National Guidelines for Post Abortion Care in Zimbabwe

Ministry of Health and Child Welfare
Chapter 4

MANAGEMENT OF COMPLICATIONS AND PROBLEMS

47
Post-evacuation care
42
Management of second trimester
40
Performing sharp curvection
28
Incomplete abortions
25
Equipment and supplies needed for MVA
22
Preparing MVA instruments
21
Prevention of haemorrhage
21
Palpation of the uterus
20
Abdominal catheter
19
Information
19
Pre-operative assessment

Chapter 3

MANAGEMENT OF INCOMPLETE ABORTION

16
Elements of post-abortion care

Chapter 2

POST ABORTION CARE

15
Current post-abortion care in Zimbabwe
15
The law on therapeutical abortion in Zimbabwe
15
Analysis of post-abortion care in Zimbabwe

Chapter 1

INTRODUCTION

14
Acronyms and abbreviations
10
Glossary of terms
8
Acknowledgements
7
Tables and figures

Table of Contents
preserve their emotional well-being.

and treat those at risk of complications with empathy so as to encourage them to treat incomplete abortion as a medical condition and treat it appropriately. Health personnel are generally taught with appropriate post-abortion family planning counseling and care.

The concept of post-abortion care must be conducive and offer a feasible and accessible service.

As any health institution.

Abortion does not justify absence of post-abortion care. In fact all practitioners should be conversant with the setting and medical guidelines. The post-abortion care techniques contained in the guidelines are relatively inexpensive and simple.
The Zimbabwe Society of Obstetricians and Gynaecologists

Sincere gratitude:

This edition of the Post Abortion Care National Guidelines was reviewed by many individual societies and institutions.

This edition was reviewed by the following institutions:

- Dr. Chidozi Zvundisera
- Dr. Godfrey Sanyangwema
- Dr. Mischke Chinese

Lecturers and Members of the Department of Obstetrics and Gynaecology at the University of ZMMPMB.

We are grateful to the following individuals for their contributions to this edition:

- Mrs. Hadebe, Mrs. Nkomo, Mrs. Chivayo, Mrs. Moyo, Mrs. Kwekwa, Mrs. Musasingwa, Mrs. Ndlovu
- Dr. Chidozi Zvundisera
- Dr. F. Ndlovu (UZMO)
- Dr. J. Runwende (UNFPA)
- Dr. K. Chidozi (UNFPA Regional Office)
- Dr. M. Mbhele
- Dr. P. M. Mbanje
- Dr. R. Mbanje
- Dr. S. Mbanje
- Dr. T. Mbanje
- Dr. V. Mbanje

And all others who contributed to the preparation of the guidelines, particularly Dr. Z. K. Kwekwa, who contributed to the guidelines for post-abortion care in the health system.

We are grateful to the medical personnel of the central, provincial, and district hospitals throughout Zimbabwe who contributed to the guidelines.

We are also grateful to the UNFPA, PAHUR, and UNFPA's Country Office for their financial support and for helping to implement the guidelines for post-abortion care in the health system.

Acknowledgements

This publication was made possible with funding from the UNFPA and the Ministry of Health and child welfare.

We would like to express our gratitude to the following individuals and organizations:

- Dr. R. H. M. H. (UNFPA)
- Dr. M. C. M. G. (UNFPA)
- Dr. J. K. N. (UNFPA)
- Dr. S. M. M. (UNFPA)
- Dr. T. M. M. (UNFPA)

We would like to express our gratitude to the following individuals and organizations:

- The Secretariat of the National Guidelines for Post-Abortion Care (NGPAC)
- The Secretariat of the National Guidelines for Post-Abortion Care (NGPAC)
- The Secretariat of the National Guidelines for Post-Abortion Care (NGPAC)
- The Secretariat of the National Guidelines for Post-Abortion Care (NGPAC)
- The Secretariat of the National Guidelines for Post-Abortion Care (NGPAC)

We would like to express our gratitude to the following individuals and organizations:

- Dr. R. H. M. H. (UNFPA)
- Dr. M. C. M. G. (UNFPA)
- Dr. J. K. N. (UNFPA)
- Dr. S. M. M. (UNFPA)
- Dr. T. M. M. (UNFPA)

We would like to express our gratitude to the following individuals and organizations:

- Dr. R. H. M. H. (UNFPA)
- Dr. M. C. M. G. (UNFPA)
- Dr. J. K. N. (UNFPA)
- Dr. S. M. M. (UNFPA)
- Dr. T. M. M. (UNFPA)
GLOSSARY OF TERMS

Definition of abortion
Spontaneous or induced termination of pregnancy before 22 weeks gestation or less than 500 grams foetal weight.

Clinical types of abortion

Unsafe abortion
Termination of an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal standards or both (WHO definition).

Spontaneous Abortion
Also referred to as miscarriage; abortion in which termination of pregnancy is not provoked.

Threatened abortion
Bleeding and /or cramping during pregnancy without dilatation of the cervix. Threatened abortion may progress to loss of the pregnancy

Inevitable abortion
Bleeding and /or cramping in pregnancy as in threatened abortion, with the addition of cervical dilatation. Once cervical dilatation has occurred, abortion is inevitable.

Incomplete abortion
Bleeding and /or cramping with cervical dilatation and expulsion of part, but not all, of the pregnancy tissue (retained products of conception). Incomplete abortion may result in:

Complete Abortion
Complete expulsion of all products of conception from the uterus

Missed Abortion
Foetus dies with delayed expulsion of the products of conception. With missed abortion, the uterus does not increase in size and may decrease in size because of absorption. Retention of this tissue may cause problems with blood cloting.

Induced Abortion
Termination of pregnancy caused by deliberate interference including those performed in accordance with legal sanctions and those performed outside the law.

Therapeutic abortion
Therapeutic abortion refers to medically indicated abortion for women whose life or health is threatened by continuation of the pregnancy or when the health of the foetus is threatened by congenital or genetic factors.

Septic abortion
The abortion is associated with infection and may result in septicaemia and septic shock if not properly managed.
Background of Post Abortion Care in Zimbabwe

Introduction

Chapter 1

Acronyms and Abbreviations
Current Post Abortion Care in Zimbabwe

Historically, the legal and social context for abortion in Zimbabwe has been restrictive and punitive, reflecting the continent's conservative approach towards sexuality and reproduction. The current legal framework is based on the Termination of Pregnancy Act (No. 29 of 1977) which permits legal abortion under specific circumstances. However, access to post-abortion care remains a significant challenge, particularly in rural and remote areas.

1. Risks of economic and social marginalization due to maternal and infant mortality.
2. Psychological distress and stigmatization.
3. Physical and mental health implications.

The law on Therapeutic Abortion in Zimbabwe

The Termination of Pregnancy Act (No. 29 of 1977) permits legal abortion under certain circumstances. However, access to post-abortion care remains a significant challenge, particularly in rural and remote areas.

The Termination of Pregnancy Act (No. 29 of 1977) permits legal abortion under certain circumstances. However, access to post-abortion care remains a significant challenge, particularly in rural and remote areas.

