MINISTRY OF HEALTH
REPUBLIC OF BOTSWANA

COMPREHENSIVE POST ABORTION CARE REFERENCE MANUAL
September 2013

VSI  World Health Organization  UNDP  UNFPA
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FOREWORD

Unsafe abortion is a persistent and yet preventable pandemic. Ending this silent pandemic is an urgent public-health and human-rights imperative. As with other more visible global-health issues, this scourge threatens women throughout the developing world. It is important to recognize that maternal health is one aspect of women’s overall reproductive health. There are good reasons to believe that options and constraints that women face on other reproductive health issues such as contraception, abortion, and risks of HIV have considerable implications for their overall health as mothers. Because of gender-based power dynamics with regard to sexuality in many cultures, women often do not have the power to negotiate safe sex or to prevent or safely deal with unwanted pregnancy. Consequently women are vulnerable to greater risks of maternal morbidity and mortality because of risky sexual experiences and pregnancies that occur under less than ideal circumstances.

Unsafe abortion has a clear and well-established link to maternal morbidity and mortality: the consequences of unsafe abortion can include severe maternal health complications, such as haemorrhage, infection, intra-abdominal injuries, severe emotional and physical trauma, secondary infertility, as well as death. This link is further substantiated by the 2007-2011 Maternal Mortality Audit Committee Report which indicated that unsafe abortion is the third leading cause of maternal mortality in Botswana: accounting for 15% of the total deaths. It is therefore only logical that to meet the fifth Millennium Development Goal (MDG 5) of improving maternal health and attain the target of reducing maternal mortality by 75% between 1990 and 2015; considerable milestone has to be done in addressing unsafe abortion and its resulting complications.

With this hindsight, the Botswana government recognized the dramatic effect high quality standardized post abortion care can have on unsafe abortion rates. It is against this background that the government of Botswana, through the Ministry of Health found it necessary to develop Comprehensive Post Abortion Care Guidelines to guide provision of post abortion services. The guidelines provide a full range of evidence based protocols and standards that will improve access to family planning, post abortion care, counselling and community outreach services to substantially reduce unsafe abortion rates and maternal deaths and morbidity related to unsafe abortion.

I note with appreciation that a lot of work, commitment and dedication has gone into the development of this guiding document and therefore take this opportunity to urge service providers to ensure its implementation for improvement of the lives of women towards 2015 and beyond!

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Acting Director-Department of Public Health
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ACKNOWLEDGEMENTS

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Sincere appreciation and gratitude is further extended to a team of local experts who extensively participated in the development process. Based on the available evidence-based materials, advantage was taken to use these materials in the development of the Comprehensive Post Abortion Care: Reference Manual and it is this team that researched, adopted and adapted materials to be relevant to the local setting. The team included: Boitumelo S. Thipe, Tshiamo R. Keakabetse, Mabole Masweu, Yvonne Mokandla, Tsetsa Mokgadi, Mosamarea Osenyeng, Esther Obotseng, Kedibonye Kgomoato, Nametsu Moremedl, Motlalepula Mmipi, Boiketlo Leswena, Letlhogonolo Mabote, Dr Oliver Thekwini, Dr Irung Kasombo, Happy Motlogelwa, Dr Thato Kaponorah, Dr Jean-Ricky Mobando Mogala, Jonas Mphela, Dr Ntebo Ramotshabi, Goitsemadimo Chabe, Sinah Kgomoato Phiri, Seipati Mogotsi and Lucy Maribe (WHO).

Finally, this product would not have been possible without the leadership of the institutions from which contributors to the development of this document came from, hence the management is highly recognized.

Thank you Bagaetsho. Le ka moso!

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LIST OF ABBREVIATIONS/ACRONYMS

AIDS Acquired Immunodeficiency Syndrome
ASRH Adolescent Sexual Reproductive Health and Rights
ANC Antenatal Care
BTL Bilateral Tubal Ligation
CAT Cost Analysis Tool
CBO Community Based Organization
CBR Crude Birth Rate
CLEAR Clarify, Listen actively, Encourage, Repeat or Reflex
CAT Cost Analysis Tool
COC Combined Oral Contraceptives
COPE Client Oriented Provider Efficiency
CPAC Comprehensive Post Abortion Care
CPR Contraceptive Prevalence Rate
CDR Crude Death Rate
CTU Contraceptive Technology Update
D&C Diagnostic Curettage
DHS Demographic Health Survey
Ebola HF Ebola High Fever
EC Emergency Contraceptive
EMOC Emergency Obstetrics Care
ELC Experiential Learning Cycle
EVA Electric Vacuum Aspiration
FP Family Planning
GATHER Greet, Ask, Tell, Help, Explain, Refer
GMs Grammes
HBC Home Based Care
HBV Hepatitis B Virus
HIV Human Immune Virus
HLD High Level Disinfection
HMT Health Management Team
HPV Human Papilloma Virus
HMT Hospital Management Team
IAI Intrabdominal Injuries
ICPD International Conference on Population and Development
IEC Information Education Counseling
IMCI Integrated Management of Childhood Illness
IMR Infant Mortality Rate
IUCD Intrauterine Contraceptive Device
IUD Intrauterine Contraceptive Device
IV Intravenous
CHAPTER 1
Introduction/Overview of Comprehensive Post abortion Care Services (CPAC)

Definition of CPAC
Comprehensive Post abortion Care (CPAC) is defined as a series of medical and related interventions designed to manage the complications of spontaneous and induced abortions, both safe and unsafe and addresses women's related health care needs.

Globally, an estimated 287,000 maternal deaths occurred in 2010, 99% of them in the developing countries and most of them preventable (WHO, UNICEF, UNFPA, WB 2012. Trends in Maternal Mortality). These women leave behind millions of motherless children whose survival is precarious due to lack of maternal support and care. Children who are left moterless due to maternal mortality are up to ten times more likely to die within two years than children with two living parents (Safe Motherhood Website 2002).

It was estimated that in 2003 approximately 42 million pregnancies were voluntarily terminated: 22 million safely and 20 million unsafely (WHO 2011, Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008). Unsafe abortions are frequently performed by providers lacking qualifications and skills to perform induced abortion, and some abortions are self-induced. Unsafe induced abortions do not meet officially prescribed circumstances and safeguards; they are aggravated by unhygienic conditions, dangerous interventions or incorrect administration of medication. Although unsafe abortions are preventable, they continue to pose undue risks to a woman's health and may endanger her life (WHO 2011). For every woman who dies of unsafe abortion, many more suffer serious injuries and permanent disabilities.

There is a growing global commitment to reduce the unacceptably high maternal death rates in developing countries including Botswana. Botswana Maternal Mortality Rate (MMR) is estimated at 148/100 000 (Statistics Botswana: 2012), total fertility rate (TFR) 2.9, Crude Death Rate (CDR) 12.4, Life expectancy 55.7 years. Contraceptive Prevalence Rate (CPR) is 52.8 %.

In its vision 2016, the government of Botswana intends to reduce the MMR from 200 to 150 by 2011 (MDG 5 Target). In Botswana, abortion complications account for 15% of all maternal deaths, which is quite high (2007-2011 Maternal Mortality Audit Committee report). Progress towards this goal in Botswana demands strategies to assess the causes of maternal death and provide guidelines regarding maternal care, to ensure that quality health services are rendered. One of the strategies to curb the problem is to improve PAC services through training of SRH service providers in CPAC and counseling, training of hospital staff in treatment methods and strengthening post abortion family planning (PAFP) as an important component of CPAC.

Comprehensive Post abortion care (CPAC) is an approach for reducing morbidity and mortality from incomplete and unsafe abortion and resulting complications and for improving women's sexual and reproductive health and lives. It emphasizes quality of care, access and choice.

1. FIVE ESSENTIAL ELEMENTS OF CPAC:

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

1.2 Counseling: to identify and respond to women's emotional and physical health needs and other concerns.

1.3 Treatment: of incomplete and unsafe abortion and complications that are potentially life-threatening.

1.4 Contraceptive and family planning services: to help women prevent an unwanted pregnancy or practice birth spacing.
1.5 **Reproductive and other health services**: that are preferably provided on-site or via referrals to other accessible facilities in providers' networks.

2. **BARRIERS TO QUALITY COMPREHENSIVE PAC SERVICES**

2.1 **Stigma around abortion and negative attitudes of the service providers and the community**

Each year, throughout the world, approximately 210 million women become pregnant and over 135 million of them deliver live born infants. The remaining 75 million pregnancies end in stillbirth, or spontaneous or induced abortion (WHO, 2012). Women who are thought to have abortion, or the providers providing abortion or post abortion care services may be stigmatized due to cultural and religious beliefs about abortion in the community (Norris et al, Women’s Health Issues 2011). For example, both the service providers and the community associate any woman who has lost or is in the process of losing a pregnancy to have interfered with it.

*a. Community Attitude.*

This leads to a situation where the community do not empathize with a woman whose life is at risk and do not support or assist her to go to a facility where she can get appropriate life saving services.

*b. Service provider attitude.*

If the woman manages to somehow reach the health facility, the service providers often may not take immediate and appropriate action. In some instances, as documented in Gabon, patients who are admitted for an abortion related condition may be kept waiting for up to two days from the time they get to the facility to the time they get emergency care or until elective theatre is free for evacuation to be carried out (Mayi-Tsonga et al., Reproductive Health Matters 2009).

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

Until recently, the operational policy for example in Botswana was that only doctors could be trained in providing comprehensive PAC services especially emergency care. However, this has led to a lot of suffering among patients since qualified doctors in the country are very few and are mostly urban-based while rural areas are under-served.

**Note:** There is a need to train mid-level service providers to provide PAC services to expand availability of services. Training should support positive attitudes, respect and confidentiality of patients. Community sensitizations are also necessary to avoid stigma and support women seeking services.

3. **WHY WOMEN RESORT TO ABORTION**

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

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

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

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

**Medical problems such as:**
- Failure to get FP services;
- Lack of information on FP
- Lack of access to FP services;
- Contraceptive method failure;
- She knows the child will be born with serious health problems.
In many cases if women had better information about and access to family planning services, the need for abortion would be eliminated.

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

Some of the socio-cultural elements that can affect abortion mortality and morbidity rate include:

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

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

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

- **Providers’ attitudes towards women’s abortion care needs.** Women are unwilling to seek care from facilities that make them feel uncomfortable or where they have been treated badly.

**GUIDING PRINCIPLES:**

1. **Botswana National Health Policy**
   - Recognizes the enjoyment of a level of health that allows every citizen to lead an economically and socially productive life as a human right.
   - Recognizes health care as one of the key determinants of health.
   - Emphasizes the role of the government as policy maker, professional guide and supervisor of health care in its entirety in Botswana, irrespective of the provider or institutions.
   - Commits the government through the ministries of health (MOH) to ensure that all the institutions that provide health care are provided with information on recognized standards of care in line with WHO recommendations.
   - Commits MOH to conform to such recognized standards and through its supervisory activities ensure that districts, cities and private providers establish appropriate systems for ensuring that recognized standards are complied with.
   - Reaffirm the MOH’s supervisory role by means of information and systematic and independent audits and ensuring that all activities are planned, executed and maintained in accordance with accepted technical and professional standards.

2. **National Sexual and Reproductive Health Programme**
   - Reaffirms the steps taken by the government to shift from MCH/FP to SRH by signing the RH development and capacity building project with UNFPA (BOT/98/P02)
   - Sets the goal for improving the sexual and reproductive health of all people living in Botswana through nine specific objectives. These are to:
     - Improve understanding of SRH by parents and children/youth
     - Improve ASRH and youth health
     - Reduce maternal and perinatal morbidity and mortality
     - Enhance gender equality and equity
     - Control STI’s and HIV/AIDS
     - Meet FP needs
     - Prevent and manage infertility, reproductive tract cancers and midlife concerns
     - Ensure national capacity to conduct operational research and manage functional health information system
Recognizes the critical nature of both management and service delivery issues and their interactions in facilitating the process of expanding SRH services and enhancing quality of care.

5. CPAC PROGRAM

PAC is singled out as one of the skills providers are supposed to be equipped with in order to provide complete EmONC. The MOH is categorical in defining PAC, where it can be provided, the elements and components.

The guidelines are also specific that the service can be provided by the following categories of people: Obstetricians/Gynecologists, Medical officers, midwives, nurses with relevant trainings, family nurse practitioners, social workers, health educator and Health Education Assistants (HEAs).

Several national documents such as the Botswana National SRH programme; Policy Guidelines and service standards for National SRH; National Sexual and Reproductive Health Programme Framework; National population Policy; Policy on women and development; National Health Policy; National Youth Policy; National Policy on HIV/AIDS provide further authority and justification for dealing with abortion and its complications.

6. THE RIGHTS APPROACH TO SEXUAL REPRODUCTIVE HEALTH.

- SRH&R derive from the fundamental human rights and freedoms that are already enshrined in the constitution of Botswana and are included in several international agreements and treaties to which the government of Botswana is a signatory.
- Upholds the basic rights of couples and individuals to attain the highest standards of sexual and reproductive health and to decide freely (without discrimination, coercion or violence) and responsibly the number and the spacing of their children and to have access to information and education to make informed choices, and the means to do so.
- Quality SRH services can lead to increased demand for and acceptability of services. Quality of services should therefore be regarded as the right of the client and everyone in the community who is in need of SRH services.
- Needs of service providers are equally important in ascertaining SRH rights. Providers relate to clients as human beings and have attitudes and skills that are influenced by the working environment.

7. THE ELEMENTS OF CLIENT RIGHTS.

- Right to scientific information on SRH
- Right to access to services regardless of social status, economic situation, religious affiliation, ethnic origin, marital status or geographical location.
- Right of choice and continuity to SRH care, services and commodities e.g. contraceptives.
- Right to safety in the practice of SRH services
- Right to privacy during the discussion or basic examination.
- Right to dignity, treatment with courtesy consideration, attentiveness and full respect, regardless of level of education, social status, age etc
- Right to comfort when receiving services.
- Right to confidentiality, this entails information that patient give to health providers on trust. Providers have a duty to protect patients' information against unauthorized disclosures, and to ensure that patients who do authorize disclosure of their confidential information to others do so freely and on the basis of clear information.
- Right of opinion to express their views on the type of services they receive.
8. **The provider needs.**

- Need of regular training and regular updates in order to access knowledge and skills to perform designated tasks
- Need for information on issues related to their duties (clear job description)
- Need for infrastructure that is appropriate for provision of acceptable quality of care and observance of clients’ rights to privacy and comfort.
- Need for supplies to ensure quality and continuity of care
- Need for guidance to reinforce their knowledge and skills for delivering high quality of care.
- Need for back up whenever referral for consultation is needed
- Need for encouragement in order to stimulate creativity and autonomy commensurate with their capabilities,
- Need for feedback given in a positive and constructive manner.
- Need for self expression regardless of level of health care facility in which they are deployed.
- Providing SRH services including PAC are emotionally draining. The providers need counseling from time to time. Like patients the providers should also have their rights respected such as:
  * Right to safety,
  * Right to hold religious convictions as long as they do not jeopardize the care they provide as professionals,
  * Right to conduct safe abortion only with consent,
  * Right to respect.
CHAPTER 2
LEGAL FRAMEWORK ON ABORTION

The provision of post abortion care need not be affected by whether abortion is legal or not. The medical profession has the responsibility to provide comprehensive post abortion service including family planning to all women who need them, to the full extent of the legal limits. Emergency care for the complications of abortion (post abortion care), both spontaneous and induced, is legal and not punishable by any part of the law. Emergency abortion care (post abortion care) is a requirement of the ethical practice of medicine in every country, as this care is often essential to save woman's life and preserve health (Kleinman, 1998). The laws and regulation regarding post abortion are not often understood, either by women needing care or by the health care providers, therefore PAC services are not adequately put in place.

The constitution of Botswana states thus;

160. Attempts to procure an abortion
1. Any person who, with intent to procure a miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever is guilty of an offence and is liable to imprisonment for a term not exceeding seven years.

2. Notwithstanding the provisions of subsections (1), it shall not be an offence under this section if a pregnancy is terminated or an abortion is caused within the first 16 weeks of pregnancy, in the following circumstances and under the following conditions-
   a. where the medical practitioner carrying out the operation is satisfied, by acceptable evidence, that the pregnancy is the result of rape, defilement or incest, and the termination or abortion is requested by the victim, or, where the victim lacks the capacity to make such a request, by her next of kin or guardian or the person in loco parentis; or
   b. where the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health, and such two medical officers consent to serious physical or mental abnormality or disease as to be seriously handicapped, and the pregnant woman consents to the termination or abortion, or, if she lacks the capacity to give such consent, it is given on her behalf by the next of kin or guardian or the person in loco parentis; or
   c. where established evidence shows that there is a substantial risk that, if the child were born, it would suffer from or later develop such;

Provided that-
1. The termination or abortion is carried out by a registered medical practitioner in a government hospital or a registered private hospital, or a clinic approved for the purpose by the Director of Health Services; and
2. two medical practitioners have given their opinions in good faith, in writing, in the case of paragraph (b) above, that continuation of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health, or in the case of paragraph (c) above, that there is substantial risk that, if the child was allowed to be born, it would suffer such serious physical or mental abnormality or disease as to be seriously handicapped.

161. Woman with child procuring abortion
Any woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing, or means to be administered or used to her, is guilty of an offence and is liable to imprisonment for a term not exceeding seven (7) years.

162. Supplying drugs or instrument to procure abortion
Any person who unlawfully supplies to or procures for any person any thing whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, is guilty of an offence and is liable to imprisonment for a term not exceeding three years.

163. Knowledge of age of person immaterial
Except as otherwise expressly stated, it is immaterial in the case of any of the offences committed with respect to a person under a specified age, that the accused person did not know that the person was under that age, or believed that such person was not under that age.
The issues surrounding abortion are as complex as the physiology of societal development. The legal provisions have not made this emotive subject any better in several countries and Botswana is not exempt. Globally when a pregnancy threatens a woman's life, almost all countries permit abortion to save the woman's life. Nearly two thirds of countries allow abortion when there is serious risk to the woman's physical or mental health. In 40% of countries, additional grounds for permitting abortion are rape, incest; and a similar percent age allow for abortion in cases of fetal impairment (United Nations Abortion Policies, 2013).

Many women seek abortion because they cannot afford to look after the child. There are many women and especially the young, single women for whom continuing a pregnancy would be socially difficult or impossible. Since October 11th 1991, the indications for safe abortion in Botswana broadened to embrace the following: Section 160(1) of the penal code as amended by act No.5 of 1991 and section 160(2) of the penal code states when abortion may be carried out. Note in the same legal notice: Section 236 states a person is not criminally responsible for performing in good faith and with reasonable care and surgical skill:

- Safe abortion within the first 16 weeks of pregnancy
- When the pregnancy is as a result of rape, defilement or incest
- When the pregnancy would injure the woman's physical or mental health or threaten the woman's life
- When the unborn child would suffer or later develop serious physical or mental abnormality or disease that would handicap the child
- Can be done by a registered medical practitioner in a government hospital, or a registered private or a clinic approved for abortion by the director of health services and two doctors should confirm in writing that the continuation of the pregnancy would indeed involve the risk to either the mother or child.

It is essential for health professionals and others such as the police or court orderlies as well as the public to understand clearly what is allowed under the law in their country. In Botswana the government has created an enabling policy environment that allows for provision of abortion services to the full extent of the law. The policies and guidelines have ensured that there are opportunities to minimize the rate of unwanted pregnancy by providing and availing a full range of services and information on FP to all those who are sexually active.

In addressing the training needs of health providers in providing PAC services, it is envisaged that both administrative and legal barriers to comprehensive abortion care services will appropriately be addressed.
CHAPTER 3
ABORTION

The termination of pregnancy or expulsion of non viable fetus weighing 500g or less before 24 weeks of gestation.

1. Causes and classification of Abortion

Abortion can either be spontaneous or induced. Induced abortion is the deliberate termination of pregnancy before stage of viability. Spontaneous abortion occurs without any deliberate external intervention. It can be caused by either maternal or fetal factors.

1.1 Maternal causes

- Systemic disease
  - Infections e.g. Malaria, Chlamydia, Herpes simplex, HIV/AIDS
  - Endocrine disorders e.g. Diabetes Mellitus, Hyperthyroidism
  - Hypertension
- Malnutrition
- Uterine abnormalities and defects
  - Uterine fibroids
  - Cervical incompetence
  - Congenital abnormalities of the uterus
  - Repeated or over curettage and other uterine scarring
- Trauma
  - Physical trauma on the gravid uterus
- Other disorders
  - Psychological and emotional disorders
  - Immunological disorders
  - Unfavorable habits e.g. alcoholism, smoking and drug abuse

1.2 Fetal causes

- First trimester
  - abnormalities of chromosomal structure
  - blighted ovum
  - poor implantation and inefficient placental development
- Second trimester
  - congenital infections e.g. syphilis
  - erythroblastosis

1.3 Other causes

- Psychological and emotional disorder
- Immunological disorders
- Unfavourable habits e.g. alcoholism, smoking, drug abuse.
Abortion can be classified as in the table below:

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<tr>
<th>TYPES OF ABORTION</th>
<th>CLINICAL PRESENTATION</th>
<th>MANAGEMENT</th>
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| **Threatened Abortion:** This is a clinical diagnosis in which vaginal bleeding occurs, but the cervix remains closed and the pregnancy is still viable. | Mild lower abdominal pains and backache  
Slight PV bleeding  
Cervix is not effaced  
Cervical os is closed  
Uterus is enlarged | Counseling, rest, avoid strenuous activities.  
Investigate and treat the cause |
| **Inevitable Abortion:** This is the state in which there is uterine contraction with progressive effacement and dilatation of the uterine cervix with or without uterine bleeding before the stage of foetal viability. | Painful cramps or contractions  
Uterine bleeding  
Cervical effacement and dilatation  
Membranes may be ruptured | Facilitate abortion by evacuation of the uterus; if pregnancy is <12 weeks by oxytocin drip or prostaglandins for spontaneous expulsión if pregnancy >12 weeks. |
| Incomplete Abortion; The partial expulsion of the product of conception before viability stage. | Abdominal cramps may or may not be present  
Cervical os is generally open  
Varying degrees of uterine bleeding  
Uterine size will be considerably less than gestational age | Treat as emergency I/V line with or without a drip depending on amount of blood loss |
| Complete Abortion: The expulsion of all the products of conception before viability stage. | Abdominal pain or cramps have subsided  
No active uterine bleeding  
Cervical os is generally closed  
Uterine size is considerably less than gestational age or is almost normal size | Give broad spectrum antibiotic if necessary  
Provide haematemics if necessary |
| **Septic Abortion:** Abortion associated with localised/generalised infection. | Pelvic pain of varying degrees  
Offensive blood stained or brownish vaginal discharge  
Varying degrees of fever  
Pelvic tenderness  
Fluid (pus) collection in the POD  
Cervical canal is generally open  
POC may be felt through cervical canal  
Commonly patient is anaemic | I/V line for Rehydration  
Endocervical swab or HVS for culture and sensitivity test  
Start on broad spectrum i/v antibacterial cover, immediately do evacuation  
If there is peritonitis, may require laparotomy for drainage  
Transfuse blood if anaemia is severe  
Give haematemics if anaemia is mild or moderate |
### Missed Abortion:

**Missed Abortion:** (or anembryonic gestation) is diagnosed by ultrasound and is defined as a pregnancy in which there is no embryo (empty sac) or unrecognized fetal death.

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<th>Coagulation screen: clotting time, prothrombin time index</th>
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<td>Uterine size progressively decreases</td>
<td>X-match blood</td>
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<tr>
<td>Pregnancy test may be negative</td>
<td>Evacuate the uterus under general anaesthesia</td>
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**Note:** Spontaneous abortion can be called recurrent abortion when there are three or more consecutive abortions.

- All Rh negative women should be given anti-D within 72 hours of abortion.
- All women with unsafe abortion should be given tetanus toxoid and immunoglobulin.
CHAPTER 4
CLINICAL ASSESSMENT

Introduction

Prior to performing an abortion procedure, it is essential to perform a rapid initial assessment for shock and do complete clinical assessment. This allows the provider to properly diagnose the woman’s clinical status and to help determine her best options. Although the clinical-assessment process for women seeking abortion is rarely complicated, it does sometimes reveal specific pre-existing conditions that may require special attention or management. The first step in clinical care for a woman seeking an abortion care services is to determine if the patient has signs of shock and to confirm pregnancy. If she is pregnant, the next step is to determine the length of the pregnancy.

The assessment should be conducted in private place where the woman and provider cannot be seen or overheard by others so that the provider can meet with the woman alone to discuss her situation and perform an examination.

