.5 Step by Step in Performing MVA

Ensure sterility

Ensure that part of the instrument required to enter in the uterus is sterile.

No part of tip of the tube should be allowed to touch the vaginal wall.

1. Explain the procedure to the client.
2. Position the patient in lithotomy position.
3. Clean vulva and perineum with antiseptic e.g. savlon.
4. Drape patient with sterile towel
5. Perform bimanual pelvic examination to ascertain;
   ▪ Size, position of the uterus and extent of cervical dilatation.
6. Insert bivalve speculum into the vagina and remove blood tissue from the vagina
   and cervical os using sponge holding forceps.
7. Clean vagina and cervix with povidone using gauze or cotton wool swabs.
8. Hold the anterior lip of the cervix using a single Tenaculum/volsellum at position 12
   o’clock.
9. Select appropriate cannula according to the cervical os.
10. Gently apply traction on cervix to straighten/align the cervical canal and uterine
    cavity.
11. Create vacuum in the syringe.
12. Gently insert the cannula into the uterine cavity while holding the cervix steady
    until it touches the fundus
    ▪ Note the depth by the dots visible on the cannula
    ▪ Withdraw the cannula slightly
    ▪ Attach the prepared syringe to the cannula by holding the end of the cannula
      in one hand and the syringe in the other hand; ensure the cannula is properly
      attached to the syringe.
    ▪ Release the valve(s) on the syringe to transfer the vacuum through the cannula
      to the uterine cavity.
    ▪ Evacuate the contents of the uterus by moving the cannula gently back and
      forth and rotating within the uterine cavity.
    ▪ Check for signs of complete evacuation;
      ▪ Red or pink form,
      ▪ No more tissue in the cannula,
      ▪ Gritty sensations,
      ▪ The uterus contracts around the cannula.
17. If the syringe is full with products of conception and no signs of complete evacuation
    close the valve, disconnect syringe from the cannula and empty the products. Repeat
    the evacuation procedure.
18. If there are signs of complete evacuation, close the valve, detach syringe from the
    cannula, withdraw syringe and remove the cannula.
19. Clean and inspect the cervix for bleeding, if there is bleeding apply pressure using a
    gauze for 5-10 minutes, then remove.
    ▪ Give Oxytocin 10 IU IM or Ergometrine 0.2 mg IM or Misoprostol 600mcg orally.
20. remove the tenaculum/volsellum and speculum
20. Remove the patient from lithotomy position to rest for 10 to 20 minutes.
21. Inspect the tissue for product of conceptions, complete evacuation and molar
    pregnancy.