Reasons for Post Abortion Care Guidelines

1. To promote human rights and dignity.
2. To prevent complications from abortion.
3. To ensure psychological and emotional support for women.
4. To promote reproductive health and rights.
Chapter 2

POST ABORTION CARE

Every level of women's services and improving the quality and range of care at the health system requires decentralizing these services to most rural women. Increasing the availability of emergency post abortion care is a crucial step. Post abortion family planning counseling and supply services are out of reach for most rural women. Apart from a few referral hospitals, there are no specific days. Apart from a few referral hospitals, there are no specific days.
health services of youth-friendly clinics

- Provision of or referral for adolescent sexual reproductive health services
- Referral for management of gynaecological pathology such as microbes
- Management of current spontaneous abortion
- Follow-up of referred for women with special needs as in the case of organ cancer
- Screening at the time of treatment for referral to a facility that offers provision of screening for cancer of the breast and cervix
- Diagnosis and STI treatment or referral for general pact intake

Examples of such services are:

- Referral for post-abortion care
- Referral for women presenting for post-abortion care

4. Links to other reproductive health services

The care should be linked to reproductive health counseling.

- Provision of family planning methods (FPMs, including implants) should also be linked to services that are available in the family planning service centers. The FPMs should be guided by the recommendations of the Ministry of Health and should be provided in a manner that respects the woman’s autonomy and right to make decisions about her body.

2. Post-abortion Family Planning (PAFP) Counseling and Services

- Surveillance and evaluation of referral products of contraception
- Abortion
- Management of complications
- Education and counseling
- Referral and transfer
- Follow-up care
- Post-abortion care
### Health Care

#### Table 1. Post Abortion Services Appropriate for Each Level of Care

<table>
<thead>
<tr>
<th>Level</th>
<th>Services Appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Community counseling, referral, and follow-up</td>
</tr>
<tr>
<td>Level 2</td>
<td>Emergency contraception, misoprostol, and evacuation</td>
</tr>
<tr>
<td>Level 3</td>
<td>Surgical abortion, emergency obstetric care</td>
</tr>
</tbody>
</table>

**Health Care**

#### 1. Pre-operative Assessment

<table>
<thead>
<tr>
<th>Management of Incomplete Abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 3</td>
</tr>
</tbody>
</table>
The provider explains both the diagnosis and planned treatment to the patient and obtains consent.

2. Information

- If there is clinical evidence of amenorrhea, hCG should be done.
- If VDRL should be performed if there is suspicion of exposure to STI. If any major complications such as sepsis, severe vaginal bleeding, etc., are present, other investigations e.g., LMP are required according to clinical condition.
- Laboratory Investigations

- Presence of uterine fibroids in pregnancy
- Abnormal pregnancy
- A uterine filled with blood clots
- Presence of multiple pregnancies

- A more advanced pregnancy than the LMP suggests

3. Resuscitation

- If uterus is larger than expected, if any indications:
  - note any cervical effacement/softening
  - note any cervical dilation
  - note any vaginal bleeding
  - note any bleeding/tenderness
  - observe the position of the uterus and note any sensation of pressure

- any pain between 3 days of insertion of abortifacient drugs or 2 days before abortion

4. Pain Control

- for 5 days after 400 mg. of mefenamic acid or 2 days of 500 mg. if dais.
- Day 3: 500 mg. bid, for 5 days.
- Day 2: 500 mg. bid, for 5 days.
- Day 1: 500 mg. bid, for 5 days.

- antibiotic cover

L & T, blood group and cross match may be necessary.

- anti-inflammatory drugs

- peripheral nerve block
- regional anesthesia
- local anesthesia
- infiltration of local anesthesia
- sedatives

- patient experiences minimum anxiety and discomfort.

- The purpose of pain management is to ensure that the patient is not subjected to pain control measures below.

- The clinician should provide one of the combination of over-the-counter pain management measures below, unless the patient declines.

- Local anesthesia
- Sedatives
- Anti-inflammatory drugs

- Antibiotic cover

- The combination provided by an electric or foot pump or a specially designed manual vacuum aspiration (MVA) syringe.
In addition, use of MVA offers the potential for earlier access to
the resources used are reduced,
the cost of post-abortion services is reduced, and
access to services is increased,
the risk of complications is reduced,

using MVA as the method of uterine evacuation to treat incom-

Table 2. Results of four studies evaluating MVA

<table>
<thead>
<tr>
<th>Study</th>
<th>% MVA %</th>
<th>% MVA %</th>
<th>% MVA %</th>
<th>% MVA %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>4.3</td>
<td>&gt; 98</td>
<td>2</td>
<td>&gt; 18</td>
</tr>
<tr>
<td>1994</td>
<td>0.3</td>
<td>100</td>
<td>7</td>
<td>&gt; 12</td>
</tr>
<tr>
<td>1995</td>
<td>3.7</td>
<td>88</td>
<td>N/A</td>
<td>&gt; 16</td>
</tr>
<tr>
<td>1996</td>
<td>9</td>
<td>&gt; 98</td>
<td>6</td>
<td>&gt; 16</td>
</tr>
</tbody>
</table>

Table 2: Results of four studies evaluating MVA
cannula to the syringe.

mm and 12 mm, with a set of colour coded adapters to fit each.

Table 3, those in double valve kits come in six sizes, 6-10.

come in two sizes (outside diameter): 5mm and 6mm. As ilus-

set openings for maximum effectiveness. Cannulae in single kits

kits also include sterile, flexible cannulae with two opposing, off-

Figure 1 - MVA Instruments

MVA Instrument kits

and silicone for lubricating the syringe o-ring.

ringe (fig.1) with a locking valve, plunger handle, collar stop

diagram contains either a single valve or double valve 60 cc sy-

Basic MVA Instrument Kit for Emergency Treatment of Incomplete

MVA. Readily available.

It is essential to have the instruments and supplies required for

Continued on next page (see chapter 5, page 63)

The patient must be stabilized before proceeding to the surgery.

In the event of severe vaginal bleeding must be attended to immediately.

under general anesthesia.

These may be indications for performing evacuations in theatre

Utter, size beyond the first trimester

from that determined by LMP (size greater than dates) or

Utter size determined by pelvic examination differs greatly

when

the uterine cavity. In particular, special precautions are needed

gaining the MVA or the need to use a different technique to empty

need that indicates the need to initiate other treatment before be-

In the course of the initial assessment, conditions may be discover-

Precautions prior to performing MVA
Sterile, For tissue inspection
Cutting edges or disposable surgical gloves of new
Antisepsis solution (preferably an iodophor or any locally available swab/ gauze
Light source (to see cervix and inspect lesion)
Valve syringes and silicone for lubricating MVA syringe o-ring,
Valve syringes, flexible cannula of different sizes, adaptors for double
MVA instruments include MVA vacuum single or double valve
10-12mm syringe and 22 gauge needle (for perineal block)
Biocalve speculum, medium or large
Cannula type, (cm)

Equipment and Supplies Needed for MVA

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Single</th>
<th>Double valve</th>
</tr>
</thead>
<tbody>
<tr>
<td>OHC-I</td>
<td>4,5,6</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Adaptor</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Colour</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>OHC-I</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>OHC-I</td>
<td>4,5,6</td>
<td>12</td>
</tr>
<tr>
<td>OHC-I</td>
<td>4,5,6</td>
<td>12</td>
</tr>
</tbody>
</table>

Table 3 – Cannula and Adaptors for MVA
or transcervical.