1. The components of rapid initial assessment for shock.

The rapid initial assessment for shock is urgent and consist of quickly checking the following:

- Pulse
- Blood pressure
- Pallor
- Extremities
- Breathing
- Mental state

Signs and symptoms of shock include:

**EARLY SHOCK**
- Anxious, restless
- Fast heart rate at 110 b/m or more
- Fast and shallow respiration (30 or plus b/m)
- Pale conjunctiva, palms, mouth, capillary refill
- Low BP (systolic less than 90mmHg)
- HB of 8g/dl or greater, haematocrit more than 26%
- Clear lungs
- Cool and clammy skin although patient sweating.

**LATE SHOCK**
- Confused or unconscious
- Very fast, weak pulse
- Very fast shallow breathing
- Pale and cold
- Low BP
- Pulmonary oedema
- Haemotocrit less than 26%
- Low urine output (less than 30ml/hr)

If the woman is in shock the initial steps to address it must be taken without delay as shock can be life-threatening. Complete pelvic exam should not be done at this time. After stabilization identify the underlying cause of shock by performing a complete clinical assessment.

Shock can develop rapidly in any patient at anytime during treatment especially if injuries were not initially detected. When shock is present with abortion, it’s likely the result of one of the following complications:

- Haemorrhage
- Infection / sepsis
- Intra-abdominal injury.
2. The components of a complete clinical assessment are:
   - client history
   - psychosocial assessment
   - physical examination, including pelvic exam
   - optional collection of specimens and the ordering of any lab investigations

2.1 Client History

It is important that providers take a client history early on in their interactions with the woman. This will help determine the length of the pregnancy and identify any known concerns such as medication allergies or other medical conditions.

For most women, a late or missed menstrual period is the first sign that they may be pregnant. Therefore, the provider should ask the woman the date on which her last menstrual period (LMP) began. Although knowing the date of the woman's LMP can be helpful, it is not always easy to correctly determine this date. Because women can experience non-menstrual bleeding that is mistaken for a menstrual period, some pregnant women may report a later date for their last period, or they may report never having missed a period. Other women may become pregnant without having regular menstrual periods, for example, breastfeeding women who become pregnant before their first postpartum menses. All these factors can lead to the misdating of a pregnancy. Therefore, the date of a woman's LMP should not be the sole factor in determining the length of a pregnancy. The majority of women do not have any specific physical signs during early pregnancy. Those that do, however, may experience symptoms such as breast soreness and enlargement, nausea, vomiting, fatigue, appetite changes and increased frequency of urination.

Ask the woman about and record her medical history, including:
   - First day of LMP
   - Signs and symptoms of pregnancy
   - Bleeding or clotting disorders
   - Drug allergies
   - History of previous pregnancies e.g. ectopic pregnancy, abortion, live births or fetal deaths
   - Any recent abortion-related care
   - Any recent medications taken, including misoprostol or herbal remedies
   - Known medical conditions e.g. hypertension, diabetes, epilepsy if one the condition are found refer or manage appropriately
   - Physical or cognitive disability, including mental illness
   - Surgical history
   - Sexual history
   - HIV status and presence of sexually transmitted infection (STI)
   - History of contraceptive use
   - History of alcohol or drug use, including smoking

2.2 Psychosocial Assessment

The contact that a provider has with the woman while taking her medical history and performing a general physical examination provides an ideal opportunity to assess her emotional state. Although many women will be emotionally stable and comfortable with their decision, some women may show signs of nervousness or other distress. Providers should use a gentle, nonjudgmental tone and display a sense of concern and confidentiality. Because of social and cultural issues, the woman may not want to disclose full information about the pregnancy. Open, supportive communication helps ensure that the health-care worker has all relevant information needed to determine the best possible care for the woman.

It is also important to note any cognitive disabilities or mental illness or indications that the woman has been subjected to violence. Providers should encourage the woman to discuss the circumstances that led to her seeking care:
   - When did she suspect she was pregnant?
   - Is there anything she feels the provider needs to know?
   - Does she have a history of drug use or abuse?
   - Does she have a stable family environment and support system?
   - Is she subject to violence?

2.3 Physical Examination

Accurately determining the length of the pregnancy is a critical factor in both selecting an abortion method and preventing complications. Risks associated with induced abortion are low when it is conducted by trained
providers; however, risks do increase with length of pregnancy. In induced abortion care, miscalculation of length of pregnancy is a significant cause of complications.

Bimanual pelvic examination and recognition of other signs of pregnancy are usually adequate indicators; other laboratory tests such as human chorionic gonadotropin (HCG) and ultrasound may also be useful for confirmation of pregnancy, but are not necessary for the provision of first-trimester abortion. Before beginning any uterine evacuation procedure, it is critical to estimate the uterine size as accurately as possible.

2.3.1 General Health

The physical exam should begin with a general health assessment that includes:
- Checking and recording the woman’s vital signs, such as pulse, temperature and blood pressure
- Noting signs of general health, including weakness, lethargy, anemia or malnourishment
- Checking the woman’s abdomen for masses and tenderness

2.3.2 Pelvic Examination

The pelvic examination includes a speculum and bimanual exam, which may be conducted consecutively or in either order. The woman should empty her bladder before the pelvic exam, because a full bladder may make it difficult to assess the uterus and may mask findings.

i. Verbal reassurance

Explain to the woman what to expect before beginning the pelvic exam. If this is her first pelvic exam, she may be anxious, and it is particularly important to let her know what you are doing and to reassure her. In all cases, it is important to describe to the woman how she might feel.

ii. Positioning the woman

- Help the woman move into the lithotomy position
- Ensure that she is protected and well-supported
- Use drapes or linens to make sure her privacy is protected
- Attend to any special anatomical or physical needs, including disability, arthritis or injuries
- Attend to any IV lines or other critical items.
- Where leg supports are not available, the dorsal or “frog-leg” position can be used. In this position, the woman’s pelvis should be raised by placing a stack of blankets or linens under her lower back or upper buttocks.

iii. Speculum exam

The speculum exam can be performed during the clinical assessment or during preparation for the uterine evacuation procedure. Before inserting the speculum, inspect the external genitalia and perineum. Note whether there are ulcers or signs of STIs on the external genitalia.
- Warm the speculum if possible; this can be done under the exam light.
- Gently insert a speculum of the appropriate size and inspect the cervix and vaginal canal carefully.
- Check for bleeding. If present, check the amount and source of the bleeding.
- Note if the blood or any discharge has an odour. Infection is sometimes indicated by a foul odour.
- Note any pus or discharge from the cervical os. Active cervical infection present at the time of a uterine evacuation procedure increases the chance of post abortal infection.
  - If infection is present or suspected, take samples for culture, if possible.
  - Even if it is not possible to confirm the type of infection using laboratory tests, broad spectrum antibiotics should be administered and the uterus evacuated immediately.
  - Women with advanced HIV and others who may have compromised immune systems may need more aggressive treatment for possible infection.
- Note any cervical lesions; visual inspection of the cervix can help identify cervical dysplasia.

iv. Bimanual exam

- Assess the size of the uterus. Compare the actual size the uterus with date of the LNMP. With an incomplete abortion, the uterine size is usually smaller than the LNMP might suggest.
- Assess the shape and position of the uterus. Correctly determining the shape and position of the uterus is critical to the safety and success of the procedure.
- If the uterus is larger than expected, it may indicate:
A more advanced pregnancy than the LNMP suggest
- Presence of multiple pregnancies
- Uterus filled with blood clots (i.e. post-abortion syndrome)
- Molar pregnancy (i.e. trophoblastic disease)
- Presence of uterine fibroid (i.e. smooth muscle tumours of the uterine wall).

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

Providers will need to assess women with existing acute purulent cervicitis and determine treatment. Common infections, such as yeast (candida) and bacterial vaginosis, can be treated concurrently when providing uterine evacuation, which should not be delayed. Other forms of acute purulent cervicitis may be a result of sexually transmitted infections (STIs). Women with active STIs should receive counseling and begin treatment with antibiotics. Once antibiotic coverage is established, perform the uterine evacuation. These women will also need a course of antibiotics after the procedure to ensure that the infection has been eradicated.

2.4 Laboratory Tests
- Urine pregnancy test if the sign of pregnancy are unclear
- FBC (haemoglobin and haematocrit) to detect anaemia
- Grouping and cross-match
- Rh factor to determine group if Rh negative to attend appropriately
- HVS for m/c/s for appropriate antibiotics
- RHT
- Cervical cytology to rule out cervical cancer
- LFT, UREA, CREATININE AND ELECTROLYTES (In case of sepsis)

**NB:** This and similar types of reproductive health laboratory services (RHT, cervical cytology) may be offered to women where available, but are not required to perform an abortion safely and should not be a precondition.

2.5. Ultrasound Exam
Ultrasound may be helpful for accurate dating when there is a discrepancy revealed by the bimanual exam, but is not a requirement for the provision of an early abortion (WHO, 2012). Where it is available, it can be used along with quantitative b-hCG measurements to help detect ectopic pregnancies. Uterine evacuation methods, whether vacuum aspiration or medication methods using misoprostol and mifepristone, cannot terminate an ectopic pregnancy. A woman with an early Ectopic pregnancy may be asymptomatic. If she does have symptoms, they might include:
- Uterine size that is smaller than expected
- Sudden, intense and persistent lower abdominal pain or cramping, usually one sided, that may be accompanied by:
  - irregular vaginal bleeding or spotting
  - palpable adnexal mass
- Fainting or dizziness that persists more than a few seconds, possibly indicative of internal bleeding; internal bleeding is not necessarily accompanied by vaginal bleeding
- No POC after a vacuum-aspiration procedure.

2.6. Special Populations to Consider During Clinical Assessment
Providers should be particularly cautious when physically examining adolescents or women who have experienced violence.
- Adolescents may have never had a clinical pelvic exam and may be particularly apprehensive.
- Women who have experienced violence may be afraid or uncomfortable about being touched in their genital area.
- Women who have undergone female genital cutting (FGC) will likely need a de-infibulation procedure prior to physical examination.
There are often no physical signs of violence against women. However, providers should be alert to the following signs, while understanding that these signs can also be present outside the context of violence:

- New or old bruises on the woman’s body, including the genital area, head, neck or upper arm
- Injuries that do not fully match the explanation of how they occurred
- Burns or marks with distinctive patterns, such as cigarette burns
- STIs, pelvic inflammatory disease, urinary-tract infection, chronic irritable bowel syndrome, chronic pelvic pain
- Vaginal bleeding, painful defecation or painful urination and abdominal or pelvic pain

These signs may indicate the need for further discussion and screening for violence by providers or counselors to determine if a woman is in a dangerous situation. If this proves to be the case, providers should do what they can to help the woman before she leaves their care. Referrals to any existing resources should be made before she leaves the facility, as many women may not return for follow-up appointments.
Chapter 5

Uterine Evacuation Methods

1.0 Introduction

Uterine evacuation is the removal of the contents of the uterus. There are several methods for accomplishing uterine evacuation in the first trimester, including: vacuum aspiration, medications (pharmacological agents) and sharp curettage.

Within these categories there are various techniques and agents that can be used, depending on the training and skills of the staff, the equipment and medical agents available. The woman's individual clinical situation, uterine size, length of pregnancy and personal preferences are also key factors in determining which method is most appropriate.

Vacuum aspiration—electric or manual—and sharp curettage, also known as dilatation and curettage (D&C), are commonly referred to as surgical methods of uterine evacuation. However, evacuating the uterus with vacuum sources is increasingly referred to as an aspiration method rather than a surgical method.

Methods of treatment for termination of pregnancy, or for treatment of incomplete abortion and miscarriage (TiAM) that involve the administration of medications (pharmacological agents) are often referred to as medical methods. Medications used for termination of pregnancy interfere with the continuation of pregnancy and cause uterine contractions which expel the products of conception (POC). In the case of TiAM, medical treatment with misoprostol assists in uterine contractions and cervical dilatation resulting in uterine evacuation.

According to the World Health Organization (WHO) in the 2012 Safe Abortion: Technical and Policy Guidance for Health Systems (Second Edition), vacuum aspiration and medication abortion are preferred over sharp curettage for uterine evacuation in the first trimester. However, many settings still use the sharp-curettage method.

The WHO guidelines state that since sharp curettage carries greater risk, it should be used only when vacuum aspiration and medication abortion are not available. Therefore, health managers should make all possible efforts to replace sharp curettage with vacuum aspiration or medication abortion.

Medication abortion has become more widely available using safe protocols based on various research trials. The most effective regimens in the first trimester work up to nine weeks from the last menstrual period (LMP). Researchers continue to study the optimal mechanisms, protocols, client eligibility and dosages. Back-up services, preferably vacuum aspiration, are required in the event of a failed medication abortion.

In the second trimester, there are a few methods used for uterine evacuation. The preferred methods for any length of pregnancy in the second trimester are:

- Dilatation and evacuation (D&E), which uses a combination of medical or mechanical dilatation of the cervix, vacuum aspiration and forceps, or
- Medication abortion using the administration of mifepristone followed by repeated doses of misoprostol. In some settings, misoprostol alone is safely used, but with lower efficacy than the combined regimen.

Many different types of health-care professionals can perform or assist with uterine evacuation. Pre- or in-service training provides an opportunity for healthcare workers to achieve clinical competence in this skill.

This section provides a brief overview of the first-trimester uterine-evacuation methods used in abortion-care settings. When available, information is included on clinical safety and effectiveness, cost, acceptability to women, and specific risks and side effects associated with each method. Although sharp curettage is not recommended, a description of the technique is included because it is still used in many settings.

2.0 Uterine Evacuation Methods

2.1 Vacuum Aspiration

Vacuum aspiration is considered an essential service by many national and international authorities. WHO and the International Federation of Gynecology and Obstetrics (FIGO) issued a joint statement in 1997 declaring: "Properly equipped hospitals should...adopt the aspiration method [of uterine evacuation], selecting manual vacuum and/or electric vacuum according to the expertise available" (FIGO/WHO Task Force, 1997).
Description
Vacuum aspiration is a method by which the contents of the uterus are evacuated through a plastic or metal cannula that is attached to a vacuum source. The primary difference between vacuum-aspiration options is the source of the vacuum. Manual vacuum aspiration (MVA) uses a hand-held, portable aspirator, whereas electric vacuum aspiration (EVA) employs an electric pump. Although these sources provide equivalent suction at the initiation of the procedure, the level of vacuum provided by the MVA aspirator decreases as the cylinder fills with blood and tissue. An electric pump provides a continuous, constant level of suction.

In most cases, the vacuum-aspiration procedure involves dilating the woman’s cervix, inserting a cannula through the cervix into the uterine cavity, then attaching the cannula to the vacuum source. The POCs are then suctioned out. Depending on the uterine size and amount of POCs, the procedure takes from 3-10 minutes to complete.

Clinical safety and effectiveness
Vacuum aspiration is extremely effective and very safe. Most studies show that vacuum aspiration is successful in 98% to 100% of cases (Greenslade et al., 1993). The method results in few complications, especially when performed before or at 12 weeks since the LMP. Specific safety benefits of vacuum aspiration, compared to sharp curettage, include significantly reduced risk of infection, reduced risk of cervical injury or uterine perforation, reduced amount of cervical dilatation required, decreased blood loss, shortened hospital stay and reduced need for anesthesia.

Cost
Vacuum aspiration can be very cost-effective when performed on an outpatient basis in a clinic or ambulatory setting, because it requires fewer facility resources such as staff time, general anesthesia, hospital beds and operating theaters. Vacuum aspiration can result in savings to the facility that can then be passed on to the woman.

Acceptability to women
Vacuum aspiration is well-accepted by women (Bird et al., 2003; Dean et al., 2003). In most cases vacuum aspiration requires lower levels of pain management than sharp curettage. Typically a local anesthesia (paracervical block), oral analgesics, verbal -assurance and, if desired, light sedation allow women to be awake during the procedure and aware of what is happening to them. With lower levels of pain medication, abortion care can be provided in an outpatient setting, which is generally more acceptable to women than a hospital stay.

When vacuum aspiration is performed by well-trained providers, complications are rare. However, possible complications include:
- incomplete evacuation
- cervical or uterine injury, such as perforation or tearing
- anesthesia complications
- sepsis
- hemorrhage
- acute hematometra
- failed abortion

Note: In rare cases, these conditions can result in secondary infertility or other serious injury or, in some cases, death.

2.1.1 Manual Vacuum Aspiration (MVA)
In an MVA procedure, a hand-held plastic 60cc aspirator providing a vacuum source is attached to a cannula and hand-activated to suction out the uterine contents. To perform the MVA procedure, a cannula of the appropriate size, depending on uterine size, is inserted through the cervix into the uterus. The cannula is attached to a vacuum-charged aspirator. Then the vacuum is released by depressing the buttons on the aspirator. The cannula is then gently and slowly rotated while it is moved back and forth within the uterus. The aspirator serves as the source of vacuum to pull the POCs through the cannula into the cylinder. MVA is safe and effective, can be performed by trained midlevel providers and, because it does not require electricity, can be used in decentralized, rural settings with intermittent electrical supplies (Baird and Flinn, 2001). As with vacuum aspiration in general, MVA services can be provided in a clinic setting on an ambulatory, outpatient basis, requiring fewer facility resources and reducing cost of care. Particularly in settings where instruments can be reused, the cost per procedure can be relatively low. Reduced waiting times and increased local availability of care also make this an acceptable method for many women. MVA creates little noise during the procedure, which some women find preferable (Bird et al., 2001).

2.1.2 Electric Vacuum Aspiration (EVA)
EVA uses an electric pump or suction machine attached to a cannula to evacuate the uterine contents. The cannula is inserted into the uterus and then attached to the suction-machine tubing. The thumb valve on the hose is then opened
and the machine turned on. The cannula is rotated gently back and forth until all the POCs are evacuated through the hose and into a glass container at the end of the hose.

Because the initial cost of an EVA machine is high, it is typically used in centralized settings with high caseloads. EVA is less appropriate for settings with intermittent electrical supply. EVA has been found acceptable to women (Bird et al., 2001).

2.2 Medication Abortion

Description
Medication abortion uses various agents, most commonly misoprostol and mifepristone, to expel the contents of the uterus. Misoprostol is a prostaglandin analogue developed for gastrointestinal indications that also has the effect of softening the cervix and stimulating uterine contractions. It is used for labor induction and is increasingly used around the world, often in combination with mifepristone, for medication abortion. Mifepristone blocks progesterone activity in the uterus, leading to detachment of the pregnancy. Mifepristone also causes the cervix to soften and the uterus to contract.

Used in combination, these medications stimulate uterine contractions and cause expulsion of the pregnancy. Other medications that have been used for abortion include methotrexate and various other prostaglandins, but clinical evidence currently supports the combined use of misoprostol and mifepristone as the most effective and safe method.

Misoprostol alone may be useful where mifepristone is not available and studies to identify ideal regimens are ongoing. Guidance on the use of misoprostol alone may be useful to providers given the widespread use of the drug in many settings globally.

Clinical safety and effectiveness
Combined regimens using mifepristone and misoprostol through 9 weeks since the LMP have been widely studied and safely used by millions of women in many countries. Studies to date indicate that the combination of mifepristone plus misoprostol is more effective in stimulating complete abortion than either drug used alone. Research protocols for pregnancies up to and including nine weeks since the LMP report success rates up to 98% (WHO, 2012). Studies investigating the use of misoprostol alone for abortion in pregnancies up to 9 weeks LMP indicate a potential for some regimens to result in complete abortion in 85-90% of cases (Reproductive Health Technologies Project, 2003).

Most women undergoing medication abortion experience some amount of abdominal cramping and bleeding. Other possible side effects, depending on dosage and route of administration, include vomiting, nausea, diarrhea, chills and fever. Some studies suggest that misoprostol is teratogenic; therefore, once misoprostol has been taken, providers must ensure that the abortion process is completed.

Cost
The cost of a medication-abortion procedure depends on the specific clinical regimen, the technology used to monitor and confirm complete evacuation, and the cost of providing backup for re-evacuation if needed.

Acceptability to women
Studies show that medication abortion is acceptable to many women in a variety of settings, including where resources are limited. The non-invasive aspect of medication abortion, as opposed to a vacuum-aspiration procedure, is often cited as a significant benefit. Some women also perceive medication abortion as a more private and natural method.
THE RECOMMENDED METHOD FOR MEDICAL ABORTION IS MIFEPRISTONE FOLLOWED BY MISOPROSTOL

**For pregnancies of gestational age up to 9 weeks (63 days)**
- 200 mg mifepristone administered orally.
- Administration of misoprostol is recommended 1-2 days (24-48 hours) following ingestion of mifepristone.
- For vaginal, buccal or sublingual routes, the recommended dose of misoprostol is 800 mcg.
- For oral administration, the recommended dose of misoprostol is 400 mcg.
- With gestations up to 7 weeks (49 days) misoprostol may be administered by vaginal, buccal, sublingual or oral routes. After 7 weeks of gestation, oral administration of misoprostol should not be used.
- With gestations up to 9 weeks (63 days) misoprostol can be administered by vaginal, buccal or sublingual routes.

**For pregnancies of gestational age 9-12 weeks (63-84 days)**
- 200 mg mifepristone administered orally, followed after 36 to 48 hours by:
- 800 mcg vaginal misoprostol, administered in a health-care facility. A maximum of hour further doses of misoprostol 400 mcg may be administered at 3-hourly intervals, vaginally or sublingually.

**For pregnancies of gestational age over 12 weeks (>84 days)**
- 200 mg mifepristone administered orally, followed after 36 to 48 hours by:
- 400 mcg oral or 800 mcg vaginal misoprostol followed by 400 mcg vaginal or sublingual misoprostol every 3 hours up to a maximum of five doses, administered in a health-care facility. For pregnancies of gestational age greater than 24 weeks, the dose of misoprostol should be reduced due to the greater sensitivity of the uterus to prostaglandins, but the lack of clinical studies precludes specific dosing recommendations.

**Where mifepristone is not available**

**For pregnancies of gestational age up to 12 weeks (84 days)**
- The recommended method of medical abortion is 800 mcg of misoprostol administered by vaginal or sublingual routes. Up to three repeat doses of 800 mcg can be administered at intervals of at least 3 hours, but for no longer than 12 hours.

**For pregnancies of gestational age over 12 weeks (>84 days)**
- The recommended method of medical abortion is 400 mcg of misoprostol administered vaginally or sublingually, repeated every 3 hours for up to five doses.


### 2.2.3 Treatment of incomplete abortion and miscarriage with misoprostol

Misoprostol is included in the WHO Essential Medicines List as well as Priority Medicines List for Mothers and Children for the treatment of incomplete abortion and miscarriage (WHO 2010, WHO 2012), and is one of the two WHO recommended treatment methods for incomplete abortion along with vacuum aspiration. It has been shown to be as effective as manual vacuum aspiration (MVA) in treating incomplete abortion (Ipas and VSI, 2011), and the WHO approved its use for this indication up to uterine size of 13 weeks gestation (WHO 2012). The WHO regimen is 600 mcg oral, but studies have also shown similar efficacy with 400 mcg sublingual dose (Ipas and VSI, 2011).

Misoprostol is a prostaglandin-E1 analogue and causes uterine contractions and cervical dilatation. It is a heat-stable tablet with an excellent safety profile and effective for treating incomplete abortion and miscarriage. As a safe, affordable, easy to use and heat-stable uterotonic, misoprostol has been used for obstetric and gynecologic uses. The following table summarizes the misoprostol regimens for uterine evacuation for different conditions.

| Table: Misoprostol Recommended Regimens for Uterine Evacuation for Different Conditions |
|-----------------------------------------------|---------------------------------|---------------------------------|
| Incomplete abortion and miscarriage          | Misoprostol dose                | Route                           | Timing                                        |
|                                               | 600 mcg                         | Oral                            | Three 200 mcg tablets taken at once (single dose) |
| OR                                             | 400 mcg                         | Sublingual                      | Two 200 mcg tablets under the tongue until they dissolve or for 30 minutes; swallow any remaining fragments. (Single dose) |

<p>| COMPREHENSIVE POST ABORTION CARE REFERENCE MANUAL |</p>
<table>
<thead>
<tr>
<th>Missed abortion/ anembryonic gestation</th>
<th>800 mcg</th>
<th>Vaginal</th>
<th>3 hourly (max x2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR</td>
<td>600 mcg</td>
<td>Sublingual</td>
<td>3 hourly (max x2)</td>
</tr>
<tr>
<td>Termination of pregnancy up to 12 weeks</td>
<td>800 mcg</td>
<td>Vaginal or Sublingual</td>
<td>Every 3-12 hours, up to 3 doses</td>
</tr>
<tr>
<td>Intrauterine foetal death 13-17 weeks</td>
<td>200 mcg</td>
<td>Vaginal</td>
<td>Every 6 hours (max x4)</td>
</tr>
<tr>
<td>Intrauterine foetal death 18-26 weeks</td>
<td>100 mcg</td>
<td>Vaginal</td>
<td>Every 6 hours (max x4)</td>
</tr>
<tr>
<td>Intrauterine foetal death 27-43 weeks</td>
<td>25-50 mcg</td>
<td>Vaginal</td>
<td>Every 4 hours (max x6)</td>
</tr>
</tbody>
</table>

Adapted from:

Criteria for the Selection of the Method for Treatment of Incomplete Abortion and Miscarriage

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Misoprostol</th>
<th>Vacuum aspiration (MVA or EVA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncomplicated case of incomplete abortion, uterine size ≤13 weeks</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Uncomplicated case of incomplete abortion, uterine size &gt;13 weeks</td>
<td>Can be used, if other methods are not available*</td>
<td>YES</td>
</tr>
<tr>
<td>Women admitting with:</td>
<td>VA or other surgical methods should be the first choice</td>
<td>YES</td>
</tr>
<tr>
<td>+ Hemodynamic instability or shock</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Signs of sepsis or active pelvic inflammatory disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Known severe allergy to misoprostol or other prostaglandins</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Confirmed or suspected ectopic pregnancy</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Women who are breast feeding</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>IUD in place</td>
<td>Remove before giving misoprostol</td>
<td>Remove before the procedure</td>
</tr>
<tr>
<td>Hemorrhagic disorder or current anti-coagulant therapy</td>
<td>If misoprostol is used, monitor closely</td>
<td>VA is preferred, monitor closely</td>
</tr>
<tr>
<td>Severe anemia</td>
<td>Monitor closely</td>
<td>YES</td>
</tr>
<tr>
<td>Women with HIV</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

* In addition, oxytocin or dilatation and evacuation can be used for larger uterine size.

