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**Foreword**

Zambia’s maternal mortality ratio remains high at 398/100,000 live births as adduced by the 2013/2014 Zambia Demographic and Health Survey. The unmet need for family planning is also high, at 21 percent (ZDHS 2014). Zambia remains committed to further reducing its maternal mortality ratio to less than 100/100,000 live births as outlined in our National Health Strategic Plan 2017 – 2021.

One of the major causes of maternal morbidity and mortality in Zambia is unsafe abortion. In response, the Ministry of Health is introducing this lifesaving package of care, the Standards and Guidelines for Comprehensive Abortion Care (CAC). These standards and guidelines when implemented adequately and to scale will contribute significantly to the reduction of maternal deaths from unsafe abortions, a preventable cause of maternal morbidity and mortality.

The Ministry of Health, while acknowledging the Termination of Pregnancy Act of 1972, is mindful of the many regional and international agreements it has ratified regarding women’s health and rights including the International Conference on Population and Development (ICPD) of 1994, Beijing Platform of Action (1995), and the Maputo Plan of Action (2006), and has put together these standards and guidelines to facilitate translation of policy into action.

The Standards and Guidelines for Comprehensive Abortion Care should not be used in isolation but in tandem with other documents, such as the Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC): A Guide to Essential Practice in Zambia 2016, among others. It is important to note that these standards and guidelines do not imply that abortion is another method for contraception. On the contrary, Family Planning (FP) and Post-Abortion Care (PAC) have been integrated as part of these Comprehensive Abortion Care (CAC) standards and guidelines in the hope that this gives impetus to better health outcomes.

It is hoped that all stakeholders working to reduce maternal morbidity and mortality resulting from unsafe abortion will find this document useful and apply the principles behind it in program planning, implementation, monitoring and evaluation. Health care workers shall also fully utilize these standards and guidelines to significantly contribute to the improvement of the health of our women and children.

Lastly, I would like to sincerely thank all individuals and partner organizations that assisted and worked tirelessly to put together these standards and guidelines.


\[\text{Dr. Chitalu Chilufya (MP)}\]
\[\text{Minister of Health}\]
\[\text{MINISTRY OF HEALTH}\]
Acknowledgements

The updated Standards and Guidelines on Comprehensive Abortion Care in Zambia are as a result of efforts from many organizations and partners that have collaborated with the Ministry of Health to reduce morbidity and mortality from unsafe abortion.

The Ministry wishes to thank these partners individually and as a team. Ministry especially thanks all member organizations and individuals in the Safe Abortion Advisory Group (SAAG), for their different inputs at various levels of these updates.

Further, the Ministry wishes to recognize most sincerely, the efforts of all the individuals and organizations that were part of the initial ‘Standards and Guidelines for reducing unsafe abortion morbidity and mortality in Zambia’ of May 2009.

Gratitude goes to Dr. Samson Chisele who consolidated the updates from all partners and stake holders.

The Ministry of Health finally wishes to thank Marie Stopes Zambia for providing technical and logistical support during the process of updating these Standards and Guidelines.