Grasp the lip of cervix with ring forceps
If needed, administer a percrential block to cervix at 3’5’7’8 & 9

Step 7

Figure II: Preparing the syringe (creating a vacuum)

Prepare the syringe and select cannula to be used

examination:

Commence size and position of uterus by doing a bimanual pelvic

Put patient in the lithotomy position, clean and drape the vulva.

Step 2

Patient if public hair is long and interferes with instruments, trim.

Step 3

Swab the perineal area with Betadine or soap and water. Shaving the patient’s public hair is not necessary. For MVA, the perineal area is washed with Betadine or soap and water.

Step 1

Prepare the uterus using MVA (Winkler et al. 1995)

The following 23 steps outline the proper procedure for evacuation.

Step 1

for MVA really available and prepared.

Step 2

Ensure that emergency back-up is available.

Step 3

Check that the MVA syringe holds a vacuum
Step 9

Holding the cannula between thumb and index finger, progress the cannula slightly but not out of the uterine cavity.

Step 8

Past the internal os. The internal os resistance is overcome. Set the cannula through the cervix into the uterine cavity just into the uterine cavity until the cannula touches the fundus. Note the depth by the dots visible on the cannula. The dot into the uterine cavity until the cannula touches the fundus. Note the depth by the dots visible on the cannula. The dot

Apply gentle traction to the cervix to align the endometrial cavity

Apply gentle traction to the cervix to align the endometrial cavity.
Release the pinch valve on the syringe to transfer the vacuum to the cannula.

Step II

Percute the uterus firmly into the uterus as you attach the syringe. Do not move the syringe as you attach the cannula. At this point it is critical to ensure that the cannula does not move further.

Source: IPAS, 1993

---

Step 10

Attach the pre-charged syringe to the cannula by holding the syringe on the other hand.

Ceps (or femur) and the end of the cannula in one hand. Measure the depth of the cannula from the skin to the cervix.

Source: IPAS, 1993

---

Fig VI - Attaching the Syringe

Fig V - Measuring the Uterine Depth with Cannula
Synchoc and push material back into the uterus until the cannula is in the uterus; doing so may cause them to be detached from the syringe and access the syringe. Never grasp the vacuum or re-attach the syringe to the cannula. Never repeat the procedure from the cannula. After the removal, the cannula should be detached from the syringe. It is important not to withdraw the opening of the cannula be-

**Step 12**

Evacuate any remaining POCs by gently rotating the syringe and moving the cannula gently and slowly back and forth within the uterine cavity.

**Fig VII** - Releasing the pinch valve through the cannula into the syringe.

**Fig VIII** - Evacuating uterine contents.
Fig. X. Inspecting Tissue

Volume of products (ml) = (size of uterus in weeks/2) x 10.

Following rule of the thumb may be used:

Step 17

Perineal examination.

Check for undue vaginal bleeding from the os. Repeat bimanual

Step 16

Tammamotion solution.

Remove the transcervical and speculum and put them into a deco-

Step 15

Stretcher by pushing on the plunger:

Fig. IX. Detaching the Syringe

Withdraw the syringe and cannula. Detach the syringe and then

Withdraw the syringe into the cannula. Insert the valve into the syringe.

Fig. VII. The uterine cavity, and check the tip for block.

If no products are moving through the cannula, the cannula may be blocked. Close the valve, remove

Fig. VI. The procedure is complete when:

Check for signs of completion.

age. Continue the procedure.

The cannula is felt as the cannula passes over the surface of

When red or pink foam and no more tissue is seen in the cannula,

difficult:

the cannula, making its movement into and out of the uterus

the evacuated uterus, the uterine cavity and the cervix grips

A gritty sensation is felt as the cannula passes over the surface of

The MVA procedure is complete when:

The volume of products should fit the size of uterus. The

Inspect the tissues obtained and send for histology if approp-

Source: IAS, 1993
Performing Sharp Curetage (Dilation & Curetage)

Abortion of Second Trimester Incomplete

Step 1

The uterus using dilatation and sharp curetage.

The following 16 steps outline the procedure for evacuation:

1. Patient empties her bladder before procedure.

2. The uterus using dilatation and sharp curetage.

3. Performing sharp curetage (dilation & curetage)

4.arten with oxytocic medications alone, therefore dilatation and

5. usually the case in this setting), the placenta may not be easily

6. incomplete abortion has been in process for several days (as is

7. examined the POC for completeness. If there is indication or if the

8. examined during this time of shorter@indexer, it is important to

9. pieces expulsion or retained POC in second trimester incomplete

10. insert solution) over 24 hours can sometimes be used to safely com-

11. venous oxycam 20 units in 500 ml ringers lactate (or equiva-

12. intrauterine oxycam is the most common available medication

13. prepared method when a specialized trained physician is available.

14. sponses or signs for manual removal of retained POC, is the

15. dilation and evacuation, when combined with the use of a

16. dilatation and evacuation, when combined with the use of a

17. second trimester must be done by an experienced clinician. In addi-

18. evacuation (D&E) by vacuum aspiration or the uterine cavity is the

19. intrauterine oxycam, sharp curetage (dpc) or dilatation and

20. any intrauterine oxycam, sharp curetage (dpc) or dilatation and

21. for treatment of middle to late second-trimester incomplete ab-

22. Step 23

23. wash hands thoroughly in water and soap.

24. Step 22

25. apply a vanilla pad or cotton wool to the patient.

26. Step 21

27. remove the gloves and discard them.

28. Step 20

29. immerse both gloved hands in decontamination solution, then

30. propely mark the plastic bag for disposal.

31. Step 19

32. decontaminate all the instruments by placing them in 0.5% chlor-

33. Step 18
Dry hands with a dry clean towel or cloth.

**Step 15**

Wash hands with water and soap and discard.

Remove gloves.

**Step 14**

Apply a sterile pad or cotton wool. Dip the fingers of both hands into a decontamination solution. Remove decontaminated disposable objects (cotton, gauze, etc.) in a properly marked plastic bag for disposal.

**Step 13**

Place contaminated disposable objects into a decontamination solution and cut off - and put them into a decontamination solution. Remove the instruments used - the speculum, the Tenaculum, the forceps.

**Step 12**

Assess uterine contraction by bimanual examination.

**Step 11**

Check for undue vaginal bleeding.

**Step 10**

More POCs are obtained on curettage.

**Step 9**

Check for completeness of the procedure by making sure no portion of the cervix is visible. If visible, it is necessary in incomplete abortion. If it is necessary, progressively dilate the cervix with dilators.

**Step 8**

Present the fundus may be soft and easily perforated.