2.3 Sharp Curettage

Description
Sharp curettage, also known as dilatation and curettage (D&C), involves dilating the cervix and using a sharp metal curette to scrape the uterine walls. During the procedure, the woman usually receives general or regional anesthesia or heavy to light sedation.

Clinical safety and effectiveness
Sharp curettage typically has higher rates of major complications than vacuum aspiration, including excessive blood loss, pelvic infection, cervical injury and uterine perforation.

Cost
Sharp curettage is typically performed in an operating theater, under general anesthesia, and involves a hospital stay, all factors that increase the cost of care.
Acceptability to women
The higher doses of pain medication typically used with sharp curettage, including general anesthesia, often necessitate longer and costlier hospital or clinic stays that may be less acceptable to women. The higher risks associated with this method also make it less preferable.

Potential side effects of all uterine evacuation procedures are:
• abdominal cramping
• mild to moderate nausea
• vomiting
• pain
• menstrual-like bleeding
CHAPTER 6

MVA PROCEDURE

1. **Introduction**
   Before beginning, it is important that the provider confirm the uterine size and position to ensure that MVA is the most appropriate method for uterine evacuation. Large fibroids or uterine anomalies may make it difficult to determine the size of the uterus and to perform intrauterine procedures, including MVA. Therefore, providers should be well trained in determining length of pregnancy prior to using MVA.

2. **Steps for Performing MVA**
   1. Prepare instruments
   2. Prepare the woman
   3. Perform cervical antiseptic prep
   4. Perform para-cervical block
   5. Dilate cervix
   6. Insert cannula
   7. Suction uterine contents
   8. Inspect tissue
   9. Perform any concurrent procedures
   10. Take immediate post-procedure steps, including instrument processing

**Step 1: Prepare instruments**
The provider should check the aspirator for vacuum retention before beginning the MVA procedure, and then create a vacuum for evacuation during the procedure.

When the uterine contents are likely to be copious, as in cases of hydatidiform mole, it can be helpful to have more than one MVA aspiration device ready for use. Where resources permit, it is always a good idea to have a back-up aspirator readily available, not just for the purpose expressed above but also in case the first aspirator has technical problems. Alternately, the provider should be prepared to quickly empty and recharge one MVA aspirator, as needed.

**Step 2: Prepare the woman**
Ask the woman to empty her bladder. Carefully help the woman onto the procedure table and ensure that she is securely positioned and that she has given permission to start the procedure.

Wash hands and put on appropriate barriers, including gloves.

Perform a bimanual examination to confirm or update findings of the earlier clinical assessment. It is crucial to have an accurate assessment of uterine size and position before performing a uterine evacuation. If there is doubt about the uterine size but the provider must continue with the procedure, the pregnancy should be treated as if it is further advanced than was initially suspected. Next, insert the speculum.

**Step 3: Perform cervical antiseptic prep**
Following the "no-touch technique" throughout, the provider should use an antiseptic-soaked sponge to clean the cervical os and, if desired, the vaginal walls. With each new sponge, start at the os and spiral outward. Continue until the os has been completely covered by antiseptic. Do not clean the cervix with the same gauze used for cleaning the vagina.

**Step 4: Perform paracervical block**
In clinical practice, techniques for administering the paracervical block vary and are subject to provider preference. The following technique, with minor variations, has been used widely. To minimize clinical risk, use the lowest anesthetic dose possible, usually 10 to 20 mL of 0.5-1% lidocaine solution (Wiebe et al., 1996). When using lidocaine, the recommended dose is less than 200 mg/person, as toxicity occurs at that level.

After inserting the needle but before injecting any local anesthetic, always draw the plunger back slightly to ensure that the needle is not penetrating a blood vessel. If any blood is visible in the syringe, do not inject. Instead, move to a different injection site, and aspirate again before injecting.
Steps for Administering Paracervical Block:
- Inject 1 to 2mL of anesthetic at the site where the tenaculum will be placed (usually 6 or 12 o’clock on the face of the cervix).
- Next, place the tenaculum at the anesthetized site. Use slight traction to move the cervix and define the transition of smooth cervical epithelium to vaginal tissue. This transition marks the site of further injections around the cervix. Compared to cervical tissue, vaginal mucosa is more elastic and appears folded.
- Inject 2 to 5mL of lidocaine into each injection site at 2, 5, 7 and 11 o’clock. In addition, some clinicians inject at 11 and 1 o’clock. Other clinicians choose to inject only at 12, 4 and 8 o’clock. Inject to a depth of 2.5 to 3.8cm (1 to 1.5 inches), using a slow technique to decrease any pain to the woman.

Whether or Not to Give Paracervical Block
When mechanical dilatation is required in an MVA procedure, it is recommended that providers administer a paracervical block. Any time a cannula is passed through the os, it causes friction and irritation of the nerves in the cervical canal, which may produce pain. Pain is also produced when the uterus contracts after the uterine evacuation.

Step 5: Dilate cervix
Cervical dilatation is required in most, but not all, cases. Dilatation is not needed when the cervix allows a cannula of appropriate size to fit snugly through the os. However, cervical dilatation is an essential step if the cervix is closed or is not yet sufficiently dilated.

It is essential to carefully examine the position of the uterus and cervix and to gently use instruments that accommodate the woman’s anatomy. Dilate the cervix as necessary to allow a cannula approximate to the uterine size to fit snugly through the os. The provider should dilate gently, never using force. Use mechanical dilators or progressively larger MVA cannulae, being careful not to tear the cervix or create a false opening. Uterine perforation can occur, particularly if the provider miscalculates the position, size and depth of the cervix and uterus or uses force to insert instruments. Dilatation or cervical preparation may also be accomplished by administering osmotic dilators or pharmacological agents such as misoprostol, where available.

Step 6: Insert cannula
While gently applying traction to the cervix, insert the cannula through the cervix, just past the cervical os and into the uterine cavity. Alternately, move the cannula slowly into the uterine cavity until it touches the fundus, and then withdraw it slightly. Rotating the cannula while gently applying pressure often helps insertion. Do not insert the cannula forcefully through the cervical os into the uterus. Forceful movements may cause damage to the cervix or uterine perforation and damage to pelvic organs and blood vessels. Remain alert to signs that may indicate perforation throughout the procedure, and stop suction immediately if they appear.

Step 7: Suction uterine contents
Attach the prepared MVA aspirator to the cannula, holding the tenaculum and the end of the cannula in one hand and the aspirator in the other hand. Suction is started by pressing the buttons in; suction will start immediately. Evacuate the contents of the uterus by gently and slowly rotating the cannula 180 degrees in each direction, using an in-and-out motion. Blood and tissue will be visible entering the cylinder of the aspiration device through the cannula. It is important not to withdraw the opening of the cannula beyond the cervical os, as this will cause the vacuum to be lost. If this happens, or if the aspirator is full, detach cannula from aspirator and re-establish the vacuum. Be aware that Ipsas EasyGrip® cannulae fit firmly into the valve body and care should be used when disconnecting a cannula from the aspirator.

The following signs indicate that the uterus is empty:
- Red or pink foam appears and no more tissue is seen passing through the cannula
- A gritty sensation is felt as the cannula passes over the surface of the evacuated uterus
- The uterus contracts around (grips) the cannula
- The woman complains of cramping or pain, indicating that the uterus is contracting

When the procedure is finished, depress the buttons and disconnect the cannula from the aspirator. The wings can aid in this action. Alternately, carefully withdraw the cannula and aspirator together without depressing the buttons. Keep the instruments available in case re-aspiration is required.

Step 8: Inspect tissue
Empty the contents of the aspirator into an appropriate container by removing the cannula, if still connected, releasing the buttons, if not depressed, and gently pushing the plunger completely into the cylinder. Do not push aspirated contents through the cannula, as it will become contaminated. Keep the instruments ready in case further suction is required.

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Inspect the tissue for these signs:
- The quantity and presence of products of conception (POC)
- Complete evacuation
- Molar pregnancy

If the visual inspection is not conclusive, the material should be strained, immersed in water or vinegar, and viewed with light from beneath. If indicated, tissue specimen may also be sent to a pathology laboratory.

Villi and decidua should be visible in the tissue and the amount of tissue should correspond to the uterine size. In cases of molar pregnancy, grape-like chorionic villi are usually seen. If no POCs are visible, less tissue than expected was removed from the uterus or the tissue sample is inconclusive, this may indicate:
- Incomplete evacuation: The uterine cavity still contains POCs, even though it appeared to be empty at the end of the procedure. This may result from using a cannula that is too small or stopping the procedure prematurely.
- A spontaneous abortion that has already completed itself.
- A failed abortion.
- Suspected ectopic pregnancy: When no villi or decidua are seen, ectopic pregnancy is a possibility and should be followed up on immediately.
- Anatomical anomaly: For example, in a bicornuate or septate uterus, the cannula may have been inserted into the side of the uterus that did not contain the pregnancy.

If it appears after tissue inspection that tissue may still be present in the uterus, re-evacuate the uterus. Wipe the cervix clear with a clean swab to assess the amount of blood still coming from the uterus or any other source before removing the speculum. If significant bleeding continues or other issues are identified, the provider should intervene as needed.

Step 9: Perform any concurrent procedures
When the MVA procedure is complete, proceed with any contraceptive or other concurrent procedures to be conducted, such as inserting an IUD if not contraindicated, or repairing a cervical tear.

Step 10: Take immediate post-procedure steps, including instrument processing
When the uterine evacuation and any additional procedures are complete, providers should take the following steps:
- Immediately process or discard all instruments, including the aspirator and cannula, according to instrument processing procedures.
- Remove barriers, such as gloves, and wash hands.
- Reassure the woman that the procedure is finished.
- Help her into a comfortable resting position on the table.
- Assist with moving her to the recovery area.
- Record information about the procedure, according to local protocol.

3. Solving Instrument Technical Problems
In most MVA procedures, the aspirator vacuum remains constant until the aspirator is approximately 80%, or 50mL full. However, a decrease in vacuum may occur before the aspiration is complete for the following reasons: the aspirator is full, the cannula is withdrawn past the os prematurely, the cannula is clogged or there is a loss of vacuum due to incorrect assembly.

Aspirator is full
If the cylinder fills up so that suction stops, depress the buttons and detach the aspirator from the cannula. The cannula should be left in its current position, inserted through the cervical os. Empty the aspirator into a container by releasing the buttons, squeezing the plunger arms and pushing the plunger forward.

After re-establishing a vacuum in the aspirator, reconnect it to the cannula, release the buttons and resume the aspiration. Many providers keep a second aspirator readily available during an MVA procedure and switch aspirators if the first one becomes full.

Cannula is withdrawn prematurely
If the aperture of the cannula is accidentally withdrawn from the uterus beyond the external os into the vaginal canal, remove the cannula, being careful not to contaminate it through contact with the vaginal walls or other non-sterile surface.

Detach the aspirator from the cannula, empty it and then reestablish a vacuum in the aspirator. If the cannula has not been contaminated, it can be reinserted. If contamination has occurred, another sterile or HgH Level Disinfected HLD cannula should be inserted using no-touch technique. Reconnect the aspirator, release the valve and continue aspiration.
Cannula is clogged
If the cannula becomes clogged, ease it back toward, but not through, the external os of the cervix. This movement will often unplug the cannula.

Alternately, depress the buttons, close the valve on the aspirator and withdraw the cannula from the uterus or remove the cannula without depressing the buttons. Remove the tissue with sterile or HLD forceps. If necessary, reinsert the cannula using no-touch technique, reattach the aspirator and continue the procedure. Never try to unplug the cannula by pushing the plunger back into the cylinder while the cannula is in the uterus.

Aspirator loses vacuum
If the aspirator does not seem to hold a vacuum at all, reassemble and test the vacuum of the instrument. Incorrect assembly is likely to cause loss of vacuum.

4. Uses of Ipas MVA Plus® Aspirator and Ipas EasyGrip® Cannulae
All Ipas aspirators and cannulae up to 12mm are intended for uterine evacuation/uterine aspiration in obstetrics and gynecology clients. Clinical indications for uterine aspiration with this product are: treatment of incomplete abortion for uterine sizes up to 12 weeks since the last menstrual period (LMP), first-trimester abortion (menstrual regulation) and endometrial biopsy.

4.1 Contraindications, Warnings and Precautions
Endometrial biopsy should not be performed in cases of suspected pregnancy. There are no known contraindications for other clinical indications.

As with any uterine evacuation procedure, one or more of the following may occur during or after an MVA procedure:
- vaginal reaction,
- incomplete evacuation,
- uterine or cervical injury or perforation,
- pelvic infection or
- acute hematometra.

Rarely, some of these conditions can lead to secondary infertility, serious injury or death. Any life-threatening conditions that are present when a woman seeks care should be addressed immediately. These include:
- shock,
- hemorrhage,
- cervical or pelvic infection,
- sepsis,
- perforation or abdominal injury, as may occur with incomplete abortion or with clandestine abortion.

Uterine evacuation is an important component of definitive management in these cases and once the woman is stabilized, the procedure should not be delayed. History of blood dyscrasia may be a factor in the woman's care.

The provider should not perform uterine evacuation until the size and position of the uterus and cervix have been determined. Large fibroids or uterine anomalies may make it difficult to determine the size of the uterus and hard to perform intrauterine procedures, including MVA.

It is important to use a cannula size appropriate to the size of the uterus and amount of cervical dilation present. Using a cannula that is too small may result in retained tissue or loss of suction. Following are the ranges of suggested cannula sizes relative to uterine size for MVA

Uterine size 4–6 weeks since the LMP: 4–7mm cannula
Uterine size 7–9 weeks since the LMP: 5–10mm cannula
Uterine size 9–12 weeks since the LMP: 8–12mm cannula
CHAPTER 7
PROCESSING IPAS INSTRUMENTS

1. Introduction
With the worldwide increase of infectious agents such as the human immunodeficiency virus (HIV), hepatitis B (HBV) and other infectious microorganisms that can be transmitted in a clinical setting, health workers must be vigilant about protecting their clients, themselves, their families and their communities. Many of these microorganisms live in blood, other body fluids and excretions and on body surfaces, and they can continue to live on every item that they come in contact with, including instruments used for MVA procedures.

Microorganisms that can live on medical instruments include endospores and bacteria, which have a hard outer coating and are difficult to destroy.

As mentioned previously, Ipas aspirators are multiple-use devices. Unless stated by the manufacturer, these cannulae are reusable after undergoing sterilization or high-level disinfection.

The four basic steps for processing contaminated Ipas MVA Plus® aspirators and Ipas EasyGrip® cannulae are:
• Decontamination soak
• Cleaning
• Sterilization or high-level disinfection
• Storage

2. Standard Precautions
It is important to follow standard precautions for infection prevention when processing instruments. Even following a decontamination soak, instruments will retain harmful microorganisms.
• Always wear gloves when handling blood or other body fluids.
• Use personal protective barriers, such as gowns or face protection, when a given part of the body may be exposed to blood or other body fluids.
• Consider all blood and other body fluids from every person to be infectious.
• Guard against skin punctures from sharp instruments.
• Wash hands immediately before and after contact with contaminated items, even if gloves were worn.

Note: Glutaraldehyde and chlorine are hazardous substances. If processing instruments, or for environmental use, take necessary precautions such as using personal protective equipment. Refer to the manufacturer’s safety instructions to establish safe use.

3. Decontamination Soak
Following the procedure, all instruments to be reused should be kept wet until they can be cleaned. A 0.5% chlorine solution can be used. Soaking instruments immediately after use removes some material and makes them easier to clean by preventing material from drying on them. For easy accessibility, the container used for the decontamination soak should be kept close to the procedure area—for example, on the bottom shelf of the instrument trolley. Soaking in a disinfectant, however, does not make items safe to handle with bare hands. It is essential to wear gloves and face protection.

3.1 Steps in Soaking
1. Fill a plastic container with solution. A 0.5% chlorine solution can be used.
2. Wearing gloves, submerge the cannula and aspirator completely. Make sure to draw the solution into the aspirator and cannula.
3. Soak instruments until ready to clean.
4. Use gloves or forceps when removing instruments from the solution.

If the cannula will not be reused, dispose it off and other infectious waste appropriately.

Caution: Do not let the instruments dry before cleaning as this may make it difficult to completely remove all contaminants.

4.0 Disassembly of Ipas Instruments
Ipas aspirators must be disassembled for processing, and they must be correctly assembled after processing in order to function properly.
To disassemble the Ipas MVA Plus® aspirator:
1. Pull the cylinder out of the valve.
2. Press down the cap-release tabs to remove the cap. Then open the hinged valve by pulling open the clasp and remove the valve liner.
3. Disengage the collar stop by sliding it sideways under the retaining clip or removing it completely from the cylinder.
4. Pull the plunger completely out of the cylinder.
5. Displace the O-ring from the plunger by squeezing the sides of the O-ring and rolling it down into the groove below. It is not necessary to completely remove it.

5. Cleaning
Because it does not come into contact with the client, the Ipas MVA Plus® aspirator can be used after cleaning. However, if desired, it can also be high level disinfected or sterilized. Cannulae must be sterile or HLD when used.

5.1 Steps in Cleaning
Disassemble instruments before cleaning.
1. Remove remaining tissue or blood by washing all surfaces thoroughly in water and detergent or soap. Detergent is preferable, as soap may leave a sticky residue. If tissue or dried blood is trapped inside the cannula, flush water through the cannula repeatedly or use a cotton-tipped probe or soft cloth to remove material.
2. Clean the crevices and interior of the cylinder, valve parts and plunger using a soft-bristle brush, being careful not to splash.
3. Clean each item until no tissue or blood is visible upon careful inspection, then rinse.
   - Allow items to dry.

Caution: Do not use any pointed or sharp objects to clean the valve or to move the O-ring. This could damage the valve liner or the O-ring and prevent the device from maintaining vacuum.

6. Sterilization and High-Level Disinfection
Sterilization or high-level disinfection of instruments further inactivates microorganisms. Sterilization effectively eliminates all microorganisms, including endospores. High-level disinfection eliminates all microorganisms except endospores.

For any sterilization or high-level disinfection process to be effective, physical cleaning to remove all visible traces of soil is required.

Because it does not come into direct contact with the woman, the aspirator can be used after cleaning. However, steam sterilization at 121°C (250°F) or high level disinfection can be used to process the aspirator in the same way as the other gynecological instruments, such as the speculum, tenaculum and Ipas EasyGrip® cannulae. If using the aspirator after cleaning, it should not be placed where it might come into contact with other instruments that have been sterilized or high-level disinfected.

6.1 Ipas cannulae must be sterile or HLD at the time of use.
High-level disinfection or sterilization according to one of the options below is required to reuse Ipas cannulae and can also be done for aspirators.
   - Steam autoclave instruments at 121°C (250°F) with a pressure of 106kPa (15 lbs/in2) for 30 minutes.

Note: Ipas Double-Valve and Single-Valve aspirators and flexible Karman cannulae will crack or melt if autoclaved.

   - Sterilizing using glutaraldehyde. Soak the clean instruments in glutaraldehyde (Cidex or a similar product) for 10 hours. Follow the manufacturer’s recommendations for the product used. (All Ipas aspirators can withstand glutaraldehyde processing.)
   - High-level disinfecting using glutaraldehyde. Soak the clean instruments in glutaraldehyde (Cidex or a similar product) for 20 minutes. Follow manufacturer’s recommendations for the product used.
   - High-level disinfecting using a 0.5% chlorine solution. Soak the clean instruments in a 0.5% chlorine solution for 20 minutes.
   - High-level disinfecting by boiling. Place the clean instruments in water at a rolling boil for 20 minutes.

Note: The Ipas MVA Plus® aspirator, Ipas EasyGrip® cannulae and flexible Karman cannulae can be boiled; however, Ipas Double-Valve and Single-Valve aspirators can crack or melt if boiled.

6.1.1 Steps to Sterilize Using Steam Autoclave
1. All parts of the Itpas MWA Plus® aspirator and Itpas EasyGrip® cannulae can be steam sterilized at 121°C (250°F). Parts should not touch each other and the collar stop should be completely removed from the cylinder. Arrange the instruments without obstructing apertures or the opening at the base end of the cannulae to allow drainage.

2. Since the cannulae, particularly the smaller sizes, may curve in a steam autoclave, package them in paper or linen. Place the clean Itpas EasyGrip® cannulae and the Itpas MWA Plus® aspirator in a single layer in a steam autoclave. Note that steam sterilizing unwrapped Itpas EasyGrip® cannulae for 30 minutes may result in slight curvature.

3. Process instruments in the steam autoclave for 30 minutes at 121°C (250°F).

4. Cool all instruments before using.

Caution: Do not use temperature settings over 121°C (250°F). Specifically, do not use higher temperature settings for shorter periods of time (known as "flash" autoclaving), as this may damage the instruments. Be sure that the autoclave is set to the correct parameters before autoclaving.

6.1.2 Steps to Sterilize Using Glutaraldehyde
1. Completely immerse the instruments so that the solution fills them completely.
2. Soak in glutaraldehyde solution for the time recommended by the manufacturer—for example, 10 hours for Cidex.
3. Remove with sterile gloves or forceps.
4. Rinse all parts with sterile water. Do not use tap water to rinse.
5. Dry with a sterile cloth.
6. Change the solution according to the manufacturer's instructions. Generally, glutaraldehyde has a 14-day shelf-life after being activated, but it should be discarded sooner if the solution becomes cloudy. Do not use below 25°C (77°F).
7. Once instruments have been sterilized, anything that subsequently comes in contact with them must also be sterile, for example, gloves or a storage container.

6.1.3 Steps to High-Level Disinfect Using Glutaraldehyde
1. Completely immerse the instruments so that the solution fills them completely.
2. Soak in gluteraldehyde solution for the time recommended by the manufacturer—for example, 20 minutes for Cidex.
3. Remove from solution using sterile gloves or forceps.
4. Rinse all parts with sterile or boiled water.
5. Dry with a sterile cloth.
6. Change the solution according to manufacturer's instructions—every 14 days or sooner if the solution becomes cloudy.

6.1.4 Steps to High-Level Disinfect Using a 0.5% Chlorine Soak
1. Completely immerse instruments so that the solution fills them completely. Use a plastic (non-metal) container.
2. Soak in a 0.5% chlorine solution for 20 minutes.
3. Remove from solution using sterile gloves or forceps.
4. Rinse all parts with sterile or boiled water.
5. Dry with a sterile cloth. Chlorine solution should be changed daily or sooner if it becomes cloudy.

6.1.5 Steps to High-Level Disinfect by Boiling
1. Place the instruments in water at a rolling boil. Items do not need to be fully immersed.
2. Boil for 20 minutes.
3. Remove using sterile gloves or forceps.
4. Dry with a sterile cloth.
5. Cool before use. Handle the cannulae by the base ends when removing.

Grasping hot instruments may cause flattening. The boiling process may discolor cannulae without affecting their function.

In addition to these options for sterilization and high-level disinfection, Itpas EasyGrip® cannulae can be sterilized with ethylene oxide (ETO). The Itpas MWA Plus® aspirator should not be processed with this method. Do not boil Itpas Single-Valve or Double-Valve aspirators.
6.1.6 Assembly and Lubrication of the Aspirator
Aspirators should be reassembled after processing and the plunger O-ring should be lubricated. They must be correctly assembled after processing in order to function properly. To assemble the Ipas MVA Plus® aspirator:
1. Place the valve liner in position inside the valve by aligning the internal ridges.
   Close the valve until it snaps in place.
2. Snap the cap into place on the end of the valve.
3. Push the cylinder into the base of the valve.
4. Place the plunger O-ring in the groove at the end of the plunger and lubricate it by spreading one drop of lubricant around the O-ring with a fingertip. Silicone, which is not sterile, is provided with the aspirator; other non-petroleum-based lubricants can also be used.