Dr. Jabbin Mulwanda
Permanent Secretary (Health Services)
MINISTRY OF HEALTH
<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>CAC</td>
<td>Comprehensive Abortion Care</td>
</tr>
<tr>
<td>CBA</td>
<td>Community Based Agents</td>
</tr>
<tr>
<td>CBDs</td>
<td>Community Based Distributors</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination Against women</td>
</tr>
<tr>
<td>COC</td>
<td>Combined oral contraceptives</td>
</tr>
<tr>
<td>CRC</td>
<td>Convention on the Rights of Children</td>
</tr>
<tr>
<td>CPR</td>
<td>Contraceptive prevalence rate</td>
</tr>
<tr>
<td>CSO</td>
<td>Central Statistics Office</td>
</tr>
<tr>
<td>D &amp; C</td>
<td>Dilatation and Curettage</td>
</tr>
<tr>
<td>D &amp; E</td>
<td>Dilatation and Evacuation</td>
</tr>
<tr>
<td>DMO</td>
<td>District Medical Office</td>
</tr>
<tr>
<td>EC</td>
<td>Emergency Contraception</td>
</tr>
<tr>
<td>EHT</td>
<td>Environmental Health Technicians</td>
</tr>
<tr>
<td>FBC</td>
<td>Full blood Count</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>GMO</td>
<td>General Medical Officer</td>
</tr>
<tr>
<td>GRZ</td>
<td>Government of the Republic of Zambia</td>
</tr>
<tr>
<td>Hb</td>
<td>Haemoglobin</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency virus</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education and Communication</td>
</tr>
<tr>
<td>IOL</td>
<td>Induction of Labour</td>
</tr>
<tr>
<td>IRH</td>
<td>Integrated Reproductive Health</td>
</tr>
<tr>
<td>IUD</td>
<td>Intra Uterine Device</td>
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<tr>
<td>LMP</td>
<td>Last Menstrual Period</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>MCH</td>
<td>Mother &amp; Child Health</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MPAC</td>
<td>Medical Post Abortion Care</td>
</tr>
<tr>
<td>MVA</td>
<td>Manual Vacuum aspiration</td>
</tr>
<tr>
<td>NAF</td>
<td>National Abortion Federation</td>
</tr>
<tr>
<td>NGO</td>
<td>Non- Governmental Organizations</td>
</tr>
<tr>
<td>OBGYN</td>
<td>Obstetrics &amp; Gynecology</td>
</tr>
<tr>
<td>OJT</td>
<td>On the Job training</td>
</tr>
<tr>
<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
</tr>
<tr>
<td>PAC</td>
<td>Post Abortion Care</td>
</tr>
<tr>
<td>POP</td>
<td>Progesterone Only Pill</td>
</tr>
<tr>
<td>RCOG</td>
<td>Royal College of Obstetricians and Gynaecologists</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>RM</td>
<td>Registered Midwife</td>
</tr>
<tr>
<td>RPOCs</td>
<td>Retained products of Conception</td>
</tr>
<tr>
<td>SDGs</td>
<td>Sustainable Development Goals</td>
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<tr>
<td>SGBV</td>
<td>Sexual and Gender based Violence</td>
</tr>
<tr>
<td>SMAGS</td>
<td>Safe Motherhood Action Groups</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>TOP</td>
<td>Termination of Pregnancy</td>
</tr>
<tr>
<td>U/Es</td>
<td>Urea and electrolytes</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UTH</td>
<td>University Teaching Hospital</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>ZDHS</td>
<td>Zambia Demographic Health Survey</td>
</tr>
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# Legal and operational definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>Termination of pregnancy before the embryo/foetus is viable.</td>
</tr>
<tr>
<td>Adolescent</td>
<td>An adolescent is a person aged between 10-19 years.</td>
</tr>
<tr>
<td>Audit</td>
<td>A systemic check or assessment, especially of the efficiency or effectiveness of an organization or a process, typically carried out by an independent assessor.</td>
</tr>
<tr>
<td>Autonomy</td>
<td>Means that the mentally competent adults do not require the consent (authorization) of any third party, such as husband or partner to access a health services (WHO 2003).</td>
</tr>
<tr>
<td>CAC</td>
<td>A comprehensive abortion care (CAC) is an approach based on the epidemiological concept of primary (prevention of pregnancy), secondary (treatment of unwanted pregnancy) and tertiary (treatment of complications) health care.</td>
</tr>
<tr>
<td>Contraception</td>