Carefully insert the uterine sound to assess the length and direction of the uterus. Keep in mind that when vessels is two to four minutes for the local anaesthetic to diffuse and for is to be used, inject the cervix at 3, 5, 7, 9 o'clock. Wait for the relaxation of the vaginal forces. If necessary, block the anterior lip of the cervix and take hold of it with a pair of tenaculum. Identify the anterior lip of the cervix and take hold of it with a pair of tenaculum. Identify the anterior lip of the cervix and take hold of it with a pair of tenaculum. Identify the anterior lip of the cervix and take hold of it with a pair of tenaculum.

**Step 7**

Thoroughly apply antibiotic solution three times to the cervix POCs. If present, remove POCs by using sponge forceps. Introduce a vaginal speculum. Check for genital tears and vaginal walls using a sponge forceps with gauze or gauze.

**Step 6**

Place patient in lithotomy.

**Step 5**

Place patient in lithotomy.

**Step 4**

Depending on the patient's need, administer pain control. Give pain control. Give pain control.

**Step 3**

Check to ensure that you have all the necessary equipment and instruments needed to perform a sharp curettage.

**Step 2**

Commence size and position of the uterus by bimanual pelvic examination.
Adapted from 1995, WHO 1994 Care of Mother, WHO 1994, Clinical Management

<table>
<thead>
<tr>
<th>Action if Necessary</th>
<th>Action if Necessary</th>
<th>Action if Necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to nearest referral point.</td>
<td>After the patient has recovered, provide post-abortal family planning counseling if her social situation allows for it.</td>
<td>Provides other necessary treatment such as antibiotics, oxytocics, etc.</td>
</tr>
<tr>
<td>Do blood group cross-match and transfusion if needed.</td>
<td>Provide other necessary treatment such as antibiotics, oxytocics, etc.</td>
<td>Provides other necessary treatment such as antibiotics, oxytocics, etc.</td>
</tr>
<tr>
<td>Perform vaginal curettage if necessary.</td>
<td>Provide other necessary treatment such as antibiotics, oxytocics, etc.</td>
<td>Provides other necessary treatment such as antibiotics, oxytocics, etc.</td>
</tr>
<tr>
<td>Action same as for primary level plus:</td>
<td>Action same as for primary level plus:</td>
<td>Action same as for primary level plus:</td>
</tr>
<tr>
<td>Hospital</td>
<td>District/Mission</td>
<td>Secondary level</td>
</tr>
</tbody>
</table>

Table 4

<table>
<thead>
<tr>
<th>Action</th>
<th>Action</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check for persistent or worsening abdominal pains.</td>
<td>Check for persistent or worsening abdominal pains.</td>
<td>Check for persistent or worsening abdominal pains.</td>
</tr>
<tr>
<td>Check for severe vaginal bleeding, e.g. if fluid, antibiotics, oxytocics, etc.</td>
<td>Check for severe vaginal bleeding, e.g. if fluid, antibiotics, oxytocics, etc.</td>
<td>Check for severe vaginal bleeding, e.g. if fluid, antibiotics, oxytocics, etc.</td>
</tr>
<tr>
<td>Continue treatment which may have been started earlier.</td>
<td>Continue treatment which may have been started earlier.</td>
<td>Continue treatment which may have been started earlier.</td>
</tr>
<tr>
<td>Recovery can be monitored and documented.</td>
<td>Recovery can be monitored and documented.</td>
<td>Recovery can be monitored and documented.</td>
</tr>
<tr>
<td>Allow the patient to rest comfortably in a room where her symptoms are least disruptive.</td>
<td>Allow the patient to rest comfortably in a room where her symptoms are least disruptive.</td>
<td>Allow the patient to rest comfortably in a room where her symptoms are least disruptive.</td>
</tr>
<tr>
<td>Monitor the patient's recovery, recording all vital signs, i.e.</td>
<td>Monitor the patient's recovery, recording all vital signs, i.e.</td>
<td>Monitor the patient's recovery, recording all vital signs, i.e.</td>
</tr>
</tbody>
</table>

As part of post-evacuation care, the provider should:

**POST EVACUATION CARE**
Signs of normal recovery are:

- Post evacuation: The date for her follow-up visit should be set at 2 weeks after induction where to go for other reproductive health services.

- Pain (syncpe)
  - Fever, chills, or malaise
  - Severe or increased pain
  - Bleeding more than normal menstrual bleeding
  - Protracted bleeding (more than 2 weeks)
  - Protracted cramping (more than a few days)

Requiring immediate emergency attention include:

- If complications occur: The warning signs and symptoms she should also know what to do and where to go for emergency care if complications occur. The warning signs and symptoms are:

  - Blood stops (5 to 7 days)
  - Vaginal bleeding (no spotting, no clots) until after the bleed

- She should not have sexual intercourse or put anything into the vagina and know that:

In addition, the patient should be given instructions for taking some birth control medications and know that:

- Some spotting or bleeding which should not exceed a nor-
  - Some uterine cramping over the next few days which may be eased by mild analgesics.

Finally, the patient should obtain answers to questions she may have including where to go for other reproductive health services.

Management of Complications and Problems Arising

Chapter 4

Cannula withdrawal prematurely

- If the cannula is pulled into the vaginal canal:
  - Remove the string and cannula, taking care not to con-

- This:
  - With the valve still open, the vacuum will be lost. To correct

If the opening of the cannula is pulled into the vaginal canal:

- Cannula withdrawal prematurely

- Keep a second prepared string on hand during the aspiration. Many practitioners
  - Re-establish a vacuum in the string and cannula, reconnect it

- Cannula in place inside the nucleus. (do not push the plunger
  - Disconnect the string from the cannula, leaving tip of the string full.

- If the string is full, close the pinch valve of the string.

- Cannula in prepped or withdrawn prematurely

- Cannula may occur before the procedure is complete if the
  - In most MVA procedures, the string remains consistent

- 1. Technical problems

During MVA

Or other non-sterile surfaces.

- Remine the cannula through contact with the vaginal walls

- Syringe full
bleeding, fever, etc.) suggests that the abortion is still incomplete (persistent vaginal bleeding, fever, etc.) and further evacuation is not necessary unless the clinical findings indicate otherwise.

All POC passed before the MVA

A possible ectopic pregnancy exists. The provider is to be notified immediately. A second opinion may be required.

Incomplete Evacuation

* If the vaginal bleeding was not due to pregnancy or if all POC passed before the MVA

Possible complications include:

- Blastomyces

The most common procedure-related problem is obtaining less than expected tissue. The provider may wish to consider a second opinion.

Less than expected tissue

Remove the material from the opening in the cannula using a syringe to distend the uterine cavity. Insert another sterile syringe, if the cannula has been previously contaminated.

2. Procedure Problems

Discontinue procedure. If the syringe still does not hold a vacuum, replace the O-ring. If the syringe still does not hold a vacuum, replace the plunger and barrel with a new rubber sleeve, if this does not work, and the syringe does not seem to hold a vacuum, try irrigating the Syringe does not hold vacuum

Syringe does not hold vacuum

Note: Never try to undog the cannula by pushing the plunger back into the barrel with the cannula tip still in the uterus.