**Caution: Excessive lubrication can cause the aspirator to lose vacuum. Do not over-lubricate the plunger O-ring. Do not lubricate other parts of the aspirator.**

5. When reassembling the aspirator, ensure that the plunger is introduced straight into the cylinder and not introduced at an angle.
6. Squeeze the plunger arms and fully insert the plunger into the cylinder.
7. Move the plunger in and out to lubricate the cylinder.
8. Insert the tabs of the collar stop into the holes in the cylinder so that the plunger cannot be pulled out of the cylinder.
   Always check that the aspirator retains a vacuum before using it.

6.1.7 Storage of Instruments
Store instruments in an environment that preserves the level of processing desired. Once instruments have been processed, the challenge is to ensure that they are not re-contaminated during storage or handling. It is very important to maintain sterility or high-level disinfection of instruments until the actual time of use. After an instrument has been processed, it remains only as clean as the last item with which it came in contact. Instruments should be kept in dry, covered, HLD or sterile containers with tight-fitting lids, protected from dust and other contaminants. Ideally, instruments that have been processed by wet methods—such as soaking in glutaraldehyde or chlorine or boiling in water—should be used daily. If they are not used in that time period, they should be reprocessed. Items that have been processed using wet methods are more prone to microbial growth; there is often no efficient way to dry items that have been processed by wet methods. Reaching into storage containers repeatedly using transfer forceps also invites contamination.

6.1.8 Disposal and Replacement
Dispose of contaminated Ipas aspirators and cannulae as infectious waste.
If any of the following have occurred, the instruments should be discarded and replaced:

**Aspirators:**
- Cylinder has become cracked or brittle
- Valve parts have become cracked, bent or broken
- Buttons have broken
- Plunger arms no longer lock
- Aspirator no longer holds a vacuum
- Mineral deposits inhibit the plunger movement

**Cannulae:**
- Cannula has become brittle
- Cannula has become cracked, twisted or bent, particularly around the aperture
- Tissue cannot be removed during the cleaning process
CHAPTER 8
POST PROCEDURE CARE

Post-procedure care comprises all services provided to the woman after her medical procedures are complete but before she is released from the facility. It is necessary to ensure that any complications that occur during or immediately after medical care are identified and addressed. In addition, post-procedure care provides an opportunity for the woman to obtain information about how to identify and seek treatment for complications that could arise after she has left the facility.

MONITORING POST PROCEDURE

The purpose of monitoring is to:

- Ensure adequate recovery from the procedure as well as from peri-operative medications
- Detect and manage symptoms of post-procedure complications
- Provide counseling and referral for other reproductive-health needs, including contraceptive counseling and services
- Provide information about what to expect and what to do following discharge from the facility.

1. Physical Monitoring

Immediately after the uterine-aspiration procedure has been completed, the woman should be allowed to rest and continue recovery while being monitored. The length of recovery period will vary depending on the woman's condition, the ease of the procedure, the types of pain medication administered and any other procedures performed. The patient should be monitored by:

- Evaluating and monitoring level of conscious as it can be a sign of shock
- Monitor vitals signs until her vital signs return to normal
- If anaemia is suspected or has been diagnosed, the provider should discuss dietary recommendations and nutritional supplements with the woman. Treatments for anaemia include iron tablets and iron-rich foods such as green, leafy vegetables and red meat.
- Rh – Immunoglobulin: administer according to protocol

If any of the following symptoms are observed during the post-procedure period, the woman will either need to receive, or be referred for, immediate medical treatment:

- Significant physical decline as reflected in vital signs or physiological status.
- Dizziness, shortness of breath or fainting. These symptoms may be caused by internal or external blood loss. Fainting may also be due to anxiety or to a transient vagal reaction.
- Severe vaginal bleeding. While some post-procedure bleeding is expected, the amount of bleeding should decrease over time. Excessive bleeding may be a sign of retained POC, the lack of normal uterine tone, cervical laceration or other complications.
- Severe abdominal pain or cramps. Although some post-procedure cramping is normal, the severity of cramping should decrease over time. Severe, prolonged cramping may be a sign of uterine perforation or post abortion hematometra, which is a pooling of blood in the uterus that can occur following uterine evacuation. Post abortion hematometra can present either immediately following the procedure or several days later.

The woman should be given clear instructions about how to monitor her own health status once she leaves the facility. She should be given information on the signs of a normal recovery, as well as on behaviors and activities that may place her at higher risk for complications. She needs to be informed about the signs and symptoms of potential problems
and where she should seek treatment, including the location and hours of facilities where treatment can be obtained. With the woman's consent, the provider should also give information to her partner, other supportive family member or companion so they can help her monitor her health and seek treatment for any problems.

Women may wish to obtain more information and referral resources for various aspects of their sexual and reproductive health, such as testing for STIs and HIV/AIDS, screening for cervical cancer or counseling for violence. While the follow-up appointment is an opportune time to provide health education and referral on these topics, if women are interested in this information and it is available, it can be provided during post-procedure care.

1. A. Pain management.
Some pains are normal following even uncomplicated procedure because the uterus is contracting. Pain that increases over time requires clinical evaluation.

Mild analgesics such as paracetamol or NSAIDs as ibuprofen help relieve cramping pain. Narcotics are usually not that necessary. If narcotics or other strong medications were given before, during or after the uterine evacuation procedure, closer monitoring may be necessary depending on the route, dose and type of drug given.

1. B. Provision of antibiotics
Every woman with abortion should be given prophylactic antibiotics: amoxicillin and metronidazole if allergic to amoxicillin give erythromycin but in case of septic abortion give triple antibiotics therapeutic as follow:

- Ampicillin 2g or penicillin G 2 mu 6 hourly
- Gentamycin 5mg/Kg body weight IV every 24 hours
- Metronidazole 500mg IV 8 hourly.

**Note: other antibiotics may be preferred in some situations. A complete course of antibiotics must continue for at least 7 days even if the fever has subsided.**

- Cefotaxime
- Clindamycin
- Suprapen

2. Emotional Monitoring and Support

Staff who work with women during the post-procedure period should be trained to assess and respond sensitively to each woman's emotional state, and to monitor and provide care accordingly. A woman's emotional state affects the amount of pain she experiences and her rate of recovery. When a woman receives emotional support as an integral part of her medical care, she is better able to understand and accept her medical condition, the recommended care and possible health outcomes.

Studies have shown that when health-care staff demonstrate empathy and employ effective communication skills, clients are more satisfied with their health care (Murphy, 1997). These clients are more likely to experience a better overall recovery and to seek follow-up care, if needed. The more information a woman is given before, during and after her abortion procedure, the better equipped she is to care for herself. Before discharge, the woman should be offered counseling support. The counselor can then refer her for other services, when appropriate, such as support services for women who have experienced violence.

3. Contraceptive Counseling

Contraceptive counseling should be provided during the recovery period or prior to discharge, if it has not yet been offered. The health-care worker should sensitively initiate a discussion with the woman about her desire for future childbearing in the short and long term. If the woman wishes to prevent pregnancy, the provider should ensure that she receives the contraceptive method of her choice before leaving the facility or that she knows where to get her desired method at a follow-up appointment. If the woman desires a method that is not clinically appropriate at this time, she should be offered a choice of temporary methods to use in the interim.

4. Recovery and Discharge

For most women, the in-facility recovery period will last 30 minutes to an hour. For others, a longer period of recovery may be necessary. The post-sedation protocols of each site will differ, but full recovery generally means that the woman is awake, alert and able to walk without assistance, has normal vital signs, and agrees that she feels ready to leave. In
addition, she should be showing signs of normal recovery from the uterine evacuation and any other procedures e.g. slowed bleeding and decreased abdominal pain.

The woman may be discharged as soon as she is physiologically stable and has received all necessary information about her care, including discharge instructions and information about follow-up care. Policies and procedures vary, and providers should understand and follow the discharge protocols at their facility.

Prior to discharge, providers should schedule a follow-up visit according to the woman's clinical condition and facility protocols. It is preferable for the woman to receive follow-up care at the facility where she received abortion care; however, as women often travel long distances to obtain abortion services, it is sometimes necessary for them to seek follow-up care at facilities closer to their homes. If the woman plans to obtain follow-up care at another facility, the provider should ensure that she has identified a provider and that the chosen provider has relevant information about her abortion care. This can be accomplished by providing the woman with a referral form that summarizes her condition and care, or by mailing or faxing the referral form to the follow-up provider. Providers should maintain confidentiality by securing the woman's permission before sending her medical records to another provider.

Prior to discharge, the woman should receive post-procedure counseling and information, including:
- Instructions for taking any prescribed medications.
- Information about routine personal hygiene e.g. that bathing and showering are fine.
- Information about resumption of sexual activity and contraception:
  - After an uncomplicated abortion, the woman may have vaginal intercourse and insert tampons as soon as she desires to do so. If she wants to prevent future unwanted pregnancy, she should use an effective form of birth control when having intercourse. Conception can occur again within 10 days after a first-trimester abortion.

4.4. Signs of a normal recovery:
- Some uterine cramping may occur over the next few days, similar to that of a normal menstrual period. Discomfort from cramping may be eased by mild analgesics, warm compresses or baths.
- Some spotting or bleeding is normal, though it usually does not exceed that of a normal menstrual period. A normal menstrual period should begin within the next four to eight weeks.

Referrals for other reproductive and psychosocial needs are an essential part of abortion care. Providers should ensure that when the woman leaves the facility she has all the information and referrals she needs to care for herself and to make informed choices about her health, fertility and care following an abortion.

4.5. Discharge of Women With Complications

Women who experienced complications during or after abortion care may need additional discharge instructions. Providers should place particular emphasis on the importance of follow-up care when discharging these women. In addition, it is essential for providers and facilities to develop adequate protocols for following up with women who are at high risk for delayed complications or adverse sequelae.

- Follow Up Care

Before being discharged from the facility where they received abortion care, it is recommended that all women be scheduled for a follow-up appointment. The timing of the appointment depends on each individual woman's clinical and psychosocial needs. Following an MVA procedure, the appointment should generally occur within one week, which is when any problems are most likely to occur.

The follow-up appointment may or may not be at the same facility where the woman received abortion-care services. Sometimes follow-up care occurs in the woman's community with her primary provider. In these situations, providers can ensure a continuum of care by giving each woman a referral form with information about her abortion care that she can present to her follow-up care provider.

Although the exact nature of follow-up services will vary depending on each site's resources and infrastructure, several basic clinical and psychosocial elements should be part of every follow-up visit.

The purpose of the follow-up visit is two-fold:
- To address any lingering concerns, including unresolved physical complications, contraceptive services (including emergency contraception), or emotional issues
- To provide preventive care and referrals for other services not provided at the follow-up facility.
Some women will have experienced complications during or after the abortion procedure. At the follow-up visit, providers should ensure that any existing complications have been resolved and that no new complications have developed. Women who do present at their follow-up visit with acute medical problems should be assessed, stabilized immediately and then treated. If adequate care cannot be provided at the facility, women should be referred or transferred without delay.

In most cases, however, the woman will not be experiencing serious complications, and the visit will allow the provider to spend time with her when she may be less anxious than at the time of her initial visit. The follow-up visit is also an ideal time for the woman to receive individualized attention and care from a counselor, and to learn about or access contraceptive services and other resources that can improve her overall health and well-being.

5.A. Clinical Elements

The provider should first review information about the woman's abortion care. If the woman received initial services from a different provider, the follow-up provider will need to obtain as much information about the procedure and woman's physical status as possible.

Privacy and confidentiality protocols permit sharing of clinical information with a provider involved in the follow-up care of a woman, as long as she agrees.

5.B. Routine follow-up care may include some or all of the following clinical elements:

- Reviewing any available medical records and referral documents with the woman.
- Assessing the general physical status of the woman:
  - vital signs
  - any bleeding experienced
  - current pain or cramps
  - pain medications taken, both past and present
  - fever
  - current contraceptive use
  - signs of physical abuse
- Conducting a pelvic examination to assess uterine size and tenderness and rule out retained POC or infection. If the woman is an adolescent or has been raped, special attention should be given to providing comfort during the exam e.g. by offering verbal reassurance and using a small speculum.
- Determining whether symptoms of pregnancy, such as nausea and breast tenderness, have decreased or continued, in order to rule out continuing pregnancy.
- Re-evacuating the uterus if the POC were not entirely removed.
- Evaluating for chlamydia, gonorrhea or other sexually transmitted infections (STIs) in cases where women experience unusual discomfort, cervical motion tenderness, pus-like or foul-smelling discharge or other indications of STIs.

5.C. Psychosocial Elements

Women's experiences with abortion services are both physical and emotional, and their emotional responses vary widely. They may have fears, including concerns about their health, fertility or the reaction of others to their abortion.

The follow-up visit can be an excellent opportunity to provide emotional support, to answer questions, to continue any previous counseling and to identify women who need special care. Women who receive emotional support during their follow-up care may be better able to cope with their medical conditions and possible health outcomes.

It is possible that some women will have particular needs or concerns that were not addressed during their first visit, such as violence or involvement in commercial sex work. It is important that any special needs and concerns are identified and addressed during the follow-up visit.

5.D. Routine follow-up care may include some or all of the following psychosocial elements:

- Evaluating the woman's emotional status, level of support and referrals needed
- Assessing her fertility goals and need for contraception
- Providing counseling and an appropriate contraceptive method, if needed
- Giving referrals related to other health or social needs, if appropriate
- Following up on any diagnostic tests administered before or during abortion care, such as screening for cervical
cancer or STIs or other tests.
- Identifying and managing any physical conditions that require medical attention, including any complications that occurred.

5.E. Contraceptive Services

Women may ovulate as early as 10 days following a uterine evacuation procedure. Providers can help women prevent future unwanted pregnancies by asking about their fertility goals and offering contraceptive services at the follow-up visit.

Women who do not desire pregnancy should be offered contraceptive counseling and methods. Even if the woman received a contraceptive method before leaving the facility, there is often a need to follow up with additional contraceptive counseling or alternative method provision. The method provided initially may not have been ideal for the woman: She may have experienced negative side effects, may be unable to access a regular supply or may have a partner who objects to or is not supportive of the method.

The woman may have chosen her current method for the interim period between the abortion and her follow-up appointment, and now would like to choose a more suitable method. This may be an ideal time to prescribe oral contraceptives, to fit or re-fit a diaphragm or cervical cap, or to administer an injectable contraceptive. The woman may have scheduled the follow-up appointment specifically for female sterilization or intrauterine system (IUS)/Intrauterine device (IUD) insertion if she was not clinically eligible for these methods at the time of the abortion.

Women who want to be pregnant should be counseled on how to proceed with a healthy pregnancy. Women who have experienced multiple miscarriages should be referred for specialized gynecologic care. Sometimes it is advisable for a woman to use a temporary method of contraception before becoming pregnant again so that issues affecting her ability to sustain a healthy pregnancy may be resolved. In such cases, the woman should be counseled on why this is advisable, how long she should use contraception and what method is most appropriate for her situation.

The results of the clinical and psychosocial elements of a follow-up visit should be recorded in the woman's records. If the woman receives follow-up care at another facility, results from that visit ideally should be obtained using referral or follow-up protocols and recorded by the facility that provided the initial abortion care.

6. REFERRALS.

It is common for additional medical and psychosocial issues to surface before, during or after an abortion. While providers may be capable of assessing these issues and providing initial services, more intensive services may be needed than the abortion or follow-up facility is able to provide. In particular, adolescents need appropriate referrals to sexual and reproductive health services that are sensitive to their age group.

Referral protocols and resource lists that provide simple, accurate and up-to-date information are essential components of an effective referral system. Providers need to be aware of high-quality resources available in their area and how to refer women to them. It is helpful to provide the woman with written information on where and when referral services are available, as long as she feels comfortable taking written information with her. Appropriate referrals to other medical, gynecologic or counseling services and treatment should be made wherever indicated. The woman should also be informed that she can come back to the referring facility if she is unable to access a referral or resource.

Receiving facilities should have processes in place for accepting women who are referred to them and, if they are outside a woman’s community, for reintegrating her into health facilities in her community for follow-up care. They should also provide feedback to the original, referring institution.
CHAPTER 9
MANAGEMENT OF COMPLICATIONS

1. Introduction
When performed by a trained provider, abortion procedures rarely result in immediate or long-term complications. In many cases, complications can be avoided by accurately estimating the duration of the pregnancy. It is important, however, to be prepared to diagnose complications and provide treatment quickly and safely—or make appropriate referrals—if and when they do occur.

Complications can occur during the abortion procedure, in the recovery period or later, or at a combination of these times, and facilities must have an established protocol that addresses them. In most cases, complications associated with abortion can be managed successfully if appropriate treatment is initiated promptly. Serious complications are rare, and can usually be treated effectively by a trained clinician providing general emergency medical and surgical care. If such emergency facilities are not available on site, complications should be managed through the timely transfer of the woman to an acute-care facility.

This section presents information on the most common complications that can occur during or after a first-trimester induced abortion, as well as their accompanying signs and symptoms. Women may also present with pregnancy-related or gynecologic complications—such as molar pregnancy, ectopic pregnancy or uterine abnormalities—that require specific clinical consideration and management.

However, such complicating conditions are often discovered during the clinical assessment phase of client care and can be addressed before the procedure is performed.

Women who experience abortion-related complications need clear, honest explanations of their situation. They should be included in decision making about treatment options with the support and guidance of informed clinic staff. Fears about complications, perhaps compounded by pain, can add to the stress of what may already be a very emotional situation.

2. Complications of Vacuum Aspiration
Vacuum aspiration is an extremely safe procedure with only rare complications.

Those complications that do occasionally occur are:
- retained products of conception (POC)
- infection
- continuing pregnancy
- uterine atony
- cervical, uterine, and abdominal injuries
- medication-related complications
- hematometra
- vaso vagal reaction.

2.1 Retained POC and Infection
Retained POC are decidua and fetal tissue that have remained in the uterus after a spontaneous or induced abortion. Large amounts of retained POC can result in heavy bleeding and infection if untreated.

Severe complications, such as shock and sepsis, occur more frequently in environments where unsafe abortions are common and where contraceptive services and safe abortion care are lacking. Retained products of conception (POC) often contribute to these complications, causing bleeding, infection and pain. Uterine evacuation is usually required for women presenting with retained POCs. In cases of shock and other life-threatening conditions, complete clinical assessment and voluntary informed consent may be deferred until immediate actions have been taken to save the woman’s life. Once the woman is stabilized, the provider should make a complete clinical assessment and obtain her voluntary informed consent for continuing treatment.

Close monitoring until the retained products are expelled may be sufficient.

Otherwise, treatment involves evacuation of the uterus, preferably using vacuum aspiration. Note that some women with retained POC may be asymptomatic.
Even in the absence of retained POCs, uterine infection, or endometritis, may result after vacuum aspiration. Risk factors for postabortal endometritis include the presence of an underlying sexually transmitted infection (STI) that is then exacerbated by uterine instrumentation during the abortion. If a woman is suspected of having postabortal endometritis, the provider should obtain cervical cultures, if possible, and then treat the woman with a full course of broad spectrum antibiotics. The routine use of antibiotics at the time of a vacuum aspiration has been shown to reduce the risk of postabortal endometritis (WHO, 2003).

**Signs and Symptoms of RPOCs**

**Immediate**
- Heavy vaginal bleeding
- Less tissue than expected
- Sharp or cramping lower abdominal pain

**Delayed**
- Enlarged and softened uterus
- Uterine tenderness
- Fever
- Elevated white blood cell count

**2.2 Continuing Pregnancy**
If the termination of the pregnancy was ineffective, the pregnancy may continue. Also known as failed abortion, continuing pregnancy can result from various reasons. In vacuum-aspiration procedures, continuing pregnancy may be due to failure to evacuate the gestational sac, passage of instruments into the uterine wall without entering the uterine cavity, severe uterine arteversion or retroversion, uterine anomalies such as bicornuate uterus, extraterine pregnancy, and aspiration of only one sac of a multiple pregnancy. Treatment requires uterine-evacuation, preferably with vacuum aspiration.

**Signs and Symptoms**
- Positive pregnancy test
- Increasing pregnancy symptoms, such as breast tenderness and fatigue
- Less vaginal bleeding than expected
- Enlarged and softened uterus, larger than prior to uterine evacuation
- Inadequate amount of POC based on estimated duration of pregnancy

**2.4 Uterine Atony**
Uterine atony is a condition in which the uterus loses muscle tone and does not stop bleeding. It is a potentially serious complication due to the risk of hemorrhage. This complication is most common in multiparous women and those with later pregnancies. Uterine atony can usually be treated with uterine massage and uterotonicics.

**Signs and Symptoms**
- Copious vaginal bleeding
- Large, soft, boggy uterus

**2.5 Cervical, Uterine and Abdominal Injuries**
Minor cervical lacerations can occur, for example, from movement of the tenaculum or dilatation. Usually, applying pressure, for example by clamping a ring forceps over the tear, will stop the bleeding, or it can be repaired by suturing or applying silver nitrate. Uterine perforations that may occur during vacuum aspiration are usually very small and undetected, and may possibly resolve without the need for surgical intervention. Where available, laparoscopy can be used to investigate the perforation, diagnose any associated abdominal injuries and perform a laparotomy to repair injuries, if needed.

**Signs and Symptoms**

**During the procedure**
- Excessive vaginal bleeding
- Sudden, excessive pain
- Instruments pass further than expected
- Aspirator vacuum decreases
- Fat or bowel in aspirate
Postprocedure
- Rapid heart rate
- Falling blood pressure
- Pelvic tenderness
- Fever and/or elevated white blood cell count

2.6 Medication-Related Complications
Although medications are widely used in a safe and effective manner for abortion care, there are potential complications associated with their use.

Complications can be caused by overdosage, intravascular injections or a hypersensitivity reaction. General anesthesia during vacuum aspiration has been shown in some settings to produce increased risk of complications as compared to local anesthesia (Thonneau et al., 1998). Treatment for anesthesia- and other medicine-related complications may include using reversal agents, treating respiratory and cardiac depression and stabilizing convulsions.

Signs and Symptoms
- Dizziness
- Muscular twitching or seizures
- Loss of consciousness
- Drop in blood pressure and/or pulse
- Respiratory depression

2.7 Hematomata
Hematometra refers to the accumulation of blood clots in the uterine cavity. In such cases, the uterus cannot properly contract. In most cases, re-evacuation with vacuum aspiration will resolve the condition.

Signs and Symptoms
- Enlarged, firm, tender uterus
- Pelvic pressure
- Intense cramps and pain
- Light headedness
- Mild fever
- Scant vaginal bleeding

2.8 Vasovagal Reaction
Vasovagal reaction is fainting as a result of vagal-nerve stimulation during a vacuum-aspiration procedure. In most cases, women will recover within several to 60 seconds and will not require further treatment. In very rare cases, atropine injection will be necessary if the reaction is prolonged.

Signs and Symptoms
- Fainting/loss of consciousness
- Cold or damp skin
- Dizziness
- Nausea
- Moderate drop in blood pressure
- Drop in pulse

3. Complications of Medication Abortion
Medication abortion results in few serious complications. Those that do occasionally occur are:
- persistent gestational sac
- continuing pregnancy
- hemorrhage
- infection
- undiagnosed ectopic pregnancy

3.1 Persistent Gestational Sac
If the woman has not expelled the pregnancy by the time of her follow-up visit and the pregnancy is nonviable, she can be offered expectant management. This means that she will wait for the pregnancy to be expelled naturally; with time, this usually occurs without further intervention. To choose expectant management, the woman must be willing to return to the clinic in approximately one week to ensure that the process is complete. Alternatively, some clinicians prefer to administer an additional dose of misoprostol to women who have persistent nonviable gestational sacs. Proper pre-procedure counseling can help prepare a woman for the potential need for follow-up visits to monitor her progress.
if intervention is to be avoided. If the woman prefers not to make return visits or is experiencing uncomfortable symptoms, such as heavy bleeding, she may prefer vacuum aspiration to remove the POCs.

3.2 Continuing Pregnancy
The continuation of a pregnancy is uncommon in women using mifepristone and misoprostol up to 63 days (9 weeks) since the last menstrual period (LMP). Continuing pregnancy is more likely in women who use misoprostol alone. In this case, the abortion must be completed, preferably using vacuum aspiration.

3.3 Hemorrhage
Providers must have clearly documented procedures for assessing and managing abnormally heavy bleeding. Acute hemorrhage associated with medication abortion—assuming there is no physical trauma to the pelvic organs—is likely to require vacuum aspiration along with fluid replacement and, in some instances, transfusion.

3.4 Infection
Infection of the uterus is rarely associated with medication abortion. If POCs are retained and the woman displays signs and symptoms of uterine infection, uterine evacuation with vacuum aspiration should be performed as soon as broad-spectrum antibiotic treatment has been established.