<td>The deliberate use of artificial methods or other techniques to prevent pregnancy as a consequence of sexual intercourse.</td>
</tr>
<tr>
<td>Counselling</td>
<td>A professional process of providing non-judgmental guidance to help a person make an informed decision.</td>
</tr>
<tr>
<td>Emergency</td>
<td>Sudden state of danger or condition requiring immediate treatment or action to restore life of a person or patient or to prevent grave permanent physical or mental injury.</td>
</tr>
<tr>
<td>Emergency abortion Care</td>
<td>Life-saving services that help to meet the needs of women suffering complications of abortion.</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Assessing the relevance effectiveness, efficiency, sustainability and impact of services using service statistics from monitoring and special investigations to assess the extent to which program goals are being achieved.</td>
</tr>
<tr>
<td>Guidelines</td>
<td>Principles directing actions for implementation per policies that must be rational, logical and documented.</td>
</tr>
<tr>
<td>Health Practitioners</td>
<td>Health personnel licensed and registered under the Health Professions Act.</td>
</tr>
<tr>
<td><strong>Legal Abortion</strong></td>
<td>Termination of pregnancy within the legal framework.</td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td><strong>Maternal Mortality Ratio</strong></td>
<td>The number of women who die due to pregnancy and child birth complications per 100,000 live births in a given year.</td>
</tr>
<tr>
<td><strong>Medical Abortion</strong></td>
<td>Use of pharmacological methods to terminate pregnancy.</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>Subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one’s intellectual and emotional potential” (World Health Organization).</td>
</tr>
<tr>
<td><strong>Medical Age of Consent</strong></td>
<td>A child with sufficient maturity at the age of 18 years or above can be treated as an adult and is legally competent to decide on all forms of treatment, and medical and surgical procedures.</td>
</tr>
<tr>
<td><strong>Monitoring</strong></td>
<td>Overseeing the processes of implementing services, including changes over time using defined indicators.</td>
</tr>
<tr>
<td><strong>PAC</strong></td>
<td>Post abortion care is an integrated package of care for women who have had a spontaneous (miscarriage) or induced abortion with or without its complications. It includes emergency treatment, family planning counselling and provision, linkages to other RH services and community linkages.</td>
</tr>
<tr>
<td><strong>Reproductive Health (RH)</strong></td>
<td>A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive health system and in its functions and processes (ICDP 1994). Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide when and how often to do so.</td>
</tr>
<tr>
<td><strong>Reproductive health care</strong></td>
<td>Defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems, including that of sexual health.</td>
</tr>
<tr>
<td><strong>Skilled Attendant</strong></td>
<td>A trained provider with a technical competence for providing a health service.</td>
</tr>
<tr>
<td><strong>Standards</strong></td>
<td>Measures of performance.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>----------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Surgical Abortion</td>
<td>Use of trans-cervical procedures for terminating pregnancy, including vacuum aspiration, dilatation and curettage (D&amp;C), and dilation and evacuation (D&amp;E).</td>
</tr>
<tr>
<td>Unsafe abortion</td>
<td>A procedure for terminating an unintended pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both (WHO 1993).</td>
</tr>
<tr>
<td>Unintended pregnancy</td>
<td>An unintended pregnancy is a pregnancy that is mistimed, unplanned, or unwanted at the time of conception.</td>
</tr>
<tr>
<td>Uterine Evacuation</td>
<td>Is the removal of contents of the uterus in termination of pregnancy or incomplete abortion.</td>
</tr>
</tbody>
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Introduction