Note: Never try to undog the cannula by pushing the plunger back into the barrel with the cannula tip still in the uterus.

Release the pinch valve.

Re-insert the cannula, attach a prepared syringe, and re-

another sterile or high-disinfected cannula.

another sterile or high-disinfected cannula. If contamination occurs, use a sterile or high-disinfected forceps or sponge, without removing the material from the opening in the cannula using a syringe to distend the uterine cavity. Insert another sterile syringe, if the cannula has been previously contaminated.

Close the pinch valve of the syringe.

May be danger:

If no tissue or bubbles are flowing into the syringe, the cannula may be clogged:

Cannula clogged

Level disinfected cannula.

If contamination has occurred, insert another sterile or high-

purchase (see above, p-5).

Re-insert the cannula if it has not been contaminated. (If

Re-insert the cannula if it has not been contaminated. (If

Detach the syringe from the cannula, empty the syringe.

Close the pinch valve of the syringe.

Re-connect the syringe, release the valve and continue as-
available

Ventilate the patient with an Ambu bag or oxygen, if

If recovery is not immediate:

Raising the patient’s legs

Prevent aspiration if the vomits

Tumining the patient’s head and should to the side to

Maintaining an open airway

Stopping the procedure immediately

Risk of complications:

Prostatic Surgery

The condition usually lasts only a few seconds to
minutes. Provided the cause of pain is stopped, Tread by:

Fainting (Vagal Reaction or Neurogenic Shock)

Oxytocics or massaging the uterus to keep it contracted.

Injection is repeated by re-evaluating the uterus and administering
the procedure and externally tender on examination. This could-
usually within a few hours after completion of the procedure.

Postoperative Syndrome (Acute Haematemesis)

Extrusion of oral contraceptive pills)

Any contraceptive method (i.e., "insemination, Norplant
Progestrone-negative breakthrough bleeding with use of progesterone
missed or skip periods) followed by vaginal bleeding due to:

Women of reproductive age may have irregular periods (i.e.,
Vaginal Bleeding Not Due to Pregnancy

Prevalence of ectopic pregnancy, stopping bleeding and replacing blood lost, if

required

The hemostasis through immediate surgical removal of the ecl-
dymic (minimal resection or laparoscopy) is not available. Rup-
gety of an ectopic pregnancy is a real and the threatening possi-

If ectopic pregnancy is suspected, check again for the signs of

IU or progesterone-only contraceptive use

Pelvic Infections

Previous ectopic pregnancy

A history of any of the following:

1. The risk of an ectopic pregnancy is greater if the patient has

2. Delay in treatment of ectopic pregnancy is particularly danger-

Ectopic Pregnancy

Oesrogen breakthrough bleeding (anovulation)

in the wall of the uterus.

Uterine fibroids (enlarging smooth muscle tumors that grow

Implants or oral contraceptive pills)

Any contraceptive method, (i.e., "insemination, Norplant

Progestrone-negative breakthrough bleeding with use of progesterone

missed or skip periods) followed by vaginal bleeding due to:

Women of reproductive age may have irregular periods (i.e.,
Vaginal Bleeding Not Due to Pregnancy

3. Other problems
Air Embolism

Failure of transsection or surgery, such as (i) cannula, uterus, or impacted cerclage, when bleeding occurs, may result in severe hemorrhage. When this occurs, repeated curettage or other treatment is required. The treatment of severe vaginal bleeding depends on the cause of the bleeding itself. If the bleeding is due to trauma, prompt recognition and treatment is crucial. Because these complications can result in serious injury or in some cases death, their prompt recognition and treatment is crucial.

Shock, Severe Vaginal Bleeding and Post MVA Infection

When not been damaged, leading to intra-uterine or intra-abdominal hemorrhage may occur. In that case, immediate referral and observation are advisable. Treatment of cervical perforation requires immediate referral. The most likely to occur during forceps cervix perforation is uterine perforation. The incision should be made on the uterine wall, then the incision is sutured. If this complication is observed in the tissue removed from the uterus, the incision should be made further than expected, or if the bowel is perforated.

Uterine Perforation

If the cannula perforation is observed, then expect it, or if there is bowel perforation, expect it. Because these complications can result in serious injury or in some cases death, prompt recognition and treatment is crucial.

Air embolism

Severe bleeding (haemorrhage)

Uterine or cervical perforation

Manual vacuum aspiration for treatment of incomplete abortion is the procedure that involves minimal trauma to the uterus and cervix. When abortion is complete, the cervix is usually dilated, and the procedure can be performed safely.

Complications

The recovery

Request assistance to check for the initial signs and monitor.

Start an L.V. with a large bore (16-18 gauge) needle using either isotonic saline or Ringer’s lactate solution.
Dies by flushing (3 times) with clean water.

Instruments to be cleaned. Rinse hypodermic syringes and needles immediately take the preventive corrosion of metal instruments, or immediately take the preventive
After decontamination, rinse items with clean cool water to help

If visibly contaminated, in order to be effective.

The chlorine solution should be changed daily, or more frequently.

Soak for 10 minutes before removing them for cleaning.

Soak for 10 minutes prior to soaking. Allow all items to
dermic needles and syringes. All assembled needles and syringes
solid instruments and gloves in the chlorine solution. For hypo-
the MVA syringe, and then place the syringe and cannulae, other
the treatment table. Draw the solution through the cannula into
By having a plastic container filled with chlorine solution next to
immediately after the MVA procedure and is best accomplished
for 10 minutes before cleaning. This step should be done
Soak all instruments, including cannulae, the MVA syringe and

hold (utility) gloves work well for this.

When cleaning used instruments, inexpensive rubber or vinyl house

dear. Personnel should wear gloves while decontaminating and
immediately after use to make it easier for staff to handle and
All items including surgical gloves, should be decontaminated.

Decommission

Storage and re-assembly

Sterilization or high level disinfection

Cleaning

Decommission

The four basic steps for processing MVA equipment and other

Processing MVA Equipment and Other Items

Chapter 5
Processing IV/IA Syringes

Before the sheet is boiled, fill plastic dilators (penumbers) and cannulae, that are to be boiled. Use dry gloves (if necessary, however, for instruments induction ride). When using, observe the water may dilute the denatured residue with clean water to remove any residue. After cleaning, rinse the instruments with IV/IA and hypodermic syringes.

To remove the sheet, from the vessels, fill the side of the sheets with water, until visibility clear. The syringe should not be placed with dry water. After cleaning, rinse the instruments with IV/IA and hypodermic syringes.

Remove the sheet of the instruments with a soft brush (old toothbrushes work well) or cloth in soap water. Scrub the syringe with a soft brush or cloth. Let the sheet come to remove all traces of blood or tissue. Scrub the syringe with a soft brush or cloth. Let the sheet come to remove all traces of blood or tissue. Scrub the syringe with a soft brush or cloth.

After decortication, thoroughly wash all instruments including IV/IA and hypodermic syringes. Take apart all instruments, including IV/IA and hypodermic syringes.