3.5 Undiagnosed Ectopic Pregnancy
Ectopic pregnancy is a pre-existing condition rather than a complication of the abortion procedure. Therefore, ectopic pregnancy may be diagnosed when a woman seeking a medication abortion undergoes clinical assessment before the procedure. However, ectopic pregnancy can go undetected during clinical assessment and even remain undetected after a medication abortion is performed since, unlike vacuum aspiration, the provider will not necessarily examine the expelled tissue to confirm the termination of the pregnancy. Therefore, diagnosis and treatment of ectopic pregnancy may take place in the course of follow-up treatment.

4. Rare Complications
The following diagnoses are made less frequently during induced abortion than those discussed above. However, providers should be aware that they may occur and will require treatment.

4.1 Disseminated Intravascular Coagulopathy
Disseminated intravascular coagulopathy (DIC) occurs when a woman's blood fails to clot and normal bleeding progresses into serosanguineous flow. This condition is seriously life-threatening and requires aggressive treatment in an emergency-care setting. Therapy involves eliminating the precipitating cause, administering a clotting factor and replacing the blood volume lost.

4.2 Asherman's Syndrome
Asherman's syndrome is a rare complication that can occur after vacuum aspiration in which the inside of the uterus can become scarred. Signs and symptoms include amenorrhea, cyclical cramping and infertility.

Providers may also encounter Asherman's syndrome when it appears as a preexisting condition from a woman's previous dilatation and curettage (D&C) procedure. However, Asherman's syndrome is linked to decreased fertility, thus reducing the chance that women with this condition would experience unwanted pregnancy and seek abortion care.
CHAPTER 10
INFECTION PREVENTION

1. Introduction
Until fairly recently, the principal focus of infection prevention was on reducing the number of client infections resulting from clinical procedures. However, in light of the worldwide increase in incurable viruses—such as human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), hepatitis B virus (HBV), hepatitis C virus (HCV) and Ebola hemorrhagic fever (Ebola HF)—and other infectious agents that can be transmitted in a clinical setting, workers must now be vigilant about protecting themselves and their coworkers, families and communities, as well as clients.

Health-care facilities are prime settings for infection transmission because of the presence of numerous and varying types of infectious agents. Health-care workers are exposed to infectious agents and contaminated materials as part of their daily work, while clients are exposed when they receive health-care services. In addition, families and communities may be affected when clients and health-care workers unwittingly carry infections home from the health-care facility. Most formally trained health-care workers are knowledgeable about infection prevention techniques. It is the health-care worker’s responsibility to take correct and consistent measures to guard against the spread of infection, using appropriate hygiene and infection-prevention techniques and behaviors. This section addresses the application of infection-prevention principles in abortion-care settings.

2. Infection Transmission
Although they may not be visible without a microscope, microorganisms are on and within the body, on medical instruments and equipment, and on every surface. Each microorganism has a specific route of transmission from one person to another. A pathogen is any microorganism that can cause infection and lead to disease. Airborne pathogens travel through the air and blood borne pathogens are primarily transmitted through blood and certain other body fluids.

Each pathogen requires specific prevention measures, depending on how it is transmitted. This section focuses on preventing infections from blood borne pathogens that are primarily transmitted through exposure to blood and other body fluids in a health-care setting.

Bacteria, viruses, protozoa, fungi and parasites are examples of pathogens that can be present in blood and certain other body fluids and can cause infection and disease in humans. These pathogens include, but are not limited to, viruses such as HIV, HBV, HCV and Ebola.

Most blood borne pathogens:
- Cannot be seen with the human eye alone
- Can be transmitted through blood, secretions, excretions and certain other body fluids
- Can cause infection when fluid enters the body through a cut, open sore or other opening in the skin or mucous membranes of the eyes, mouth or genitals
- Can cause disease in humans without noticeable signs or symptoms.

At any time in the clinic setting, blood borne pathogens can spread:
- From client to health-care worker
- From health-care worker to client
- From client to client
- From health-care worker to health-care worker
- From health-care worker or health facility to family and community members

Health-care workers most often risk infection with blood borne pathogens, especially HIV and HBV, via punctures with contaminated sharp instruments, such as hypodermic needles, and contact with blood on non-intact skin such as cuts or sores. The transmission of blood borne pathogens, especially HIV, from healthcare workers to clients is extremely rare. Accordingly, work assignments should not be based on workers’ medical diagnoses, but on their skill and abilities.

3. Elements of Infection Prevention
Because infectious agents are transmitted in different ways, infection-prevention protocols are employed broadly to prevent infections regardless of their transmission routes. Health-care workers are required to use standard precautions, also called universal precautions, during contact with all clients and other workers, as a person may carry infection without showing any noticeable signs or symptoms.
Standard precautions involve infection-control measures that are designed to block transmission between the person and potentially infectious body fluids. They minimize the risk of pathogen transmission among health-care workers and clients.

In particular, standard precautions are intended to minimize infection transmission from:
- contaminated sharp instruments that can penetrate the skin,
- infected blood or body fluids that can splash into the eyes or other mucous membranes or enter the body through a cut or broken skin.

Health-care workers should treat the blood and body fluids of all persons as potential sources of infection, independent of diagnosis or perceived risk. Standard precautions should be followed with all clients and all workers, regardless of their presumed infection status or diagnosis, and there is no reason to treat individuals with known blood borne diseases differently.

NOTE: All health care workers should be vaccinated against HBV to reduce their risk of infection by that virus.

4. Essential Elements of Infection Prevention:
- Hand washing
- Personal protective barriers (plastic aprons, protective eye wear)
- Proper handling and disposal of sharp instruments and items
- Proper handling and processing of instruments and materials
- Aseptic technique
- Environmental cleanliness
- Proper disposal of infectious waste

4.1 Hand washing
Hands are the most common vehicle for infection transmission and hand washing is one of the most essential, yet most neglected, elements of infection prevention in health-care settings. Hand washing should be routine before and after each client contact, and after contact with potentially contaminated items, even if gloves are worn.

Health-care workers should wash their hands using the techniques outlined below. It is essential to use fresh water because microorganisms can thrive in a container of water used by multiple people. When running water is not available by faucet, spigot or pump, one person can pour fresh water from a container, enabling another person to wash.

Because shared and reused towels can transmit pathogens, it is ideal to use disposable towels or a clean towel each time hand washing occurs. Large towels can be cut into smaller towels or hands can be air-dried to conserve resources. To prevent soap becoming a breeding place for microorganisms, thoroughly clean soap dispensers before refilling with fresh soap.

**Technique of proper hand washing**
- routine hand washing
  - Remove gloves and discard them.
  - Consider the sink, including faucet controls as contaminated. Avoid touching them. Turn water on using paper towel and wet your hand and wrists.
  - Work soap into a lather. Vigorously rub together all surfaces of the lathered hands for 15 seconds. Wash around and under rings, and under finger nails in circular motion. A brush may be used.
  - Rinse hands under a stream of water. Running water carries away dirt and debris. Point the fingers down so that water and contamination don't drip towards the elbows
  - Dry hands completely with a paper towel

4.2 Use of Personal Protective Barriers
Health-care workers must decrease the likelihood of their exposure to microorganisms by wearing personal protective barriers such as gloves, gowns, aprons, footwear, eyewear, masks or shields to reduce their risk of infection. Appropriate barriers must be worn whenever there is the possibility of contact with blood or other body fluids.

4.2.1 Using gloves properly:
- Always change gloves between client contacts; after contact with a potentially contaminated item; before touching sterile instruments; and between rectal and vaginal examinations.
• Wear gloves when drawing blood or starting an intravenous line or any other time blood vessels are accessed.

4.3 Proper Handling and Disposal of Sharp Instruments and Items
Sharp instruments or items, called sharps, include hypodermic and suture needles, scissors, tenaculum, glass and blades. Sharps present a special risk of infection to health-care workers, clients and community members because they can puncture skin and introduce pathogens directly into the bloodstream. Such punctures occur most often when needles are recapped, cleaned, or disposed of inappropriately. The proper handling and disposal of sharps can significantly reduce this risk.

4.3.1 Proper handling of sharps
• Do not carry hypodermic needles.
• Set aside a specific area to keep sharp objects during procedures.
• Announce the presence and passage of any “sharps.”

4.3.2 Proper disposal of sharps
• Dispose of needles and syringes immediately without recapping, removing, cutting or bending them.
• Dispose of sharp instruments and items quickly and safely in designated, puncture-resistant containers which should not be more than two thirds full.
• Place these containers wherever sharps are used.

If syringes must be recapped for repeated use during a procedure, use the “scoop and pull method”:
• Hold the syringe and scoop the cap onto the needle without touching the cap or needle.
• Pull the cap onto the needle by holding the cap near the base.
• Never put fingers on the tip of the cap while pushing the cap onto the needle, as the needle can perforate the tip of the cap and stick the fingers.

4.4 Handling and Processing Instruments and Materials
Microorganisms can live on instruments and materials used during abortion procedures. Health-care workers must remove microorganisms from contaminated instruments and materials to prevent them from infecting other women during subsequent procedures. The techniques for properly removing microorganisms from instruments are discussed in the Instrument Processing section of the Uterine Evacuation Procedure with Ipas MVA Plus®.

4.5 Aseptic Technique
The three critical components of aseptic technique for invasive procedures are:
• Antiseptic preparation
• No-touch technique
• Properly processed instruments

4.5.1 Antiseptic preparation
Prior to any invasive procedure, the point of entry or affected body area must be cleaned with an antiseptic. The health-care worker should ask the woman about any allergic reactions to antiseptics before selecting an antiseptic solution.

During vacuum-aspiration procedures, post-procedure infection can be caused by the introduction of a woman’s resident vaginal flora into her uterus. Therefore, it is critical to remove microorganisms normally present in the vagina and cervix prior to inserting an instrument. The provider should ensure that the perineal area is clean, swab the cervix and, the vagina with a water-based (not alcohol-based) antiseptic solution, such as Betadine®, using sponge forceps and gauze or cotton wool. The cervix should not be cleaned with the same gauze used for cleaning the vagina.

4.5.2 No-touch technique
To avoid introducing pathogens, it is essential to use no-touch technique during invasive procedures and when handling sterile instruments, such as hypodermic needles and cannulae. Providers should always handle instruments by the end that does not come into contact with the woman.

It is possible to introduce pathogens, especially vaginal ones, into the uterus when passing an instrument into the uterine cavity. In the case of vacuum aspiration procedures, the use of no-touch technique means that no instrument that enters a woman’s uterus comes in contact with a contaminated surface before insertion through her cervix. Specifically, the tenaculum, cannula or dilator tips should not touch the providers’ gloves, the woman’s vaginal walls, or unsterile parts of the instrument area.
4.6 Environmental Cleanliness
Because health-care workers can spread infection when touching clinic surfaces and clients, it is important that everything in the clinical setting, including clients, instruments and equipment, be kept clean and dry. Ideally, a disinfectant of 0.5 percent chlorine or precept solution can be used for cleaning rooms and equipment, although it is acceptable to use soap and water.

Note: Glutaraldehyde and chlorine are hazardous substances. If processing instruments or for environmental use, take necessary precautions such as using personal protective equipment. Refer to the manufacturer’s safety instructions to establish safe use. Attempting to disinfect a room by fumigating or fogging is not only ineffective in preventing the spread of pathogens, but is also toxic and expensive.

4.6.1 At the beginning of each clinic session:
• Wipe all horizontal surfaces with a clean cloth, including procedure tables, chairs, trolley tops, lamps and counters
• Mop floors with a clean mop to remove any dust that may have accumulated overnight

4.6.2 Between clients and at the end of each shift:
• Clean spills of blood or other body fluids with a 0.5% chlorine solution or other disinfectant immediately
• Clean any potentially contaminated surfaces, such as procedure tables and trolley tops, with a clean cloth dampened with a disinfectant cleaning solution
• Clean visibly soiled areas of the floor, walls or ceiling with a disinfectant cleaning solution
• Check sharps disposal containers and replace them if they are three-quarters full
• Remove infectious waste

4.7 Disposal of Infectious Waste
Any material that has come in contact with body fluid should be considered infectious waste and must be cleaned or disposed of properly. Infectious waste include human tissue, body fluids and material containing fresh or dried blood such as bandages, surgical sponges, blood transfusion bags and pads. These should be disposed of into the red plastic bag and be sent to the incinerator. Hypodermic and suture needles, scalp blades, blood tubes and pipettes should be discarded into secured sharp container

5. Management of Occupational Exposure
In the event that a health-care worker is exposed to blood or other body fluids in any way—for example, by needle puncture or a splash to the face or skin—follow these procedures:
• If the exposure caused a bleeding wound, briefly allow the wound to bleed.
• Immediately flush the exposed area with clean water. Wash wounds and skin thoroughly with soap and water. Flush the mucous membranes (nose, eyes, mouth) with water or saline only. Although antiseptic solutions have not been proven effective, use them in the absence of water.
• Determine the exposure risk—that is, the type of fluid and type of exposure. Evaluate the exposure source by testing a known source or by evaluating the risk posed by an unknown source. Evaluate the exposed person’s immune status, including his or her history of HBV vaccination.
• Give post-exposure prophylaxis, for exposures posing a risk of infection. Offer voluntary, confidential HIV, HBV and HCV counseling and testing, if available.
• Record the exposure and actions taken according to facility protocols.
• During follow-up care, advise the exposed person to seek medical evaluation for any acute illness that develops.
CHAPTER 11
COUNSELING

Introduction
A woman's experience during abortion care is both physical and emotional. When providers deliver emotional support in addition to medical care, the woman is better able to comprehend her medical condition, the various options available to her, possible outcomes and related health concerns. Women are likely to experience fewer psychological difficulties in the long term when their emotional needs are addressed as they arise. Counseling, when done privately and confidentially, is a highly successful way for providers to offer emotional care to women receiving abortion services.

All women receiving abortion care have the right to high-quality counseling, regardless of their medical or psychological circumstances. Effective counseling, an integral part of high-quality abortion care, provides an opportunity to assess the woman's ability to cope as well as helping her explore her feelings and comprehend the information she needs to make informed decisions. It is essential to provide complete, accurate and easy-to-understand information that assists the woman in understanding and considering her medical options. Counseling helps providers identify when women need special care because of emotional distress or personal circumstances. The most immediate benefits of counseling are more effective client-provider relationships, care that is comforting to the woman and greater overall client satisfaction with the healthcare encounter (Baker, 1999).

Optimally, a staff member with an appropriate background and experience should be trained and designated to serve exclusively as a counselor. Even if the healthcare facility does not have full-time counseling positions designated, existing staff members can be trained to provide basic abortion and related health counseling. In some settings, the clinicians who provide medical care must also function as counselors. In such cases, providers must remain mindful that they are not serving in a clinical capacity while acting in the role of counselor and that client-counselor dynamics differ from client-clinician relations. In any case, whether or not they are responsible for formal counseling, clinicians should possess counseling knowledge and skills and a caring, nonjudgmental attitude.

This section covers essential information on how counselors can interact and communicate with clients in a respectful, effective manner. Topics covered include: privacy, confidentiality and informed decision making; counselor values, attitudes and empathy; methods for effective communication; and common feelings experienced by women receiving abortion care. This section also includes instructions on making appropriate referrals and information on counseling special populations.

1. What Is Counseling?
Counseling is a structured interaction through which a person voluntarily receives emotional support and guidance from a trained person in an environment that is conducive to openly sharing thoughts, feelings and perceptions. Counseling should always involve respectful, woman-centered, two-way communication.

Counseling is...
- Soliciting the woman's feelings and thoughts
- Accepting the woman's perceptions and feelings, regardless of societal norms
- Respecting the woman's privacy and confidentiality
- Focusing on the woman's, not the counselor's, needs and concerns
- Communicating effectively
- Providing complete, accurate information in an accessible way and helping the woman apply that information to meet her needs
- Supporting the woman in making her own decision and acting on it

Counseling is not...
- Strictly providing information
- Giving advice
- Trying to influence the woman's attitudes, beliefs and behaviors by persuading, admonishing or threatening her.

2. Voluntary Informed Consent
Voluntary informed consent refers to the process by which a woman is given full information about her options—for pregnancy decisions, abortion procedures, pain medications and contraception—and the benefits, risks, likelihood of success and alternatives associated with any part of those options. Informed consent means that the woman makes her
decisions freely, without pressure or coercion of any type.

Voluntary informed consent should be confirmed before beginning care or administering any medications that could make it difficult for the woman to make an informed decision. She should be given as much time as she needs to make decisions, even if this entails returning to the clinic at a later date. The counselor, however, should provide the woman with appropriate information on the safety and effectiveness of earlier, versus later, abortion procedures.

Providers should adapt the counseling process as needed for each woman. They must remain mindful of any circumstances that may limit a woman’s ability to make independent decisions or to comprehend the information and, therefore, give informed consent. Such circumstances include situations where the woman:
- is under pressure from her partner or family members to have an abortion
- Determine if the woman is capable of listening to and understanding the information offered
- Explain the procedure(s) available to her, including benefits, risks and alternatives, in clear, non-technical language
- Always ask her in private if she wishes to include others, and include her partner or family members only if she desires their presence; otherwise, speak to her privately
- Encourage the woman to ask questions and discuss her condition
- Ensure that the woman understands the information you have provided; if she does not, explain the procedure and her options again
- Ask the woman—or her representative if she is unable to comprehend medical explanations—to give consent for care
- If customary according to local protocols, have the woman or her representative sign the appropriate consent form
  - has difficulty communicating due to language barriers
  - is hard of hearing or deaf
  - is cognitively disabled or mentally ill
  - is very young
  - has experienced a traumatic event (for example, has been subjected to violence or has had an unsafe abortion)

3. Counseling in the Abortion Setting
Effective counseling occurs before, during and after the abortion procedure. All effective counseling begins with assessing and addressing each woman’s unique needs and includes respectful, woman-centered, two-way communication. Abortion counseling can help the woman prepare for every step of the process, as well as help her make future plans to ensure her well-being. Although elements of effective counseling should be present throughout the visit, it is important that providers offer each woman a formal counseling session with a trained counselor at some point during her visit.

The counselor should:
- Solicit and affirm the woman’s feelings
- Provide accurate information about the woman’s medical condition, test results, pregnancy options, abortion options and pain-management options
- Discuss the benefits, risks and alternatives associated with the abortion procedures and pain-management options
- Help the woman clarify her thoughts and decisions about her pregnancy, her options, the procedures available, resumption of ovulation after an abortion and her future sexual and reproductive health needs
- Help the woman explore her feelings about her life circumstances as they relate to her abortion-related decision making
- Ensure that the woman receives appropriate answers to any questions she has
- Address any other concerns that the woman has at that time
- Refer the woman to additional services, if necessary

The circumstances of abortion care can create several counseling challenges. First, the woman may have conflicting feelings about her pregnancy, the outcome of the pregnancy and other life circumstances. Second, if the woman is in emotional distress, she may be temporarily unable to fully comprehend her situation. Finally, the woman and counselor may have different values or cultural and language backgrounds that create barriers to mutual understanding. Because a woman may have infrequent contact with the healthcare system, counseling is an excellent opportunity for providers to determine the entire scope of her physical and emotional needs and to refer her to appropriate services.

4. Basic Elements of Abortion Care Counseling

Privacy and Confidentiality
Women have the right to privacy and confidentiality in the abortion setting.

Ideally, all abortion-related counseling should take place in a setting where no one else can see or overhear and in which communication between the woman and the counselor is not shared with staff members not involved in her direct care, other clients or visitors. Another individual—for example, a partner or family member—may ask to be in-
cluded in the counseling session. It is crucial for the counselor to first meet with the woman alone and, at that time, ask her permission to invite anyone else to join the counseling session. By asking for her permission privately, she is less likely to feel pressured to include others in the counseling session.

The counselor should inform the woman that any medical and personal information discussed during counseling is confidential, and then ensure that this information is not released without the woman's voluntary authorization. Offering the woman respectful, confidential counseling in a private setting will contribute to her sense of dignity and the overall quality of her care.

**Informed Decision making**

In a counseling setting, informed decision making refers to the process by which a woman makes decisions of her own free will after she understands complete and accurate information.

**5. Counselors’ Values, Attitudes and Empathy**

In order to provide high-quality abortion care, counselors need to:

- Identify their values and attitudes with regard to sexual- and reproductive health care
- Separate their values from those of clients
- Recognize how their attitudes could negatively or positively affect counseling
- Receive counseling training, if available

Effective counselors remain open and nonjudgmental even when their personal beliefs differ from, or even conflict with, those of their clients. Such counselors can have a beneficial impact on women’s emotional and physical health. Conversely, counselors who allow their biases to affect their interactions can have a negative effect on women’s emotional and physical well-being.

Counselors should strive to practice empathy, which is the ability to understand another person’s feelings and point of view and to communicate this understanding to the person. Empathy does not mean “feeling sorry” for the person. Rather, empathetic abortion counselors imagine how they would feel and how they would like to be treated if they were in the woman's situation, while understanding that the woman’s feelings may differ from their own.

**Clients respond most favorably to counselors who:**

- Remain open, empathetic and nonjudgmental
- Extend compassion and respect to every woman, regardless of her reproductive behaviors and decisions
- Separate their own principles and attitudes from those of clients
- Respect women’s independent values and viewpoints
- Honor each woman’s feelings, perceptions and decisions

**It is helpful for counselors to examine their attitudes and assess their potential biases against women who:**

- Seek an abortion
- Undergo multiple abortions
- Do not want to be pregnant but do not use contraception
- Have multiple children
- Do not have children
- Carry pregnancies to term even though the pregnancies were not intended or desired
- Terminate a pregnancy due to fetal malformation
- Have multiple sexual partners
- Have been sexually assaulted
- Are unmarried and pregnant
- Are of a certain race, ethnicity, social class, religion, age, sexual or gender orientation, health or STI status or political affiliation
- Have become pregnant while living with HIV
- Have little or no formal education
- Are sexually active at a young age

**Effective contraceptive counselors share several attributes. For example, they:**

- Are aware of their own attitudes and keep interactions with clients free of personal judgments.
- Extend compassion to every woman regardless of her reproductive behaviors and decisions.
- Honor every woman’s right to confidentiality and privacy.
- Encourage the woman to speak openly about the circumstances surrounding her pregnancy, her fertility history and goals, her contraceptive needs and any related health concerns.
- Respond directly and honestly to information the woman provides about her situation and concerns and ask appropriate, clarifying questions.
• Acknowledge and reassure clients with both verbal and nonverbal cues that are appropriate for the cultural setting. Nonverbal cues may include facing the woman, leaning forward slightly, nodding and making appropriate eye contact.
• Give accurate, relevant information about how soon the woman can again become pregnant, her contraceptive options, instructions for use and re-supply, and any other needed information.
• Assist with other health needs, including referrals for services not available at the facility.
• Are honest about gaps in their knowledge and make every attempt to refer the woman to appropriate sources of information.

6. Communication Techniques

Effective Communication
A woman seeking an abortion may be experiencing a variety of emotions, including fear, sadness, relief, shame, gratefulness, anger or guilt. Effective counselors use active-listening skills, including both verbal and nonverbal communication, to show that they are completely attentive and responsive to client’s needs. They use encouraging statements and open-ended questions to support women’s exploration of their feelings. When counselors employ effective communication skills, clients feel understood and experience increased satisfaction with their health care. These women are more likely to experience a better overall recovery and to seek follow-up care if needed. That said, counselors should never insist that a woman talk or reveal information that she is not comfortable sharing with the counselor.

Woman-Centered, Two-Way Communication
Woman-centered counseling is structured completely around the woman’s needs and concerns. When counseling a woman, the counselor should take into account her emotional state, medical condition, cultural and religious background, ability to understand medical terms and level of general understanding. A counselor can assess the woman’s most pressing needs by asking her what her greatest concerns are and then use those concerns as the starting point for counseling. Counseling always involves two-way communication between the health-care provider and the woman. Each person spends time talking, listening, and asking and answering questions. In general, effective counselors listen more and talk less.

Active Listening
Active listening is the key to establishing trust and rapport with a client, and involves more than just hearing. A counselor who is practicing active listening uses multiple senses to gather relevant information, convey understanding and encourage the woman to talk about her feelings and circumstances. A counselor who does not employ active listening, on the other hand, communicates a lack of interest and may alienate the woman. A counselor can show attentiveness while the woman talks by interjecting phrases such as “I see” or “I understand” and by making encouraging sounds, facial expressions and gestures. However, counselors should resist the temptation to offer statements that seem reassuring initially, but ultimately make women feel unsupported or offer false reassurance. For example, saying to a woman “don’t worry,” “you’ll feel better soon,” or “everything will be fine” can make her feel that her concerns have been dismissed or invalidated.

Verbal Communication: Open-Ended Questions and Reflecting Feelings
The way people ask questions can either encourage or discourage others from engaging in conversation. Open-ended questions begin with “how,” “what,” “when” and “tell me about.” They cannot be answered with just “yes” or “no.” By asking questions that require more complete answers, a counselor is encouraging the woman to offer more information and engage fully in the conversation. Closed-ended questions often begin with “do,” “will” or “are” and are answered by “yes” or “no.” When the counselor asks a closed-ended question and the woman responds with “yes” or “no,” the counselor must ask another question to continue the conversation.

Counselors should avoid asking open-ended questions that begin with “why,” as this may be perceived as judgmental. For example, a counselor might ask a woman, “Why do you feel relieved about having had an abortion?” The implied judgment is that a woman who has had an abortion should not feel relieved. The counselor can follow up the woman’s response to an open-ended question with a statement that reflects understanding of the woman’s feelings and concerns. If the counselor is unsure whether she has understood the woman correctly, she can add a question at the end of the statement, such as, “Is that correct?” This gives the woman the opportunity to confirm or correct the counselor’s understanding. Also, in order to ensure that all the woman’s concerns are addressed, it may be helpful to ask her what other questions she has or what else she would like to discuss.

Nonverbal Communication
People communicate many of their thoughts and feelings without speaking a single word. A perceptive person can often tell how someone else is feeling simply by observing the person’s facial expressions and body language. Body language refers to the ways in which a person’s physical position, posture and gestures communicate their emotions. By paying close attention to both verbal and nonverbal cues, a counselor can more fully understand a woman’s feelings.
Counselors should also remain observant about differences between a client's verbal and nonverbal cues, as some people have difficulty expressing their feelings verbally. After observing nonverbal communication, counselors should verbally confirm their interpretation of the cues with women to prevent any miscommunication. For example, if a woman says she feels fine but has a sad facial expression, the counselor may ask: “You say you feel fine, but you look sad—can you tell me more about that?”

A trusting client-counselor relationship is based not only on the words they exchange but also on what they see and sense about each other. A counselor can use nonverbal communication to show concern for a woman by facing her, removing any physical barriers between them such as a desk or counter, leaning slightly forward, making appropriate eye contact, nodding and using a reassuring tone of voice. Conversely, nonverbal cues such as turning and looking away from the woman, repeatedly looking at a watch or clock or using a harsh tone of voice can convey a lack of interest. When employing and interpreting nonverbal cues—such as posture, eye contact, and distance between themselves and others—counselors should remember that nonverbal cues vary from culture to culture, as well as according to age and gender within a given culture.

Effective Verbal and Nonverbal Communication

Counselors who practice effective communication:
- Stay attentive and focused on the woman and her needs
- Use nonverbal cues to show interest in and concern for the woman
- Ask open-ended questions and use encouraging words to help the woman talk openly
- Pay close attention to the woman's spoken words
- Listen for the meaning underlying her words
- Observe the woman's nonverbal cues
- Listen carefully to the woman's responses
- Follow up with appropriate questions and feedback to encourage the woman to explore her feelings further.

Counselors who do not practice effective communication:
- Make assumptions about the woman and her needs
- Focus on their own priorities rather than the woman’s needs
- Indicate their lack of interest through nonverbal cues
- Ask only closed-ended questions
- Do not listen carefully
- Interrupt or speak over the woman
- May misunderstand the woman's words
- Do not pay attention to or misinterpret the woman's nonverbal cues
- Do not check back to make sure that the woman has understood their questions
- Allow interruptions such as telephone calls or people coming into the counseling space
- Show distraction while the conversation is taking place

7. Women's Feelings and Decisions
Cultural values and norms affect a person's feelings about fertility, pregnancy, miscarriage, abortion and parenthood. When women have feelings that in some way contradict these norms, they may experience negative emotions, such as guilt or shame. Counselors should strive to create a safe environment in which women can explore their true feelings, without being made to feel self-conscious, ashamed, embarrassed, wrong, misunderstood, angry or confused. It is essential for the counselor to convey to the woman that her feelings are valid, regardless of whether they contradict cultural values and norms. This exploration helps inform the woman's decisions, and the counselor can help facilitate that process.

Feelings About Pregnancy
News of pregnancy can invoke a range of emotions, including joy, fear, sadness, guilt, relief and disappointment. The counseling session may be the first opportunity the woman has had to speak honestly about her feelings regarding her pregnancy. Her emotional response to her abortion may largely hinge on how she felt about being pregnant in the first place. If the woman wanted to be pregnant but needed to terminate the pregnancy for medical or other reasons, she may feel a great sense of loss or guilt. If the woman did not want to be pregnant, she still may experience a sense of loss and a range of other strong emotions about seeking an abortion.

Feelings About Potential for Future Pregnancy
Some women are frightened by myths they have heard about abortion causing sterility or other health problems. If they desire future pregnancies but are not prepared to be pregnant at this time, fears about their long-term reproductive health can lead to ambivalence about what to do. Women need to be reassured that infertility due to abortion is highly
improbable when an abortion procedure is done by a competent health-care provider in a safe environment, and when the woman follows aftercare instructions properly (RCOG, 2004).

Before mentioning contraceptives, an effective counselor will help a woman clarify her feelings about future childbearing and whether she wants to become pregnant soon, delay pregnancy or avoid future pregnancies altogether. While an abortion counseling session may not be a good time for some women to make important decisions about permanent contraceptive methods, other women may have reached this decision prior to the procedure. If the woman wants to become pregnant again soon, which could be true for a woman who has miscarried or has terminated the pregnancy for medical reasons, she should discuss with her clinician how this may affect her health. In some cases, this cannot be determined until her follow-up visit.

The counselor should make sure the woman knows that she could ovulate within 10 days, which could quickly lead to another pregnancy if she resumes sexual intercourse without using a modern contraceptive. If a woman desires contraception to prevent future pregnancy, the counselor can ensure that she receives or is referred for appropriate contraceptive services during her visit. Most facilities can at the very least ensure that women receive a temporary contraceptive method and a referral for a long-term contraceptive method before leaving the facility. (moved)

### 8. Information and Options

When a woman requests an abortion, she usually has carefully considered her options and decisions prior to seeking care. However, for various reasons discussed earlier in this section, women may want more information on which to base their decision or they may not have fully considered their decision to seek an abortion.

For the purpose of informed consent, it is important that counselors always review the woman's medical condition and the basic options available to her:

- Continue the pregnancy to term and parent, or release the child for adoption
- Terminate the pregnancy

Counselors can discuss with the woman the benefits, risks and alternatives of these options and, if needed, make appropriate referrals. If the woman makes a firm, uncoerced decision to terminate the pregnancy, the counselor should then proceed by gathering certain information, such as the length of pregnancy, and offering information about:

- Confidentiality of care and the voluntary nature of the woman's decision
- Abortion methods available to the woman and their benefits, risks and alternatives
- Available pain medications and their benefits, risks and alternatives
- Which tests, if any, may be performed—for example, blood tests
- If applicable, the nature and extent of fetal anomalies detected or other medical indications that indicate pregnancy termination
- Permission to treat the woman in the unlikely event of a complication or emergency

### 9. Procedure Choice

If both vacuum aspiration and medication abortion are options, the counselor should explain the differences between the methods and help the woman explore which option is best for her. Once the woman has chosen, the counselor should provide the following information about her choice of method:

- what will be done during and after the procedure
- what she is likely to experience—for example, menstrual-like cramps or pain
- how long the procedure will take
- which pain management options she can choose
- what side effects, risks and complications are associated with the method
- what kind of aftercare and follow-up is needed

If the woman chooses medication abortion, the counselor should explain that in the unlikely event the method fails, the provider will need to complete the abortion with another method, preferably vacuum aspiration.

The counselor should be certain that the woman understands the information and has provided informed consent, particularly if there are language or literacy barriers or concerns about her cognitive or developmental abilities.

### 10. Making Referrals

By providing appropriate referrals to women, counselors are performing an important service that should not be underestimated. Counselors can unintentionally do more harm than good if they attempt to counsel women about subjects in which they lack expertise or training. Counselors should also be prepared to refer women if they cannot remain nonjudgmental and impartial in counseling them. In situations where a counselor feels uncomfortable or is unable to adequately address the client's needs, it is best to refer the woman to a different counselor.
Counselors should identify common concerns that women may raise and create a resource list for referrals. They can create the list by researching and identifying local resources and then update it periodically. The counselor should also assure the woman that she can return to the original facility for additional referrals if she has trouble accessing the referred resource or if it is does not meet her needs.

The referral process will also be more effective if the facility creates referral protocols. For example, one essential protocol is to create and maintain a referral logbook in which counselors can write each client's name, the service to which she was referred and any follow-up care that took place. It is also a good idea for counselors to routinely ask each woman if it is safe for her to receive written referral information. For some women, it may be dangerous to receive information that may be found by someone else. In such situations, the counselor can work with the woman to find an alternative way to provide her with the information.

**A referral is needed when:**
- The problem or issue being discussed with the woman is beyond the counselor's knowledge or skills
- The counselor and other staff at the facility cannot answer questions being raised by the woman
- The counselor has a conflict of interest or personal values that make it difficult for them to be impartial or nonjudgmental
- The woman's needs are beyond the capacity of the health-care facility
- The woman stops communicating with the counselor

**Good referrals:**
- Include complete and easy-to-follow written or pictorial information
- Provide information that is up-to-date and accurate
- Recommend services and facilities that are within reach of the woman, both geographically and financially.

**11. Closing a Counseling Session**
- When closing a counseling session, the counselor should:
  - provide a short summary of the key concepts discussed
  - ask the woman if she has any additional questions
  - ensure that the woman understands any verbal instructions or suggestions
  - provide the woman with written instructions or referrals, if appropriate
  - explain what to expect during the remainder of the clinic visit

**12. Special Populations**
Depending on the region or specific setting, providers may see clients with special needs that should be considered when offering counseling and abortion services. These women may be uncomfortable bringing up certain issues with their counselors. Therefore, it is important that counselors ask questions that elicit additional information that pertains to the woman's situation and decision. In addition, counselors may need specialized knowledge about the woman's life circumstances and the issues she is facing. Counselors who are uncomfortable working with certain client populations may be able to obtain additional training to attain greater competency. Alternately, counselors can refer women to other counselors or agencies who are skilled in providing high-quality services that meet special needs.

**Examples of Special Populations**
Women who have experienced violence; women living with HIV/AIDS; adolescents; women engaged in commercial sex work; women with cognitive and developmental disabilities and mental illness; refugees and displaced persons; women who have experienced female genital cutting; and women who partner with women (lesbians).

**13. Summary**
- Counselling is a structured interaction through which a person voluntarily receives emotional support and guidance from a trained person.
- Counselling should be conducted in a private area or in an area where no one else can see or overhear.
- To give their voluntary informed consent, women must know about all their options for care and the benefits, risks and likelihood of success of, as well as alternatives to, any part of those options; they must also be able to choose freely among these options without any pressure or coercion.
- Information shared by the woman is confidential and should not be released without her voluntary authorization.
- Clients respond best to counsellors who provide nonjudgmental support and convey empathy.
- Woman-centered counselling includes such techniques as active listening, open-ended questioning, reflecting feelings and attention to nonverbal communication.
- Counsellors should create a safe environment in which the woman is comfortable exploring her feelings.
• Referral protocols and resource lists that provide simple, accurate, up-to-date information are essential components of an effective referral service.
• Counsellors should conclude a counselling session by providing a short summary of the key concepts discussed, explaining what to expect during the remainder of the clinic visit and ensuring that the woman has understood what was discussed and had all her needs met.
• Counsellors should prepare themselves to respond to women's unique counselling needs and concerns.
CHAPTER 12
POST ABORTION CONTRACEPTION

Introduction
International organizations, including the World Health Organization (WHO), have recognized that access to contraceptive services constitutes a basic human right and is fundamental to reproductive and sexual health (Center for Reproductive Law and Policy and the University of Toronto, 2002). In addition, the national laws and health norms in many countries increasingly support this right. The International Planned Parenthood Federation (IPPF) Charter on Sexual and Reproductive Rights includes the right to choose whether or not to marry and the right to decide whether and when to have children. However, limited access to contraceptive methods hampers the ability of many women to exercise these rights.

Providing contraceptive counseling and methods as part of abortion services can improve contraceptive acceptance and help break the cycle of repeated unwanted pregnancy. Every woman undergoing an abortion should be offered contraceptive counseling and a range of contraceptive methods so that she can control her future fertility. Since ovulation can occur soon after an abortion, contraception should be provided immediately to women who want to prevent or delay pregnancy.

Diverse circumstances apply to women receiving abortion services, and counselors should avoid making assumptions about the women they encounter. Each woman’s situation, experience and future plans will vary. Most women undergoing an abortion will have chosen to terminate their pregnancies. The reasons that pregnancies are unwanted differ, but often women feel a loss of control over the situation. Some women may have desired the pregnancy, but for medical reasons may have terminated it. Each woman’s individual clinical situation will determine her contraceptive needs. The common factor among women receiving abortion care is that they are at a critical juncture in their reproductive lives and can benefit from compassionate counseling about their sexual health, goals and contraceptive options.

In general, all methods of contraception, including intrauterine devices (IUDs) and hormonal methods, can be considered for use after a first-trimester abortion. However, when providing contraception to a woman, her medical eligibility for each method needs to be considered.

This section explains why contraceptive counseling and method provision are critical parts of abortion care. It also addresses how to successfully counsel women receiving abortion care so that those who wish to use contraception will be able to choose a method appropriate to their needs and use that method effectively.

1. Importance of Contraceptive Counseling and Method Provision After an Abortion
The goal of contraceptive counseling as part of abortion services is to work with the woman to identify factors that led to the abortion. The counselor helps the woman decide if she wants to use a contraceptive method and, if she does, assists her in choosing an appropriate method. An effective contraceptive counselor keeps in mind the woman’s personal needs, reproductive goals and clinical condition. Contraception is critical to women’s health and well-being for several reasons.

Contraceptive use can:
• Promote women’s health by limiting births to the healthiest childbearing years and avoiding more births than are good for their bodies
• Allow mothers a safe means to achieve desired spacing between births and a small family size, which evidence shows improves infant health and saves infant lives (Upadhyay and Robey, 1999)
• Allow women the freedom to improve their quality of life, pursue an education or establish a career
• Reduce maternal mortality and morbidity by helping women avoid future unwanted pregnancies and the possibility of an unsafe abortion that might end in injury or death

2. Service delivery models
Contraceptive counseling and method provision can take place at various points and in different ways during abortion services.

These models include:
• Offering counseling and interim methods, as well as permanent methods, if available, at the facility providing abortion care
• Offering counseling at the abortion-care facility with a referral for method provision at another site
• Arranging for service providers from a family planning clinic to come to the abortion care facility to counsel and
dispense methods to clients or to bring the women to the family planning clinic for services.

Contraceptive counseling can take place either before or after an abortion. In general, it is best for women to receive a contraceptive method immediately after the clinical procedure is completed. If a woman indicates that she would like a permanent or long-term method, such as female sterilization or an intrauterine device (IUD), these procedures can be done concurrently with the uterine evacuation. In these cases, counseling and consent must be completed before the abortion procedure begins.

3. Women’s Fertility Goals Following an Abortion

Although some women seek abortions for medical reasons and desire to become pregnant again soon, most women who seek elective, induced abortions are facing an unwanted pregnancy. Women who have recently terminated an unwanted pregnancy will often desire contraception to prevent or delay another pregnancy. These women generally seek more effective, long-term contraceptive methods and have high continuation rates with their method of choice (Johnson et al., 2002).

When counseling a woman who has experienced a spontaneous abortion or an abortion that was conducted for medical reasons, a counselor may begin by asking whether and when the woman wants to become pregnant again and if she desires contraceptive counseling. In addition to receiving information about contraception, women in these situations may benefit from a referral to specialized gynecological care to evaluate the cause of the lost pregnancy or the medical reason for the abortion.

As the following section illustrates, a woman’s ability to successfully use contraception may be beyond her control. Providers should empathetically assess each woman’s individual situation and consider which factors contributed to the unwanted pregnancy. They can then help the woman address those factors so that she can delay or prevent future pregnancy as she wishes. In all cases, it is crucial that the provider does not blame the woman for not preventing the unwanted pregnancy. Such blame can perpetuate a cycle whereby the woman feels a sense of guilt and then becomes reluctant to seek out services, including contraception. This can lead to further unwanted pregnancies and repeated abortions.

4. Contraceptive Method Failure

Counselors will encounter women who have terminated unwanted pregnancies that resulted from contraceptive method failure. The reasons for method failure vary:

- the method itself was not effective
- the woman did not use the method appropriately;
- the woman discontinued use because of personal, family, religious, social or cultural reasons
- the health system failed to reach the woman with appropriate and reliable services.

In facilities where contraceptive services are not offered, providers must ensure that every woman receiving abortion care knows:

- She could become pregnant again within 10 days after the abortion procedure
- Safe contraceptive methods to prevent or delay pregnancy are available
- Where and how she can obtain contraceptive services and methods, including emergency contraception (EC)
- Most contraceptive methods can be used immediately after abortion care (Wolf and Benson, 1994)

Contraceptive may fail for the following reasons:

- No method is 100% effective. Even when a modern method of contraception is used correctly and consistently, some women will become pregnant.
- Failure to use the method or failure to use it correctly;
- The woman cannot consistently afford contraceptives.
- The woman forgets to take or use her method consistently.
- The woman is influenced by popular myths about contraception, including the belief that contraception can cause infertility.
- The woman experiences unacceptable side effects and discontinues use.
- The woman’s husband, mother-in-law or other family member does not approve of her using contraception.
- Religious leaders in the woman’s community do not support the use of contraceptive methods.
  • The woman had non-consensual sex
- Failure of the health system:
  • Family-planning counselors do not adequately explain to the woman how to use the method.
  • Family-planning clinics do not have the woman’s chosen method or do not stock it reliably.
• Contraceptive services are not located in the woman’s community or the clinics are not open at times convenient for the woman limiting access.
• Facility protocol not allowing dispensing of contraceptives on site

5. Rights to Privacy, Confidentiality and Informed Choice
Privacy and confidentiality are essential, especially in abortion-care settings. Ideally, women should receive counseling in a private area where they are not seen or overheard by others. If this is not feasible, the facility should make arrangements to approximate this ideal as closely as possible.

At the beginning of a contraceptive-counseling session, the provider should assure the woman that the information that will be discussed is confidential. After the session, the provider should follow professional protocols that protect the confidentiality of the woman’s information. This includes not releasing the woman’s information without her consent and not discussing her situation in the presence of others. The woman also has the right to make a free and informed choice about the contraceptive method she will use.

Acceptance of contraception or of a specific method should never be a prerequisite for obtaining abortion care. Free and informed choice means that a woman chooses a method voluntarily, without coercion or pressure. It requires that she has a variety of methods to choose from and a clear understanding of the benefits and risks of each method. Women who are offered multiple methods and are allowed to choose freely from among them are more likely to accept and consistently use contraceptives (Ross et al., 1989).

6. Involvement of Partners
The inclusion of partners in contraceptive counseling can increase the effectiveness of the counseling and support for the woman’s contraceptive use (Abdel-Tawah, 1999). In fact, male partners' support of contraception is a strong indicator of contraceptive use (Mason and Pilyman, 1992). In addition, counseling male partners can increase their awareness and use of male contraceptive methods, such as male condoms and vasectomy.

If the woman’s partner wants to be included in the contraceptive-counseling process, the counselor should first meet alone with the woman to determine if she wants the partner involved. If she indicates that she does not desire this, the counselor should honor the confidentiality of the woman and counsel her privately.

If the woman’s partner does not approve of her use of contraception but the woman still wants to use it, the counselor should help her select a method that does not require her partner’s cooperation or knowledge, such as an injectable or IUD. The counselor should also discuss possible consequences, such as violence, if the woman’s partner learns of her contraceptive use. If appropriate, the counselor should help the woman explore how she would protect herself in such an event and should provide referrals to appropriate services.

7. Essential Elements of Contraceptive Counseling
An effective counselor does more than describe the various contraceptive methods available; he or she establishes trust with the woman, comes to understand her personal needs and tailors the counseling session to meet those needs. Contraceptive counseling requires an open exchange of information that can only occur in an atmosphere of mutual respect.

The GATHER technique for contraceptive counseling is used widely in family planning settings.

G- Greet client
A- Ask
T- Tell
H- Help
E- Explain
R- Refer

The following steps are critical to effective contraceptive counseling.

7.1 Establish rapport
The counselor should secure a private space to talk, greet the woman in a friendly way, speak directly to her and demonstrate interest and concern. The counselor should ask if it is an appropriate time to discuss contraception, assure her that the conversation will be kept confidential and ask the woman if she wants her partner present.

7.2 Assess the woman’s needs
Use open-ended questions. Be careful not make assumptions. Discuss the factors that led to the need for an abortion and determine if the pregnancy was unplanned. If the woman was using contraception to prevent pregnancy, the coun-
sor should help assess whether there were particular reasons the method failed.

7.3 Discuss human reproduction
Some women who seek PAC services may not fully understand the basics of how they became pregnant or how contraception prevents pregnancy.

Ask if the woman desires to delay or prevent future pregnancy. Although most women accessing PAC services will want to delay or prevent pregnancy, counselors must not make that assumption. They should ask the woman about her desires and circumstances. Some women who have experienced a miscarriage or had an abortion for medical reasons are not interested in delaying pregnancy. Contraceptive counseling and information on the benefits of spacing children may still be useful for these women for future reference, or if a delay in pregnancy is medically recommended.

7.4 Assess the woman’s individual situation
Consider both the woman’s clinical condition and her personal situation and discuss in a sensitive manner any potential barriers to the successful use of contraception. The counselor and the woman can then find ways to resolve or work around those barriers.

7.5 Explain characteristics of available methods
It is important to determine which contraceptive methods are available and accessible to a woman, both at the facility and within her community. The counselor should explain the characteristics, use, side effects, contraindications and effectiveness of the methods available, and let her know where she can obtain them. They should clear any misconceptions and ensure that the woman understands how the method she selected works.

7.6 Help the woman choose her method
Counselors should support the woman in selecting the contraceptive method that best suits her and her partner’s situation. It is important to help the woman make her own informed choice. This may involve asking follow-up questions, explaining the characteristics of different methods and exploring re-supply issues, taking community resources into account.

The counselor can help her develop a plan for continued use and encourage her to return if the first method becomes unacceptable to her, if she wants to change to a new method or if she wishes to stop using contraception for any reason.

7.7 Refer the woman to related community resources as needed
Discussions about contraception may reveal other factors affecting a woman’s sexual and reproductive health, such as violence or commercial sex work. Counselors should have resource lists available to make any appropriate referrals.

8. Medical Eligibility for Contraceptive Use After an Abortion
When providing contraception to a woman, her medical eligibility for each method must be considered. In general, all modern contraceptive methods can be used immediately following a first-trimester abortion, provided that:

- There are no severe complications requiring further treatment.
- The woman receives adequate counseling and gives informed consent.
- The provider screens for any precautions for using a particular contraceptive method.

However, there are some notes of caution:

- It is recommended that women not have sexual intercourse until postabortion bleeding stops (usually five to seven days) and any complications are resolved and their chosen contraceptive method becomes effective.
- Natural family planning, or the fertility-awareness method, can be used after a woman has had at least one post-abortion menses, provided that before this pregnancy she had normal menstrual cycles (WHO 2004).
- Some medical conditions require a delay in the use of certain methods.

Women should also understand that, except for female sterilization, which is considered permanent, they can switch to another temporary method in the future.

8.1 Appropriate contraceptive methods for various post-abortal outcomes
Based on WHO data, the following section discusses which methods are appropriate or inappropriate.

The contraceptive methods referred to include:

- Barrier methods such as male and female condoms,
- Hormonal methods such as combined oral contraceptives, progestin-only oral contraceptives, combined injecta-
bles, progestin-only injectables, implants and skin patches
- Fertility awareness-based methods such as basal body temperature and calendar methods
- EC, which must be used within 3 days after unprotected intercourse and includes insertion of an IUD or a specific regimen of contraceptive pills
- Surgical methods such as male and female sterilization

<table>
<thead>
<tr>
<th>SCENARIO</th>
<th>CONTRACEPTIVE OPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncomplicated Abortion</td>
<td>All modern contraceptive methods can be used immediately.</td>
</tr>
<tr>
<td>Abortion With Infection</td>
<td>In cases where an infection is evident or presumed, the provider should advise the woman to avoid intercourse until the infection is resolved or ruled out. When complete abstinence is not realistic, certain methods are not recommended. Female sterilization is not appropriate until infection is either ruled out or resolved, as the presence of infection may increase the risk of post surgical infection. Intrauterine methods are not appropriate until infection is resolved because insertion may substantially worsen the condition.</td>
</tr>
<tr>
<td>Genital Injury</td>
<td>Genital injury includes uterine perforations, cervical tears, vaginal trauma and lacerations. These injuries may require a delay in the use of certain contraceptive methods depending on the location and severity of the injury. Methods that may be temporarily restricted include female sterilization, IUD and barrier methods other than the male condom. In these cases, the provider must make a clinical judgment about which methods to recommend for interim use.</td>
</tr>
<tr>
<td>Excessive Blood Loss</td>
<td>Excessive blood loss may require a delay in the use of female sterilization and IUDs, depending on the severity of the loss. For sterilization, delay is recommended if laboratory tests or clinical signs indicate anemia.</td>
</tr>
</tbody>
</table>

**Note:**

1. If a fertility awareness-based method is a woman's choice, she should be informed that it will not be reliable until a regular menstrual pattern returned, typically after three menstrual cycles after abortion. The woman can use other contraceptive method during these three months.