Cleaning

Easily to do an inexpensive way to decortication large surfaces. Wiping with a suitable disinfectant such as 5% chlorine solution, Wiping with a suitable disinfectant such as 5% chlorine solution, which might have come in contact with body fluids, should be decorticated. Surfaces such as examination or procedure tables, which might
Chemical sterilants should be used to sterilize canulae and cannulas.

Remember: Do not dry heat sterilize the canulae or VA syringe.

Length of time:

To be effective, sterilization must be carried out for the stated time.

- Time: 1 hour
  Temperature: 170°C (340°F)

- Or
  Time: 2 hours
  Temperature: 160°C (320°F)

Only:

To dry heat sterilize (dry heat oven) metal and glass instruments.

To steam sterilize (autoclave) metal and glass instruments and sterilization.

Sterilization and other items are listed below.

Recommended operating conditions for sterilization of HLD or IL-
repeatably, but not dry heat sterilized.

- See the sterilization plastics differ when amenable (steam sterilized)
  direction plastic syringes can be autoclaved (steam sterilized). By
dry sterilization, the needle and syringe would assemble will crack. By
be used on either the canulae or VA syringe: the canulae will
volved. Steam (autoclaving) or dry heat sterilization should not
 sterile for sterilization of IL and the types of instruments
in-disinfection, the exact methods will depend on the facility’s capa-
After cleaning, all instruments should be sterilized or high level

Sterilizing method.

- Coagulase-negative staphylococci, the process of HLD destroys all mi-
  genes. Sterile syringes, such as the factory that cause cancer and
  sterilization kills all microorganisms, including bac-
  The process of sterilization is the agent and the desired outcome.

- Be done properly in order to achieve the desired outcome.
  post-procedural handling of instruments and other items must:
  acceptable asepsis. For both methods, the preparatory steps
  sterilization is either unavailable or not suitable, HLD is the only
  instrument that come into contact with the blood stream.

Sterilization is the safest and most effective method for process-
The infection may be localized or may be generalized as peritonitis.

Historical of previous unsafe abortion or miscarriage

- General discomfort (flu-like symptoms)
- Pain in the abdomen or pelvis
- Prolonged bleeding (>8 days) or spotting

Symptoms

- Foul-smelling vaginal or cervical discharge
- Fever, chills or sweats
- Motion or pain with cervical motion.
- Tenderness of the uterus and adnexa during pelvic exam.

Signs

- Suspect infection in abortion patients with the following symptoms:
  - Malaise
  - Abdominal discomfort associated with retained products of conception (POC), general and/or abdominal pain
  - Overly sharp cramping: In the case of incomplete abortion, sepsis and easily perforated. Therefore, the use of MVA is preferable. However, that in the presence of sepsis, the funnel may be soft.
  - The general steps outlined for the evacuation of the uterus. Note, in the case of septic incomplete abortion, providers should follow the steps outlined for a higher level of care.

1. Post Abortion Sepsis

Higher level of care: Patient before proceeding to evacuate the uterus or refer to a higher level of care. If septic abortion is possible, it is important to identify any threatening complications immediately. If any threat is present, it is important to identify these and stabilize the patient before proceeding with evacuation.

MANAGEMENT OF ABORTION COMPLICATIONS

Chapter 6
Table 5: Management of Sepsis by Level of Health Care

<table>
<thead>
<tr>
<th>Central Hospitals</th>
<th>Provincial or District/Mission Hospital</th>
<th>Secondary Level</th>
<th>Tertiary Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Give any other necessary treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood transfusion as needed</td>
<td>Blood transfusion as needed</td>
<td>Blood transfusion as needed</td>
<td>Blood transfusion as needed</td>
</tr>
<tr>
<td>Perform laparotomy as needed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treat other conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Evaluate the urgency</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same action as for the primary level plus:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Refer to First or Second Referral Level</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Give pain relief</td>
<td>Give antibiotics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check for sepsis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reassess the patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Refer promptly</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action to be Taken</td>
<td>Level of Health Care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**To manage sepsis:**

- Eliminate the infection
- Reassess the patient

**The aims of treatment are to:**

- Abdominal surgery and antibiotics, laboratory investigations and possible intubation and multiple organ failure; patients with septic shock, death or long-term morbidity, such as chronic pelvic pain.
- After 3 days of antibiotic treatment, administration of IV antibiotics is only at the secondary level or higher conditions, etc.

**Plan for other treatments as necessary; such as laparotomy;**

- Administer IV antibiotics; benzylpenicillin 2.5 megunits, metronidazole 500mg t.d.s. for 3 days, 9/10 lor 3 days, chloramphenicol 500mg q.i.d. for 3 days.
- Take appropriate laboratory tests, such as pus swabs, blood for Hb, PCV, culture, and sensitivity.
- Determine possible causative factors.
- Determine the presence of other conditions.
- Reassess the patient and its extent.
- Make the decision.
**Table 6. Management of Moderate to Severe Vaginal Bleeding**

<table>
<thead>
<tr>
<th>Level of Health Care</th>
<th>Action to Be Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Level</td>
<td>Ensure the patient is comfortable during referral</td>
</tr>
<tr>
<td>Community Level</td>
<td>Refer as soon as possible</td>
</tr>
<tr>
<td>Tertiary Level</td>
<td>Referred to hospital/central</td>
</tr>
</tbody>
</table>

**Refrain from other specialized care, e.g., dialysis.**

---

**Action: Refer if necessary**

- Monitor the patient's condition and progress, e.g., urine
- Laboratory investigations: close blood type and cross
- Resuscitate and transfuse if necessary
- Fluids by mouth
  - Saline
  - Crystalloids
- Check Hb
- Ensure that the airway is open

**Management**

- Blood soaked pads, towels or clothing
- Heavy, bright red vaginal bleeding with or without clot

**Symptoms**

- Pallor, inner eyelids, palms and around the mouth

**Signs**

- Vaginal bleeding: If the patient has any of the following signs, she has severe vaginal bleeding

- Moderate to severe vaginal bleeding
### Table 7. Management of Intra-abdominal Injury by Level of Care

<table>
<thead>
<tr>
<th>Level of Health Care</th>
<th>Action to Be Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Level</td>
<td>Ensure the patient is comfortable during referral</td>
</tr>
<tr>
<td></td>
<td>Refer as soon as possible to Rural Health Centre or Primary Health Clinic</td>
</tr>
<tr>
<td>Hospital/Dispersal Mission</td>
<td>Assess the extent of patient's injuries</td>
</tr>
<tr>
<td></td>
<td>Treat the cause and other associated conditions</td>
</tr>
<tr>
<td></td>
<td>Transfusion where necessary</td>
</tr>
<tr>
<td></td>
<td>Antibiotics, antacids, and blood transfusion where necessary</td>
</tr>
<tr>
<td>Tertiary Level</td>
<td>Refer if necessary (1-2 dph)</td>
</tr>
<tr>
<td></td>
<td>Action same as for secondary level plus:</td>
</tr>
<tr>
<td></td>
<td>Action same as for secondary level plus:</td>
</tr>
<tr>
<td></td>
<td>Tertiary Level</td>
</tr>
<tr>
<td></td>
<td>Provincial or Central Hospitals</td>
</tr>
</tbody>
</table>