2. Female sterilization is not recommended during or immediately after post abortion treatment except when a woman has made a free and informed choice to undergo this permanent procedure.

3. If uterine size is greater than 12 weeks it is advisable to delay the sterilization until the uterine size return to its pre-pregnant size (4-6 weeks)

**9. Emergency Contraception**

Emergency contraception (EC) is a particularly important option for preventing pregnancy after unprotected intercourse be it method failure, consented, rape or when taken within 72 hours. For women receiving PAC services who have had difficulty using contraception successfully, providing EC may help prevent unwanted pregnancy. The pills work primarily by preventing or delaying the release of eggs from the ovaries (ovulation). Therefore, the use of EC will not terminate or interfere with a pregnancy once it is established.

**Indications for EC**
- It can be used anytime a woman is worried she might fall pregnant for example, after
- Sex was forced (raped or coerced)
- Any unprotected sex
- Contraceptive failure
- Condom was used incorrectly, slipped or broke
- Couple failed to use fertility method e.g. abstinence, LAM, calendar method
- Man failed to withdraw before ejaculation
- Woman has missed three or more COC or has started a new pack three or more days later
- IUCD has come out of place
- The woman is more than two weeks late for her repeat Progesterone only injection

**There are two types of EC:**
- Intrauterine device (IUD): When inserted within five to seven days after unprotected intercourse, a copper IUD is 99 percent effective in preventing pregnancy (WHO, 2000; Dunn et al., 2003).
- Emergency contraceptive pills (ECPs) are 75 to 95 percent effective when used within 72 hours after unprotected intercourse (Ellertson et al., 2003; Grimes, 2002; Rodrigue et al., 2001; TFPMFR, 1998). These may be Combined Oral Contraceptive or Progesteron only contraceptive.

**Standard EC regimen**

<table>
<thead>
<tr>
<th>Method available</th>
<th>Initial ECP</th>
<th>Common brand names</th>
<th>Mode of administration</th>
<th>Repeat Dosage after 12 hrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.03mg Lavonorgestrel</td>
<td>1.5 within 72 hours (50 Pills)</td>
<td>Microval</td>
<td>Oral</td>
<td>Nil</td>
</tr>
<tr>
<td>(Progesterone only pill)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combined oral contraceptive (COC)</td>
<td>0.6 mg 120ug within 72 hours (4 pills)</td>
<td>Nordette</td>
<td>Oral</td>
<td>0.6mg 120ug (4 pills)</td>
</tr>
<tr>
<td>- Oestrogen 30ug</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Progesterone 150 ug</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35ug</td>
<td>70ug</td>
<td>Norynil</td>
<td>Oral</td>
<td>70ug 2mg (2 Pills)</td>
</tr>
<tr>
<td>1mg COC</td>
<td>2mg (2 pills)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Oestrogen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Progesterone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUCD</td>
<td>Insert within 5 days of unprotected sex</td>
<td>Cu T 380A Nova T</td>
<td>Intra uterine</td>
<td>Nil</td>
</tr>
</tbody>
</table>

To be most effective, ECPs should be started as soon as possible after unprotected intercourse.

Although either progestin-only pills (POPs) or combined estrogen-progestin oral pills (COCs) may be used, POPs are more effective and produce fewer side effects.

When taken within 24 hours of unprotected intercourse, progestin-only ECPs have been found to reduce the risk of pregnancy by 95 percent.
- When taken within 72 hours of unprotected intercourse, ECPs that contain progestin-only reduce the risk of pregnancy by 89 percent, while ECPs that contain both estrogen and progestin reduce the risk of pregnancy by 75 percent.

**Side effects of EC:**
- Nausea and Vomiting
- To prevent nausea and vomiting, consider prescribing progesterone only ECPs than combined ECPs because nausea and vomiting are more likely to occur with COCs than POPs
- Women who have had nausea with previous EC use with the first dose of two dose regime can take anti-emetic medication 30minutes to 1hr before taking EC
- If a woman vomits within 2hrs after taking EC, she should take another dose but if vomiting continues a repeat EC dose can be given high into the vagina
- Headache
- Fatigue
- Abdominal pains
- Breast tenderness
- Dizziness

**Special Contraceptive-Counseling Issues**
Some women will have extenuating circumstances or situations in their lives that can impact their contraceptive needs. For these women, the same contraceptive-counseling principles of respect, compassion and openness apply. Addition-
ally, counselors may need specialized knowledge to help women deal with their situations in such cases it best to refer women to providers who can offer high-quality contraceptive services specific to the situation.

- **Women with repeated abortion**
  If a woman has a history of repeated spontaneous, incomplete abortion and wants to become pregnant, she should be referred for a specialized gynecological specialized counseling.

- **Women experiencing violence**
  Sexual violence can result in physical injury, unintended pregnancy, STIs and psychological distress. A woman who has experienced or is experiencing any type of physical or emotional abuse may have specific contraceptive needs. In addition she may desire support and counseling that will help her remove herself from the violent situation.

- **Adolescents**
  Adolescents who have undergone abortion may not have the support of their partners or parents and they are more likely to experience isolation and emotional stress. They should be referred to youth friendly clinics and/or clinical psychologist. It is important that counselors be supportive and non-punitive, taking extra care to express openness and compassion. It is important that providers do not deny adolescents access to contraception because of their age or marital status. Provider should keep in mind that pregnancy may be the result of rape or ongoing sexual abuse.

- **Women with HIV/AIDS**
  Provider should be prepared to offer or refer HIV positive women receiving PAC for specific information, counseling and services. Those with unknown status should be offered routine HIV counseling and testing. Counselors should make sure the woman understand her rights to bear children, the risk of mother to child transmission of HIV and the availability of PMTCT and HAART. Male and female condoms if used correctly all time will help protect against transmission and re-infection with new strains of HIV. Dual protection is recommended for pregnancy prevention and disease protection.
CHAPTER 13
COMMUNITY LINKAGES

1. Introduction
It is the obligation of health systems to make abortion services available at the most local level possible—in communities where women live. Communities can play a key role in reducing maternal mortality and morbidity by establishing links with facilities that offer reproductive-health services. In turn, health-care workers can play a major role by reaching out to community members to establish such links. Partnerships between health facilities, trained providers and community leaders and groups can greatly strengthen the delivery of high-quality, woman centered abortion services. Community linkages can help service providers understand the contexts in which women and their families live, the barriers to services they may face, and women's own perceptions of what constitutes high quality community-based care. Mutual trust can be built through close, productive interactions between community members and health-facility personnel, facilitating better care for women.

The term community can be defined in various ways. The term is commonly used to designate people residing in a common geographic location, such as a village. However, many diverse communities can exist based on specific, shared interests or among people with a common history or culture or shared social, political or economic interests. For example, women who face common challenges in feeding and caring for their children and families may come together around issues of health or income generation, forming associations or community-based groups.

The above definitions stress the similarities and shared interests of community members. In reality, however, although agreement and shared interests exist in all communities, differences of opinion and conflict also exist. These differences can have a significant impact on the health and well-being of community members, especially women. The issue of abortion, in particular, can be very sensitive and a source of conflict within a given community.

Studies have documented that both overt and subtle harassment by community members of health workers who provide abortion care has a negative impact on women's access to services (Varkey et al., 2001). It is important that providers be aware of the possible effects that community opposition to induced abortion could have upon other services provided by a health facility. At the same time, providers should also identify allies who can help promote women's access to high-quality abortion-care services.

Abortion-care providers and health-facility staff need to take an active role in building partnerships with community members.

To establish community links, health workers can identify problems, inform and consult community leaders and representatives, provide guidance on what can be done at both the health-facility and community levels, and offer suggestions for community involvement. At the same time, community members can also be proactive in defining community perspectives and problems and proposing suitable solutions. Together, these partners can develop appropriate sensitization messages regarding reproductive health and abortion care services. It is important to note that, in most cases, providers are also community members themselves and thus have multiple perspectives and roles, including those of advocates, health educators and role models. Additionally, there are almost always power dynamics within the medical system and vis-à-vis community members of which health-care workers should be cognizant. Providers should treat all women in the community equally and respectfully regardless of their marital status, age or decisions about pregnancy.

2. Community Assessment
Many community residents—including women, health-care providers, community leaders, family members and others—have a vested interest in the health, safety and well-being of local women and families. It is very important to tap community members' knowledge and it is critical to listen to what women say about health-related issues. Health-care providers can begin to create links by identifying and talking with key individuals who often represent the shared interests of broader communities:
- Government officials
- Health-committee members
- Leaders of women's groups
- Leaders of men's groups
- Leaders of youth groups
- Religious leaders
- Law-enforcement officials
• Traditional birth attendants
• Traditional medicine healers
• Community-based health workers.

Health-facility personnel should gather information to better understand the opportunities and constraints they face when offering abortion services in the community. Community-assessment surveys can be used to determine which reproductive-health services women have access to, what women’s prior experiences with the health system have been, what existing health structures and mechanisms are in place, what is important to women and their families, and what is relevant to their real-life circumstances. These findings will be critical to building partnerships with the community.

General elements of such a survey might include:
• Determining where and how people receive health-related information.
• Finding out what resources, such as community loan funds or community-based health agents, are available to support high-quality health care for women, as well as whether women know about their availability.
• Soliciting information about how community members define an accessible, available and skilled health-care provider.
• Exploring community members’ previous encounters with the local health system, examining such issues as trust, confidentiality and overall quality of care.
• Determining which public-health issues confront the community (for example, HIV/AIDS or adolescent pregnancy), as well as which local “hot button” concerns exist (for example, high unemployment rates or substandard housing).
• Assessing whether community members see maternal mortality or morbidity as a problem and whether they view unsafe abortion as a contributing factor.
• Examining the perspectives of community members regarding the specific issue of induced abortion.

Specific abortion-related questions might include:
• What factors lead to women facing unplanned or unwanted pregnancy?
• Where do women obtain information about pregnancy, unwanted pregnancies and available options?
• Who influences women’s decisions regarding pregnancy, including termination?
• What are community norms, myths, social patterns, customs, health-related beliefs and practices regarding unwanted pregnancy and induced abortion?
• What are local beliefs or attitudes about health providers who provide abortion care?
• Is abortion care services accessible legally and/or illegally?
• Do community members know where services are available?
• What barriers exist to accessing services?
• How can access to safe abortion care services be improved?

3. Programmatic Strategies
Health-care providers should use the information gathered in the community assessment phase to design programmatic activities that will link abortion services and community members in effective ways. Moreover, providers should be open to implementing community-generated solutions to identified problems. Community linkages are most effective when locally driven and championed by local, recognized health leaders who can provide credibility and sustainability. This allows for essential dialogue and protection of rights within a legal and culturally appropriate framework.

Increase Awareness and Education
Women, their partners and their families need information about options regarding unplanned pregnancy; the availability of contraceptive services, including emergency contraception; legal indications for induced abortion care services; where they can obtain safe abortion care services; the dangers of unsafe abortion; and the importance of seeking abortion-related care from trained providers. In general, women need to be able to exercise their right to abortion within the indications of the law, and providers should do what they can to facilitate that.

Following are some potential strategies:

Prevention and Education
• Providers can work with community leaders to educate women and their partners about human reproduction and the importance of consistent contraceptive use to prevent unwanted pregnancy.
• Community-health workers can also be trained and equipped to supply contraceptive methods, eliminating the time and expense of traveling to a clinic, and to raise awareness about emergency contraception.
• Health-care personnel can train community-based health workers and other leaders to supply educational reproductive-health information and to help dispel myths about abortion that may exist.
• Health-care workers can collaborate with community leaders to organize public meetings and sensitization discussions on women’s rights to reproductive health information, informed consent and choices in care when receiving health services. (See the Overview and Guiding Principles chapter for more information.)
• Health workers can promote community education about the harmful impact of violence on the health of women and families, while raising awareness of potential solutions and preventive measures.
• If adolescents are found to have specific concerns—such as engaging in sex with much older or married male partners, which puts them at risk for pregnancy and acquiring sexually transmitted infections (STIs)—counselors can alert community and youth leaders about those concerns.

Service Provision
• Providers can conduct values clarification workshops with community members.
• If health-care workers identify negative public-health trends among women attending their facilities, they should alert appropriate community members. For example, if, despite legal indications, many women are coming in with complications from unsafe abortions, providers could meet with community leaders to encourage further education on prevention, symptoms and prompt treatment.
• Health managers can make public announcements, postings and media messages to ensure that the public is aware of their health-care facility’s confidentiality policies and their means of enforcing them.
• If off-label use of misoprostol to terminate pregnancy is occurring in communities, providers can educate pharmacists and others who use or dispense prescription medications about safe versus unsafe doses of misoprostol. Public campaigns can encourage women to seek safe abortion services.
• Health-facility staff can identify which community, regional or national resources are available to meet specific client needs and develop a referral system to accommodate women who need specialized services.

3.2 Ensure Immediate Treatment of Complications
Key factors in reducing maternal morbidity and mortality are early counseling, referrals for safe abortion services or treatment of complications, and adequate follow-up care. Providers can work with community leaders to educate women and their partners and family members about signs and symptoms of abortion complications that require prompt medical attention, as well as how and where they can receive emergency care. Communities can prevent delays in getting women with obstetrical emergencies to life-saving health services by setting up an emergency transportation system using pooled resources. Health-facility staff can train community health workers or local volunteers to refer women in emergency situations to health-care services, to follow up with women after treatment and to link women to contraceptive and other reproductive-health services.

3.3 Monitor Service Delivery
Health facilities can form community advisory groups or quality-of-care committees to assist in assessing services, making recommendations for improvements, and participating in the implementation of recommendations as appropriate. Health-facility managers and providers can also train community members to conduct client-satisfaction surveys within the clinic or in the community, taking into account the need for client privacy and confidentiality. An important aspect of working with communities is to work with people on how to understand and use the collected information. (See the Monitoring to Improve Services chapter for more information.) Health providers should also consider attending appropriate local meetings to share their monitoring results and steps taken to enhance services. These exchanges can be useful in motivating community members to provide input for service-delivery improvements.

3.4 Prevent Infection
Neighborhoods surrounding health-care facilities may be concerned about exposure to infectious waste, including products of conception. Health managers should share with community leaders the health facility’s protocols for infectious waste disposal and work with them to ensure that the public’s health is protected. Health-care workers can also educate women and community members about actions they might take to prevent the spread of infections while in the health-care facility, at home or in the community. The improper processing and disposal of medical instruments, including abortion related instruments, is a public-health risk, particularly in settings characterized by untrained providers and unhygienic conditions. The risk of infection can be reduced when:
• Used medical instruments are disposed of appropriately, rather than discarded in places like open dumps to which the public has access.
• Health-care workers follow proper instrument-processing techniques and do not carry pathogens from the facility into the broader community. (See the Infection Prevention chapter for more information.)

3.5 Advocate for Improved Policies
Health-care workers and community members can exercise their civil liberties by organizing grassroots campaigns that encourage local government representatives to prioritize sexual and reproductive health and rights. They can also specifically advocate that local health-care facilities offer abortion care services within legal indications and that legal indications be expanded.

If counselors see large numbers of women needing specialized services—such as screening, counseling, support or treatment for HIV—they can work with community leaders to advocate that health systems fill those service gaps at a local health-care facility. Alternatively, community agencies and individuals may be interested in initiating services,
such as support groups or peer education, on a volunteer basis.

4. **Summary**
   - Partnerships between health-facility staff and communities can play a key role in reducing maternal mortality and morbidity by strengthening the delivery of high-quality, woman-centered abortion services.
   - Providers should be aware of their role in the community as role models and leaders, while working in partnership with community members to advance women's health.
   - Community-assessment surveys can inform providers and other stakeholders about general health conditions and about specific abortion-related issues.
   - Providers and staff members at health facilities can raise public awareness about the reproductive rights of women and critical health issues facing the community and provide accurate information on sexuality and reproductive health, particularly abortion care.
   - Early referral for abortion complications and follow-up care are critical steps in reducing maternal morbidity and mortality, and communities can take steps to help prevent delays in getting women with obstetrical emergencies to lifesaving health services.
   - Health facilities that involve the community in monitoring service delivery can better ensure that community needs are met and that woman-centered abortion-care services are accessible.
   - Communities surrounding health-care facilities may be at risk for exposure to infectious waste, and health managers have a responsibility to ensure that proper protocols for infection prevention are followed.
   - Communities and health staff can work together to advocate that authorities prioritize sexual and reproductive health and rights, provide necessary services and adopt policies that serve women's needs.
CHAPTER 14
MONITORING OF PAC SERVICES

Introduction
Every health service, no matter how small its caseload or how high its quality, can benefit from routine monitoring. Monitoring helps ensure that health-care services achieve and maintain a level of quality that is satisfactory to both the clients who use them and the health-care workers who provide them. This section provides some guidelines, including key characteristics of effective monitoring systems, the basic steps involved in monitoring and aspects of abortion-care service delivery that should be routinely assessed through such a process.

1. What Is Monitoring and Why Is It Important?

Monitoring, or the routine tracking of services, is a way of using information to identify the strengths and weaknesses of health services and to provide feedback on quality improvement. The regular monitoring of services and the adjustment of services in accordance with findings are essential to ensuring that clients receive high-quality services and that health-care workers have the resources they need to provide high-quality care.

Monitoring does not need to be expensive, burdensome or complicated. Instead of creating complex monitoring systems, information for monitoring purposes can be gathered using existing or slightly modified routine information-collection systems, such as logbooks, service statistics and client records. With minimal effort and simple tools, health-care providers and managers can conduct periodic investigations into certain aspects of service delivery, such as client satisfaction, that may not be addressed through other means.

Monitoring is not a one-time event; it is an ongoing process that should be continued whenever and wherever services are provided. It uses simple tools to measure the same services at several points over time. The resulting “time series” information provides a long-range overview of how services change over time. This information enables both providers and managers to recognize trends and identify problem areas, make necessary adjustments to services and later check that these adjustments have had the desired effect.

Monitoring should be conducted at both public-sector and private-sector health facilities. The number and complexity of activities will vary according to the availability of staff and resources. In larger health facilities, administrators and managers usually conduct monitoring activities. In smaller facilities, providers may need to initiate and conduct monitoring activities. In either case, monitoring systems should be simple and easy to use, and should offer relevant information to the service providers.

2. Keys to Effective Monitoring Systems

Monitoring is most effective when it:

...is integrated into routine work
The most effective monitoring systems use information collection that is integrated into routine work. When monitoring adds too many extra steps, the process becomes time-consuming and burdensome for health-care workers. Instead of creating special data-collection tools, information gathered for monitoring purposes can be culled from such existing sources as logbooks and service statistics.

...uses simple indicators
Sometimes facilities try to collect too much data or to gather information that is too complex. Providers should avoid collecting information that will never be used or cannot be analyzed at the facility level. A small number of simple, thoughtfully chosen indicators can provide invaluable information about service provision.

...is participatory and open
When the monitoring process is genuinely inclusive of all health-care staff members, they are more likely to feel a sense of ownership of the results, as well as of any improvement processes. Staff inclusion in the process of defining high-quality services also helps to clarify performance expectations. Staff members should be trained to use monitoring tools and processes, accompanied by supportive supervision, so that they can incorporate monitoring into their responsibilities. Finally, sharing the results of monitoring efforts with staff illustrates for them which aspects of services are effective and which need improvement.
...Is conducted in ethical manner
All monitoring efforts must be conducted in a manner that is respectful to both patients and providers. The privacy and confidentiality of patients must be respected at all times. No patient should feel pressured to participate in monitoring efforts. Informed consent must be obtained before patients are interviewed or any provider patient interaction are observed.

...Is not punitive
For monitoring to be most effective, it must be a non-judgmental, non-punitive process. Monitoring is most effective when members of the service-provision team monitor themselves and the information gathered is used as a basis for reward and recognition among team members.

3. Four Steps of Effective Monitoring
Monitoring involves four basic steps:
- **Planning**: establishing standards of quality, selecting information-collection methods and indicators of those standards, and ensuring staff and managerial support for the monitoring process
- **Information gathering**: collecting information about services
- **Analysis**: comparing the current state of services with quality and performance standards and with longitudinal changes in service quality
- **Action planning**: developing improvement plans to address any problems that have been identified through the monitoring process

3.1. Planning
Before initiating data collection, develop a monitoring plan that specifies how information will be collected, shared and analyzed. It is important to contact and garner the support of all administrators, managers and providers who will be affected by the process. A lead monitor or monitoring team should be selected and trained to gather, analyze and share information. With the input of staff and managers, the team should determine the aspects of services to be monitored. The team should use performance standards to establish criteria against which current services will be compared, and develop or adapt checklists and other tools to guide observations, interviews and records review. Checklists should include the features and processes essential to the delivery of high-quality care, including the availability of supplies, use of preferred medical techniques and quality of counseling.

A monitoring plan should identify:
- Members of the monitoring team
- Aspects of services to be monitored
- Performance standards
- Sources of information, such as logbooks with service statistics and client records
- Methods for gathering information, such as interviews, focus groups, observation and records review
- Tools that will be used to guide information gathering, including checklists and consent forms
- A plan for sharing results with staff and adjusting services, if needed
- A timeline for the monitoring process, with information about activities and persons responsible for their completion

3.2 Information gathering
Health facilities in a health system are usually required to collect and report service information to a centralized administrative location. The information collected for those reports can be analyzed by or shared with health workers at the facility level so that they are involved in the process beyond their role as information gatherers. Local analysis of these data also prevents redundant monitoring efforts and promotes collaboration between the administrative sectors of the health system and the health-care providers.

Once the monitoring team has developed checklists and other tools to guide observations, interviews and the review of records, they can begin collecting information. Facilities in both the public and private sector routinely collect information about services using tools such as logbooks, clients' clinical records and supply ledgers.

However, there are important aspects of services that cannot always be measured using routine data-collection tools, such as the quality of client-provider interaction and client satisfaction. Additional, periodic in-depth investigations that include observation and client interviews allow monitors to examine aspects of service delivery that are not otherwise captured through routine data collection.

3.3 Analysis
The analysis of monitored data involves compiling and reviewing the findings to reveal problem areas, develop improvement plans and assess progress in improving care. The objective is to identify those areas that are most in need of attention and to develop plans for strengthening those problem areas. The review of monitored data presents an opportunity for health-care staff to openly discuss the facility's strengths and weaknesses. The assessment of quantitative
data will involve tabulation and statistical analysis. Qualitative information, such as interviews, can be used to complement quantitative information. For example, quantitative information may reveal that client visits consistently increase on a certain day of the week; qualitative information may provide information about why this is occurring. Qualitative information adds detail to analyses and provides information about aspects of services that cannot be captured quantitatively.

The data that was collected during the information-gathering process should be compiled for review by the monitoring team. From this data, the group should be able to identify problem areas and issues of concern, as well as areas of strength and competency. Once the staff has a better understanding of the problems, they can delve deeper into the underlying causes of the identified problems. Health-care staff must ask the question, “What factors have contributed to these problems?”

For example, poor-quality counseling services might stem from a lack of staff training in counseling and a client-intake process that leaves insufficient time for counseling.

The staff review may also identify causes that are more pervasive—for instance, an underlying belief that counseling is not an important part of services.

3.4 Action planning
Once problem areas have been identified and analyzed, the monitoring team can develop an improvement plan for resolving issues and improving services. The team should first assess which problems can be addressed with relative ease, given available resources. The team can then formulate potential solutions to the problems. A range of approaches to each problem should be carefully discussed before a decision is reached about which solution is most feasible. Alternate solutions should be listed as potential future options, in case the initial solution does not meet expectations.

The team should draft a written plan that provides details on what implementation of the improvement plan entails and when, where and how it will be conducted. To effectively and efficiently carry out the proposed improvements, the monitoring team should specify who will be responsible for implementing each step of the proposed solution. The team should also prepare a timeline for implementation and assessment.

The improvement plan should then be discussed with staff members who are not on the monitoring team, but who may play a direct role in its implementation. Once everyone who will be involved has been informed, the monitoring team should present its findings and proposed solutions to the entire staff. This is an opportunity to obtain valuable staff feedback about the monitoring process and the improvement plan. It is important to share positive findings with staff, including areas of strength and competency and any improvements that have been made. Staff contributions that have led to improved services should be recognized so that staff members can celebrate their successes.

CPAC Indicators and Monitoring Tools
For effective monitoring and evaluation of CPAC services in health facilities, basic information on the services must be collected routinely, and reported to the district and central MOH in a timely fashion.

CPAC Service Delivery Indicators
The following is a list of service delivery indications that must be collected by each health facility delivering PAC services for program monitoring.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incomplete abortion cases presenting, by treatment method (including referral upon arrival)</td>
<td>Total number and percentage of cases of incomplete abortion and miscarriage presenting by treatment method Sub-indicators: • Number treated with D&amp;C • Number treated with MVA • Number treated with misoprostol • Number referred upon arrival</td>
</tr>
<tr>
<td>Gestational age</td>
<td>Gestational age of cases of incomplete abortion and miscarriage by treatment method Sub-indicators: • Number treated with D&amp;C • Number treated with MVA • Number treated with misoprostol</td>
</tr>
<tr>
<td>Return for follow-up</td>
<td>Number and percentage of women who return for a follow-up visit. The percentage is calculated by dividing by the total number of cases.</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Contraceptive method provision</td>
<td>Number and percentage of women who take a method of contraception home. The percentage is calculated by dividing by the total number of cases.</td>
</tr>
<tr>
<td></td>
<td>Sub-indicators:</td>
</tr>
<tr>
<td></td>
<td>- Took contraceptive method home at first visit</td>
</tr>
<tr>
<td></td>
<td>- Took contraceptive method home at follow-up visit</td>
</tr>
<tr>
<td>Women presenting with serious complications due to unsafe abortion</td>
<td>Number and percentage of women presenting with any serious complication due to unsafe abortion (including shock, sepsis, uterine perforation, or hemorrhage). The percentage is calculated by dividing by the total number of cases presenting at the facility.</td>
</tr>
<tr>
<td>Deaths related to abortion complications</td>
<td>Number of deaths due to abortion complications during the time period</td>
</tr>
<tr>
<td>Screening for STI/HIV</td>
<td>Number and percentage of women screened for sexually transmitted infections, including HIV. The percentage is calculated by dividing by the total number of cases.</td>
</tr>
<tr>
<td>Screening for gender based violence</td>
<td>Number and percentage of women screened for exposure to violence. The percentage is calculated by dividing by the total number of cases.</td>
</tr>
<tr>
<td>Referrals due to complication of procedure</td>
<td>Number and percentage of women referred due to complications of the procedure at the first visit. The percentage is calculated by dividing by the number of women treated at the facility.</td>
</tr>
<tr>
<td>Referrals for completion</td>
<td>Number and percentage of women referred for completion of procedure at the follow-up visit. The percentage is calculated by dividing by all women who returned for a follow-up visit.</td>
</tr>
</tbody>
</table>

**Data Collection Tools**

Data will be collected through the use of routine patient files and post abortion care clinic registers. Maternal and Perinatal Monthly Monitoring Tool (MH3123) is a summary tool used for reporting of compiled monthly data and submitted to the district and national level. A sample of this tool is provided in Appendix 5.
REFERENCES


   a. 31045183 (DNY.Sept. 13, 2002).


26. Royal College of Obstetricians and Gynaecologists. The care of women requesting abortion


## APPENDICES

### APPENDIX 1: MISOPROSTOL REGIMENS FOR USE IN OBSTETRICS AND GYNECOLOGY: POCKET REFERENCE FOR CLINICIANS (FRONT PAGE)

**Misoprostol Regimens for Use in Obstetrics and Gynecology**  
*Pocket Reference for Clinicians*

<table>
<thead>
<tr>
<th><strong>POSTPARTUM HEMORRHAGE</strong></th>
<th><strong>Route</strong></th>
<th><strong>Instructions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREVENTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>600 mcg</td>
<td>Oral</td>
<td>Take immediately after delivery of newborn with confirmation that all babies are delivered.</td>
</tr>
<tr>
<td><strong>TREATMENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>800 mcg</td>
<td>Sublingual</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td>Rectal</td>
<td></td>
</tr>
<tr>
<td>1000 mcg</td>
<td>Rectal</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>INCOMPLETE ABORTION &amp; MISCARRIAGE</strong> (uterine size up to 13 weeks)</th>
<th><strong>Route</strong></th>
<th><strong>Instructions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>600 mcg</td>
<td>Oral</td>
<td>Single dose</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>400 mcg</td>
<td>Sublingual</td>
<td>Single dose</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>INDUCTION OF LABOR</strong> (live fetus &gt;24 weeks)**</th>
<th><strong>Route</strong></th>
<th><strong>Instructions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not use with previous cesarean section.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 mcg</td>
<td>Oral</td>
<td>Every 2 hours.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oral solution can be used where 25 mcg tablets are not available. Dissolve a 200 mcg tablet in bottle of 200 ml clean water. Give 25 ml per dose every 2 hours.</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 mcg</td>
<td>Vaginal</td>
<td>Every 6 hours.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>CERVICAL RIPENING</strong></th>
<th><strong>Route</strong></th>
<th><strong>Instructions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>400 mcg</td>
<td>Vaginal or sublingual</td>
<td>Give 3 hours before the procedure.</td>
</tr>
</tbody>
</table>

---

Misoprostol regimen recommendations are based on the World Health Organization (WHO), the International Federation of Gynecology and Obstetrics (FIGO) and Cochrane Reviews.
### MISSED ABORTION

*In women with previous cesarean sections, reduce doses for 13-23 weeks.*

<table>
<thead>
<tr>
<th>Dose</th>
<th>Route</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 12 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>800 mcg</td>
<td>Vaginal</td>
<td>Every 3 hours, maximum 2 doses.</td>
</tr>
<tr>
<td>OR</td>
<td>Sublingual</td>
<td>Every 3 hours, maximum 2 doses.</td>
</tr>
<tr>
<td>13-17 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>200 mcg</td>
<td>Vaginal</td>
<td>Every 6 hours, maximum 4 doses.</td>
</tr>
<tr>
<td>18-23 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100 mcg</td>
<td>Vaginal</td>
<td>Every 6 hours, maximum 4 doses.</td>
</tr>
</tbody>
</table>

### INTRAUTERINE FETAL DEATH

*Reduce doses in women with previous cesarean section.*

<table>
<thead>
<tr>
<th>Dose</th>
<th>Route</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-26 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100 mcg</td>
<td>Vaginal</td>
<td>Every 6 hours, maximum 4 doses.</td>
</tr>
<tr>
<td>27+ weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 mcg</td>
<td>Vaginal</td>
<td>Every 6 hours.</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 mcg</td>
<td>Oral</td>
<td>Every 2 hours.</td>
</tr>
</tbody>
</table>

### MEDICATION ABORTION

Medication abortion with mifepristone and misoprostol

#### Up to 9 weeks gestation

Mifepristone 200 mg oral followed 24 to 48 hours later by misoprostol 800 mcg vaginal, sublingual or buccal. For oral route, 400 mcg misoprostol can be used up to 7 weeks of gestation.

#### 9-12 weeks gestation

Mifepristone 200 mg oral followed 36 to 48 hours later by misoprostol 800 mcg vaginal. Subsequent misoprostol 400 mcg vaginal or sublingual can be used every 3 hours until expulsion of the products of conception, up to 4 further doses.

#### 12-24 weeks gestation

Mifepristone 200 mg oral followed 36 to 48 hours later by misoprostol 800 mcg vaginal or 400 mcg oral. Subsequent misoprostol 400 mcg vaginal or sublingual can be used every 3 hours until expulsion of the products of conception, up to 4 further doses.

<table>
<thead>
<tr>
<th>Dose</th>
<th>Route</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 12 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>800 mcg</td>
<td>Vaginal or sublingual</td>
<td>Every 3 hours, maximum 3 doses.</td>
</tr>
<tr>
<td>12-24 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>400 mcg</td>
<td>Vaginal or Sublingual</td>
<td>Every 3 hours, maximum 5 doses</td>
</tr>
</tbody>
</table>

|
APPENDIX 2: CHECKLIST FOR MVA FOR UTERINE EVACUATION

Instructions: Rate the performance of the service provider for each step or task using the following scale. The checklist can be used for five (5) cases.

1. **Needs Improvement**: Step or task not performed correctly or is omitted
2. **Competently Performed**: Step or task performed correctly but learner does not progress from step to step efficiently
3. **Proficiently Performed**: Step or task efficiently and precisely performed in the correct order

   N/A   Not Applicable

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

**GETTING READY**

1. Greet the woman respectfully and with kindness

2. Assure the necessary privacy and confidentiality

**INITIAL ASSESSMENT**

3. Assesses patient for shock and other life-threatening conditions.

4. If any complications are identified, stabilizes the patient and transfers if necessary.

**MEDICAL EVALUATION**

5. Takes medical history.

6. Performs physical (heart, lungs and abdomen) and pelvic examinations.

7. Gives the patient information about her condition and treatment plan.

8. Discusses her reproductive goals, as appropriate.

9. If she is considering an IUD:
   - She should be fully counseled regarding IUD use
   - The decision to insert the IUD following the MVA procedure will be dependent on the clinical situation

**BEFORE THE MVA PROCEDURE**

10. Tells patient what is going to be done and encourages her to ask questions.

11. Tells patient she may feel discomfort during some of the steps and that s/he will tell her in advance.

12. Asks the patient about allergies to antiseptics and anesthetics

**STEP/TASK**

13. Checks that patient has thoroughly washed her perineal area.

14. Additional pain management options: verbal reassurance and relaxation; medications can be provided as needed

15. Checks the patient has recently emptied her bladder.

16. Determines that required sterile or high-level disinfected instruments and cannulae are present.

17. Checks MVA syringe and charges it (establishes vacuum).

18. Puts on apron, washes hands thoroughly with soap and water and dries with clean cloth or air dries.

19. Puts sterile gloves on both hands.

20. Arranges sterile instruments on sterile tray

**MVA PROCEDURE**

21. Explains important steps of the procedure prior to performing it.

22. Performs bimanual pelvic examination to confirm uterine size, position and degree of cervical dilation.
<table>
<thead>
<tr>
<th>STEPS/TASKS</th>
<th>OBSERVATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. Checks the vagina and cervix for tissue fragments with a speculum exam and removes them.</td>
<td></td>
</tr>
<tr>
<td>24. Start antibiotic prophylaxis by giving 100 mg doxycycline orally</td>
<td></td>
</tr>
<tr>
<td>25. Applies antiseptic solution two times to the cervix (particularly the opening) and vagina.</td>
<td></td>
</tr>
<tr>
<td>26. Puts tenaculum or vulsellum forceps on posterior lip of cervix.</td>
<td></td>
</tr>
<tr>
<td>27. Correctly administers paracervical block and waits 2-4 minutes for anesthetic to have maximum effect.</td>
<td></td>
</tr>
<tr>
<td>28. Dilates the cervix (if needed) using progressively larger cannulae.</td>
<td></td>
</tr>
<tr>
<td>29. Gently applies traction on the cervix to straighten the cervical canal and uterine cavity and inserts the cannula gently through the cervix into the uterine cavity.</td>
<td></td>
</tr>
<tr>
<td>30. Attaches the prepared syringe to the cannula by holding the end of the cannula in one hand and the syringe in the other.</td>
<td></td>
</tr>
<tr>
<td>31. Evacuates contents of the uterus by rotating the cannula and syringe clockwise and moving the cannula gently and slowly back and forth within the uterine cavity.</td>
<td></td>
</tr>
<tr>
<td>32. Inspects tissue removed from uterus for quantity and presence of POC and to assure complete evacuation.</td>
<td></td>
</tr>
<tr>
<td>33. When the signs of a complete procedure are present, withdraw the cannula and MVA syringe and removes forceps or tenaculum and speculum.</td>
<td></td>
</tr>
<tr>
<td>34. Performs bimanual examination to check size and firmness of uterus.</td>
<td></td>
</tr>
<tr>
<td>35. Inserts speculum and checks for bleeding.</td>
<td></td>
</tr>
<tr>
<td>36. If uterus is still soft or bleeding persists, repeats vacuum aspiration</td>
<td></td>
</tr>
</tbody>
</table>

**STEP/TASK**  
**POST-MVA TASKS**

<table>
<thead>
<tr>
<th>TASKS</th>
<th>OBSERVATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>37. Before removing gloves, disposes of waste materials and soaks instruments and MVA items in 0.5% chlorine solution for 10 minutes for decontamination.</td>
<td></td>
</tr>
<tr>
<td>38. Disposes of gloves by placing in leakproof container or plastic bag.</td>
<td></td>
</tr>
<tr>
<td>39. Washes hands thoroughly with soap and water and dries with clean, dry cloth or air dries.</td>
<td></td>
</tr>
<tr>
<td>40. Checks for amount of bleeding and if cramping has decreased at least once before discharge.</td>
<td></td>
</tr>
<tr>
<td>41. Instructs patient regarding postabortion care (e.g. when patient should return to clinic).</td>
<td></td>
</tr>
<tr>
<td>42. Give 200 mg doxycycline as post-procedure prophylactic antibiotic</td>
<td></td>
</tr>
<tr>
<td>43. Provide pain killers (NSAID drugs, such as 800 mg of ibuprofen)</td>
<td></td>
</tr>
</tbody>
</table>

**COUNSELING AND FAMILY PLANNING SERVICE PROVISION**

Discusses reproductive goals and, as appropriate, provides family planning. *(Note: Refer to Appendix 10.5 to use the Checklist for Postabortion Family Planning.)*

**COMMENTS**
APPENDIX 3: MEDICATION ABORTION CHECKLIST

Instructions: These checklists can be used both to develop clinical skills and for assessment purposes. Rate the performance of each step or task observed using the following scale. Use one column to report observations from one practice case, and the checklist can be used for five cases.

1. **Needs Improvement:** Step or task not performed correctly or out of order (if necessary) or is omitted

2. **Competently Performed:** Step or task performed *correctly in correct order* (if necessary) but learner does not progress from step to step efficiently

3. **Proficiently Performed:** Step or task efficiently and precisely performed in the correct order (if necessary)

N/A Not Applicable

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GETTING READY</strong></td>
<td>1</td>
</tr>
<tr>
<td>1. Greet the woman respectfully and with kindness</td>
<td></td>
</tr>
<tr>
<td>2. Assure the necessary privacy and confidentiality</td>
<td></td>
</tr>
<tr>
<td>3. Review patient assessment and treatment plan</td>
<td></td>
</tr>
<tr>
<td>• Confirm the gestational age: ____ weeks</td>
<td></td>
</tr>
<tr>
<td>• Confirm that woman is eligible for medication abortion: ____</td>
<td></td>
</tr>
<tr>
<td><strong>PREPROCEDURE COUNSELING</strong></td>
<td></td>
</tr>
<tr>
<td>• If other abortion methods are also available at your facility (such as MVA), confirm that the patient was provided counseling and informed on all available methods appropriate for her clinical situation</td>
<td></td>
</tr>
<tr>
<td>4. Confirm that the patient understands the most common transient side effects, and how to manage them, if necessary:</td>
<td></td>
</tr>
<tr>
<td>• Pain</td>
<td></td>
</tr>
<tr>
<td>• Bleeding</td>
<td></td>
</tr>
<tr>
<td>• Fever and/or chills</td>
<td></td>
</tr>
<tr>
<td>• Nausea and/or vomiting</td>
<td></td>
</tr>
<tr>
<td>• Diarrhea</td>
<td></td>
</tr>
<tr>
<td>• Headache/faintness/dizziness</td>
<td></td>
</tr>
<tr>
<td>5. Inform the patient that 2-8% of women may require additional intervention. If the drugs fail, the woman should be prepared to complete the abortion medically or surgically</td>
<td></td>
</tr>
<tr>
<td>6. Inform patient about warning signs, and tell her to consult a health facility if she experiences any of the following:</td>
<td></td>
</tr>
<tr>
<td>• Severe intractable pain and cramping, which does not respond to pain killers</td>
<td></td>
</tr>
<tr>
<td>• Heavy bleeding</td>
<td></td>
</tr>
<tr>
<td>• Fever which starts a day after treatment, or lasts more than 4 hours after misoprostol administration</td>
<td></td>
</tr>
<tr>
<td>• Vaginal discharge with foul smell</td>
<td></td>
</tr>
<tr>
<td>• No change or no bleeding after administration of drugs on the 7th day since the start of treatment (continuation of pregnancy)</td>
<td></td>
</tr>
</tbody>
</table>
7. Explain the dosage and administration of mifepristone and misoprostol to the patient:

**For pregnancies up to 12 weeks gestation**:  
- She will take 1 tablet of 200 mg mifepristone and swallow with water today (day 1). Instruct woman to mark the date and time on her calendar  
- She will wait for 24 hours  
- On day 3 (mark on her calendar), she will take 4 tablets of misoprostol (800 mcg total) sublingually.

**If mifepristone is not available, up to 12 weeks gestation**:

The regimen is to take 800 mcg misoprostol, 3 times, with 3 hour intervals, sublingually  
- She will take 4 tablets of 200 mcg (800 mcg total) sublingually now (mark the time on her file)  
- After 3 hours, she will repeat the second dose (800 mcg total) (mark the timing of the second dose)  
- She will take the 3rd dose (4 tablets, 800 mcg total), 3 hours after the second dose

8. Explain that the majority of women expel within 24 hours of misoprostol administration but the process may take up to 2 weeks to complete, during which there may be light bleeding

9. Ask the patient if she has any questions, and address her questions and concerns appropriately

**MA with PROCEDURE STEPS**

10. Give woman the tablets according to the correct regimen

11. If the option for taking pills at home is available at your clinic, provide further written information on how to take the tablets correctly at home, indicating the time (day/hour) to take the additional tablets

12. If she is taking pills to take at home, ask the patient to repeat the information on how to take the misoprostol tablets at home

13. Write the date of the follow-up (2 weeks from the day of the procedure) and give the patient follow-up card

14. Confirm with the patient that she understands the warning signs, and knows when to come back immediately, if required

15. Inform the patient about the referral facility, in case of emergency

16. Conduct contraceptive counseling and services as described in Checklist: Contraceptive Counseling and Method Provision

*The regimen provided here is based on the World Health Organization's 2012 Safe abortion technical and policy guidance for health systems. Other regimens are also available for medication abortion with mifepristone and misoprostol, including regimens for second trimester termination.*
APPENDIX 4: POST ABORTION CONTRACEPTIVE COUNSELING AND METHOD PROVISION CHECKLIST

Instructions: These checklists can be used both to develop clinical skills and for assessment purposes. Rate the performance of each step or task observed using the following scale. The checklist can be used for five cases.

1. **Needs Improvement**: Step or task not performed correctly or out of order (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in correct order (if necessary) but learner does not progress from step to step efficiently

3. **Proficiently Performed**: Step or task efficiently and precisely performed in the correct order (if necessary)

**N/A Not Applicable**

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>Clients</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Interview</strong></td>
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<tr>
<td>1. Greet the woman respectfully and with kindness</td>
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<td>2. Assure the necessary privacy and confidentiality</td>
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<td>3. Use effective interpersonal communication:</td>
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<tr>
<td>- Use two-way communication</td>
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<tr>
<td>- Use appropriate language</td>
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<tr>
<td>- Listening</td>
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<tr>
<td>- Non-verbal communication</td>
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<td>4. Encourage patient to talk (e.g. ask questions, express feelings)</td>
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<td>5. Obtain brief reproductive history</td>
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<td>6. Ask if she was using contraception before she became pregnant. If she was, find out if she:</td>
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<tr>
<td>- Used the method correctly</td>
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<tr>
<td>- Discontinued use, and why</td>
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<tr>
<td>- Had any trouble using the method</td>
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<tr>
<td>- Has any concerns or questions about the method</td>
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<tr>
<td>7. Identify fertility goals and individual needs</td>
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</table>

**Contraceptive Counseling**

Follow the steps to give the woman information about contraceptive choices available
(Use a family planning counseling flipchart or brochure if available)

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<tr>
<th></th>
<th>Clients</th>
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<th>2</th>
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<tbody>
<tr>
<td>8. Injectable contraceptives:</td>
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<tr>
<td>- Show the injectable and describe how it is used</td>
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<tr>
<td>- Explain how the method works and its effectiveness</td>
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<tr>
<td>- Explain common side effects</td>
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<tr>
<td>- Address any question or concern the woman may have about the method</td>
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<td>9. Oral contraceptive pills:</td>
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<tr>
<td>- Show the pills and describe how they are used</td>
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<td>10. Condoms:</td>
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<td>- Show the condoms and describe how they are used</td>
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<td>11. Implants:</td>
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<td>- Show the implant and describe how it is used</td>
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<td>12. Intrauterine device (IUD):</td>
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<tr>
<td>- Show the IUD and describe how it is used</td>
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<td>13. Permanent methods (female and male sterilization):</td>
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<tr>
<td>- Describe how the procedure is performed</td>
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<td>- Explain how the method works and its effectiveness</td>
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<td>14. Emergency contraception</td>
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<td>- Describe how the pills are used</td>
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<tr>
<td>- Explain how the method works and its effectiveness</td>
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<td>15. Discuss the use of intravaginal methods (diaphragms, vaginal ring, contraceptive jellies, foams, tablets or films), if available</td>
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<td>16. Help the patient to choose an appropriate method</td>
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</table>

**Contraceptive Method Provision**

| 17. Explain to the woman that she can get pregnant again, as soon as in the next 10 days, so she should start using a method immediately |
| 18. Provide the patient her method of choice if available at the facility: |
|   (The following methods can be initiated at the time of the first pill taken for medication abortion): |
|   - Injectables |
|   - Condoms |
|   - Oral contraceptives |
|   - Implants |
|   - Intravaginal methods |
| 19. Refer the patient to appropriate facility, if the method she has chosen is not available at your facility |
| 20. If method is not immediately available, the patient does not reach a decision at the time, or needs to be referred to another facility for her method of choice, provide a temporary method (e.g. condoms) |
| 21. Mark the method chosen on Patient Chart |
| 22. Confirm that woman understands what to do if she experiences any side effects or problems with the method she has chosen |
| 23. Provide follow-up visit instructions if needed |
| 24. Address other reproductive health needs (e.g. STIs, HIV) as appropriate |

Adapted from:  
*Postabortion Care Course Notebook for Trainers. Jhpiego, 2000*
1. Total number of deliveries
   - SVD
   - Caesarian section
   - Breech
   - Vacuum extraction
   - Forceps

2. Born Before Arrival at the facility

3. Multiple deliveries

4. Live Births (make sure you include BBAs)
   - Weight less than 2.5 kg
   - Weight more than or equal 2.5 kg

5. Stillbirths:

<table>
<thead>
<tr>
<th>Weight Range</th>
<th>Macerated</th>
<th>Fresh</th>
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</thead>
<tbody>
<tr>
<td>Below 1000g</td>
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<tr>
<td>1000g - 1500g</td>
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<tr>
<td>1500g - 2500g</td>
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<tr>
<td>Above 2500g</td>
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6. Number of Congenital Abnormalities

7. Maternal complications
   - Eclampsia
   - Pre-Eclampsia
   - Anaemia
   - Post Partum Haemorrhage
   - Obstructed Labour
   - Ruptured Uterus
   - Sepsis
   - Ante Partum Haemorrhage
   - 3rd Or 4th Degree Tear
   - Vaginal Fistula
   - Other __________

8. Maternal deaths

9. Perinatal deaths (0-7 days)
   - Prematurity
   - Asphyxia
   - Infection
   - Others

<table>
<thead>
<tr>
<th>Weight Range</th>
<th>Prematurity</th>
<th>Asphyxia</th>
<th>Infection</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1000g</td>
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<tr>
<td>1000-1500g</td>
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<td>&gt; 1500g</td>
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</table>

10. Neonatal deaths (8-28 days)
   - Prematurity
   - Asphyxia
   - Infection
   - Others

<table>
<thead>
<tr>
<th>Weight Range</th>
<th>Prematurity</th>
<th>Asphyxia</th>
<th>Infection</th>
<th>Others</th>
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<tbody>
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</tbody>
</table>
11. Post abortion care
• Total no of Evacuations
• Misoprostol
• MVA
• D&C
• No of Complications
• Counseled
• Accepting F/P
• No referred for other RHS

12. Domiciliary
• Total no visited
• No with complications
  - Mother
  - Newborn

13. Women Discharged after 24 hrs Post Delivery

14. Women Discharge before 24 hrs Post Delivery (Reasons)

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<thead>
<tr>
<th>Facility Space</th>
<th>Referred</th>
<th>Social Reasons</th>
<th>Others</th>
</tr>
</thead>
</table>

COMMENTS

NAME: ___________________________ DESIGNATION: ___________________________ SIGNATURE: ___________________________ DATE ____________

MAIL TO: RESEARCH AND EVALUATION SECTION, SRH DIVISION. P/BAG 00269. GABORONE. FAX: 3902092
TO BE REPORTED BY THE 7TH OF EVERY MONTH.