### Management

#### Abdominal Pain, Crying
- Reassess the baby
- Shoulder pain
- Nausea and vomiting

#### Symptoms

- Rebound tenderness
- Decreased bowel sounds
- Distended abdomen

#### Signs

- Appendicitis

If the patient has any of the signs with any of the symptoms above, the differential diagnosis is an ectopic pregnancy or if the patient has any of the symptoms above, the differential diagnosis is an ectopic pregnancy or if the patient has any of the symptoms above, the differential diagnosis is an ectopic pregnancy or

### Shock/Infection, Blood Loss, Gas Gangrene

- Treatment of shock and associated conditions
- Stabilization and resuscitation
- Assessment of the patient's condition
- Determination of the type and extent of the injury

- Management of Intra-abdominal Injury: Providers of PaC should include the following in the man

- Abdominal pain, crying
- Reassess the baby
- Shoulder pain
- Nausea and vomiting
Diazepam and midazolam: produce calm, relax muscles and promote sleep. Examples include sedatives depress the function of the central nervous system but do not actually reduce pain. They are used to reduce anxiety.

Phenobarbital and Phenacetin: examples include mor-
cur ("i.m") or intravenous ("i.v") injection. Examples include mor-
idal to severe pain and can be administered orally or by intramus-
well as block the transmission of pain. Analgesics can be used for non-medicinal analgesics reduce the sensation of pain in the spinal cord and brain. Narcotics, one type of analgesic, cause stupor as conscious. Examples include Halothane and ether.

General anaesthetics cause the patient to become completely un-
spinal cord. Examples include lidocaine and chloroprocaine.
Regional anaesthetics (spinal or epidural) allow the patient to re-
examples include lidocaine and chloroprocaine.

Anesthetics (local, regional and general) numb all physical sense-

*Types of Medication

**Use of Medications for Pain**

Chapter 7
who have suffered significant blood loss. The heightened effects of narcotics on chronically ill patients or those recovering from anesthesia are multiplied by the risk of respiratory depression. In addition, clinicians should be mindful of the risk of respiratory depression and recovery must be carefully monitored because of the risk of respiratory depression.

When a patient is given a narcotic, however, her level of pain is low, and immediate, non-narcotic analgesics are helpful for moderate or severe pain. A non-steroidal anti-inflammatory drug (NSAID) such as Ibuprofen or Celebrex may be effective in alleviating the sensation of muscle spasms. A non-steroidal anti-inflammatory drug (NSAID) may be an option for the use of lower dose of narcotics to achieve similar levels of pain.

Medications that can be reversed with oxygen (both pedilutidine and fenretinid) can be reversed with the patient experiencing severe respiratory depression. The clinician should not be alarmed, and even no intervention is needed. Narcotic analgesics can show off as a result of respiratory depression. If non-narcotic analgesics in single dose rarely produce complications or adverse reactions than do other routes.

Complications of Analgesia

Complications of analgesia should be available with use of IV, IM, or oral analgesia. Effective analgesia is immediate, and many situations call for oral analgesia. Use the procedure to allow the drug to take effect. IV injection is not given approximately 30 minutes before the procedure should not be started until the drug is in place. This may be used in combination with IV or IM analgesia. If the effect is not strong, another analgesia such as local anesthesia or sedatives may be indicated. Other agents such as local anesthesia or sedatives may be used in combination with IV or IM analgesia. Analgesia can ease both cervical and pelvic discomfort associated with pelvic inflammatory disease and pelvic dissection associated with pelvic inflammatory disease.
Complications of Sedatives

Sedatives

Table 8. Anesthetic Drugs for MVA

<table>
<thead>
<tr>
<th>Type of Analgesia</th>
<th>Drug Name (generic)</th>
<th>Dose</th>
<th>Duration</th>
<th>Usual Procedure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Anesthesia</td>
<td>Propofol</td>
<td>or 0.5mg/kg</td>
<td>0.5-1min</td>
<td>30-60sec</td>
<td>Common Side Effects</td>
</tr>
<tr>
<td>Local Anesthesia</td>
<td>Lidocaine</td>
<td>1%</td>
<td>10min</td>
<td>2-3min</td>
<td>Light to moderate doses of sedatives, such as diazepam, will relieve anxiety but in otherwise stable physical condition.</td>
</tr>
</tbody>
</table>
she could become pregnant again right away.

Planned services,

she can delay or prevent another pregnancy by using family

planning methods of her choice.

the health care provider can help her obtain and use family

Several facts before she leaves the facility. She should know that:

Every woman treated for incomplete abortion needs to know

with other methods.

HIV infection. These may be encouraged for use in combination

recommends to all sexually active women to prevent HIV and

barrier contraceptives, male and female condoms are strongly

regular menses. However, until a

natural family planning is not recommended, however, unless there are major post abortion complications,

immediately unless there are major post abortion complications.

Nearly all contraceptive methods may be used and can be started

Table 9. Anesthetics for use with Analgesics and/or Anesthesia

<table>
<thead>
<tr>
<th>Type of Sedative</th>
<th>Drug Name</th>
<th>Injection Site</th>
<th>Duration of Effect</th>
<th>Usual Dose of Analgesic</th>
<th>Type of Anesthesia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazepines</td>
<td>Valium</td>
<td>Intramuscular</td>
<td>2 hours</td>
<td>10 mg</td>
<td>General</td>
</tr>
<tr>
<td>Depressants</td>
<td>Propofol</td>
<td>Intravenous</td>
<td>3 minutes</td>
<td>2 mg</td>
<td>General</td>
</tr>
<tr>
<td>Narcotics</td>
<td>Fentanyl</td>
<td>Intravenous</td>
<td>1 hour</td>
<td>100 µg</td>
<td>Local</td>
</tr>
</tbody>
</table>
since their ability and willingness to use them.

prevent women from having access to contraceptive and infertility services. High costs of services and contraceptives can make some women unable to afford these services.

Providers should be aware of the cost to a woman of a contraceptive.

Access to Family Planning Services

Women who have been treated for post-abortion complications.

Contraception is a method, usually involving a number of elements, that may have medical conditions that affect the selection of a contraceptive method.

The health worker should provide information that is appropriate for the woman and her partner.

Method

The health worker should find out which, if any, method she was using at the time of conceiving the index pregnancy and then suggest any method that might be appropriate for her.
Several factors need to be considered when assisting a woman to select a contraceptive method. Other than the medical conditions and preferences of the woman, the following factors should be taken into account:

1. Method's effectiveness: Choose a method that is effective and reliable, considering the contraceptive's success rate and the woman's lifestyle.
2. Side effects and risks: Discuss the potential side effects and risks associated with each method, and address any concerns the woman may have.
3. Cost: Consider the cost of the contraceptive method, including any ongoing costs or fees.
4. Acceptability and preference: Ensure that the woman feels comfortable with the chosen method and it aligns with her lifestyle and personal preferences.
5. Availability and accessibility: Ensure that the contraceptive method is readily available in the area and can be accessed easily by the woman.

A flowchart illustrates the decision-making process, guiding the clinician to the most suitable contraceptive method based on the woman's needs and preferences. This flowchart is designed to help clinicians make informed decisions and provide the best possible care to their patients.
### Table I. Counseling Recommendations and Referrals for Various Types of PAC Patients (more than one may apply)

<table>
<thead>
<tr>
<th>Risk of HIV Infection</th>
<th>Barrier Methods</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should be resperated</td>
<td>To use the method she understands, how she chooses, and the method that she will be able to use effectively. If the woman does not have a partner who speaks English or who is willing to use the method she chooses, the counselor will assist.</td>
<td>If the woman is unwilling, the counselor will assist.</td>
</tr>
<tr>
<td>Is a partner who is unwilling</td>
<td>To be used effectively, the woman will not be able to use the method she chooses, and she will feel unable to use it effectively. If the woman chooses, the counselor will assist.</td>
<td>If the woman is unwilling, the counselor will assist.</td>
</tr>
<tr>
<td>Does not want to be pregnant</td>
<td>To use the method she understands, how she chooses, and the method that she will be able to use effectively. If the woman does not have a partner who speaks English or who is willing to use the method she chooses, the counselor will assist.</td>
<td>If the woman is unwilling, the counselor will assist.</td>
</tr>
<tr>
<td>Does not want to become pregnant</td>
<td>To use the method she understands, how she chooses, and the method that she will be able to use effectively. If the woman does not have a partner who speaks English or who is willing to use the method she chooses, the counselor will assist.</td>
<td>If the woman is unwilling, the counselor will assist.</td>
</tr>
<tr>
<td>Unwanted pregnancy</td>
<td>To use the method she understands, how she chooses, and the method that she will be able to use effectively. If the woman does not have a partner who speaks English or who is willing to use the method she chooses, the counselor will assist.</td>
<td>If the woman is unwilling, the counselor will assist.</td>
</tr>
</tbody>
</table>

**Recommended Methods:**
- Contraceptive method
- Use and change methods
- Get follow-up care

**Recommended Referrals:**
- Consultation
- Referral to other services

---

(continued)
The objectives of post-abortion reproductive health counseling to help the woman:

- understand how RTI/RTV can be prevented
- understand her risk of RTI, STIs, and HIV
- understand other reproductive health needs
- emotional support
- identify what and how to obtain prenatal care
- know where and how to obtain pregnancy prevention services
- use contraceptive methods of her choice properly
- use contraceptives method of her choice properly
- next menstrual
- learn that she can become pregnant again even before her
- understand the immediate and long-term steps to be
- understand the factors that led to the pregnancy and the
- understand and explain circumstances that led her to her
- decisions for the future
- overcome anxieties she may have and make adequate de-

etc.

on pregnancy, sexuality, and prevention of RTI and STIs and HIV.

and general reproductive health counseling includes counseling

herself and her social relations now and in the future. Sec-

first, assuring counseling deals with the client's immediate

There are two types of client counseling in the post-abortion set-

client.

emphasizing their roles in offering support and comfort to the

Reproductive health counseling involves an exchange of informa-

Reproductive health counseling should be extended to include relatives and friends,

client and ideas, discussions and deliberations. Where possible

Reproductive health counseling is a two-way process of com-

has used contraception.

to become pregnant again and how soon. Also ask whether she

The provider should inquire about the individual's needs and situ-

love the partner / spouse whenever possible.

consulting. With the woman's permission, the provider can in-

ings and experience and at all times observe proper counseling

she feels better. The provider should show concern for her feel-

Good counseling begins with respect for the patient. If the pa-

Post Abortion Reproductive Health Counseling

Chapter 9
Instructions on how to use chemical solutions

Annexe 2

Annexe 1
### ANNEXE 3

**High-Level Disinfection of Instruments**

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Disinfecting Agent</th>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Solution Strength</th>
<th>Minimum Time Required for Disinfection</th>
<th>Steps</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metal Instruments and Cannulae</td>
<td>Boiling water</td>
<td>Easily available; will provide HLD upto 5,500 meters (18,008 ft)</td>
<td>N/A</td>
<td>20 minutes at rolling boil</td>
<td>Fill large (at least 25 cm/10&quot; diameter) pot ¾ full with clean water; deposit instruments; cover pot; bring to boil again; boil for 20 minutes; remove items gently with HLD forceps; air dry on a HLD tray or in a HLD container.</td>
<td>Grasp cannulae gently when removing from water. Grasping hot cannulae with forceps may flatten the cannulae in previously boiled water.</td>
<td></td>
</tr>
<tr>
<td>Instruments, Cannulae</td>
<td>Glutaraldehyde (2-4%)</td>
<td>Not easily inactivated by organic materials</td>
<td>Skin, eye, respiratory irritant</td>
<td>Use full strength - never dilute; follow manufacturer's instructions for mixing</td>
<td>20 minutes</td>
<td>Submerge items completely, making sure solution fills cannula interior; soak; remove with HLD forceps; rinse with boiled water; air dry on a HLD tray or in a HLD container.</td>
<td>Discard solution (7 to 28 days) after mixing or sooner if cloudy (follow manufacturer's instructions).</td>
</tr>
<tr>
<td>Chlorine (0.1%)</td>
<td>Fast acting, very effective against HBV and HIV</td>
<td>Corrosive to metal</td>
<td>Dilute to 0.1% for clean equipment using boiled water; 0.5% if tap water used.</td>
<td>20 minutes</td>
<td>Submerge items completely in a non-metal container, making sure solution fills cannula interior, soak; remove with HLD forceps; rinse with boiled water; air dry on a HLD tray or in a HLD container.</td>
<td>Change solution daily or sooner if cloudy.</td>
<td></td>
</tr>
</tbody>
</table>

For the ratio of bleach to water, read as part 1 concentrated bleach to x parts water (e.g., JIK - 1 part bleach to 6 parts water for a total of 7 parts). Use boiled water when preparing 0.1% chlorine solution for HLD because tap water contains microscopic organic matter which inactivates chlorine.

### ANNEXE 4

**Making Dilute Chlorine Solutions**

Instructions for how to prepare 0.1% to 0.5% chlorine solutions from various commercially available liquid bleach products are shown in the table below.

<table>
<thead>
<tr>
<th>Type or Brand of Bleach (Country)</th>
<th>Chlorine % Available</th>
<th>Ratio of Bleach to Water</th>
</tr>
</thead>
<tbody>
<tr>
<td>JIK (Zimbabwe, Kenya)</td>
<td>5%</td>
<td>1:9</td>
</tr>
<tr>
<td>Robin Bleach (Nepal)</td>
<td>3.5%</td>
<td>1:6</td>
</tr>
<tr>
<td>ACE (Turkey)</td>
<td>0.5%</td>
<td>1:49</td>
</tr>
<tr>
<td>Household bleach (USA, Indonesia)</td>
<td>0.1%</td>
<td>1:49</td>
</tr>
</tbody>
</table>