The “Standards and Guidelines for Comprehensive Abortion care in Zambia” are an updated version of the “Standards and Guidelines for reducing unsafe abortion morbidity and mortality in Zambia” which were first published in May 2009.

This second and updated version is meant to reflect the evidence based practices that have changed from the time of the first publication. In particular, the updated guidelines have adapted and in some instances adopted the ‘WHO Safe Abortion: technical and policy guidance for health systems of 2012.’ Reference has also been made to RCOG (Royal College of Obstetricians and Gynaecologists) leading Safe Choices best practice papers on comprehensive abortion care as well as the Zambian family planning guidelines and protocols for 2016. These updated guidelines are within the Zambian legal framework as guided by the various legal statutes that have been quoted in the later parts of this document.

Unsafe abortion remains a major challenge in Zambia despite an abortion law that is considered liberal. Abortion remains among the top five causes of maternal mortality in Zambia whose maternal mortality ratio stands at 398 deaths per 100,000 live births (ZDHS 2014). Hospital based studies show that 30-50% of acute gynaecological admissions are because of abortion complications, most being from unsafe abortion.

In 2008 the Ministry of Health in collaboration with WHO and Ipas Africa Alliance commissioned a strategic assessment into the problem of unsafe abortion in Zambia. The exercise had the following three strategic objectives: to ascertain the scale of unsafe abortion; to find out how the need for abortion can be reduced and to ascertain how access to safe abortion services could be improved. One of the main findings was that abortion services were being provided in a vacuum. While the law existed, it did so, on a “stand alone” basis with no clear policy framework for standards and guidelines in implementing services. This led to the development of the 2009 Standards and Guidelines document, of which this document is the revised and updated version. The Standards and Guidelines mean that the Ministry of Health can respond to the challenges of unsafe abortion by introducing a holistic approach to Comprehensive Abortion Care.

The approach is based on the epidemiological concepts of primary, secondary and tertiary prevention in health care. The best of these is primary prevention which refers to all the actions taken to protect the population from a health problem. In preventing unsafe abortion, primary prevention refers to preventing unwanted/unintended pregnancy. This can be done through information, education, and counselling on contraceptive services, improving access to contraceptive services and prevention of rape and incest and thus is a function for all sectors of society including religious bodies, the education system, families, all socio-cultural structures, as well as the health system.

Applied to the problem of unsafe abortion, secondary prevention involves early detection of unwanted/unintended pregnancy and the provision of safe and comprehensive abortion services to prevent recourse to unsafe abortion. The services include woman centred counselling, termination of pregnancy to the full extent allowed
by the law and provision of ante-natal, safe delivery and adoption services to women who choose to carry their pregnancies to term, depending on whether such women want to keep the baby or have it adopted.

The third component of comprehensive abortion care is tertiary prevention which deals with complications of abortion, including from unsafe abortion by offering post abortion care. This level of care aims at preventing permanent disability and death in patients who already have complications either from spontaneous or induced abortion.

By applying all the levels of care to the problem of unwanted/unintended pregnancy, the MOH aims to drastically reduce morbidity and mortality resulting from unsafe abortion. Abortion services will also be used as entry points for other reproductive health services by strengthening the referral within the health system such as screening and management of sexually transmitted infections and pre-cancerous lesions of the cervix. Comprehensive services will be guided by the principles of a woman’s choice to available options, equitability of access to services by women of all socio-economic classes and place of residence, and high quality of services at all levels of healthcare.

This document will greatly enhance the legislative framework for matters related to or incidental to unsafe abortion. In particular, this document will seek to support the implementation of the provisions of the Termination of Pregnancy Act, and the 2005 amendments to the Penal Code on the treatment of survivors of rape and defilement. This document will also further the implementation of some parts of the Health Professions Act of 2009, the Gender Based Violence Act of 2011 as well as those of the Adoption Act (Cap 54 of the Laws of Zambia), and the Gender Equity and Equality act of 2015.

This document has been developed within the tenets of the international human rights framework. The Zambian Government, as most other Governments, has ratified several “legally binding” international agreements that protect human rights, in particular the right to life, liberty and security of the person, the right to the highest attainment of standards of health, the right to non-discrimination, the right to be free from inhuman and degrading treatment and the right to education and information.

Global consensus on the international human rights framework for reproductive health has been reached at various levels including the International Conference on Population and Development and its subsequent review and Appraisal process, the Tehran Proclamation (1968), the 1995 Fourth World Conference on Women and the 2000 United Nations Summit. These global initiatives have yielded enough leverage for municipal laws to provide for women’s rights to support their safe reproductive lives.

Further, the document seeks to operationalize provisions of the Maputo Plan of Action (2006) and the Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa (2003) that are concerned with reproductive health and abortion. The document is especially key in the attainment of the SDGs. Further, the document seeks to enhance the implementation of ICPD and its subsequent plans of action, International Covenant on Economic, Social and Cultural Rights, International Covenant on Civil and Political Rights, CEDAW and CRC.
Situation Analysis

The prevalence of unwanted pregnancy culminating into increased incidences of unsafe abortion has resulted in severe consequences of morbidity and mortality. This translates to over 70 percent of abortion complications being because of unsafe abortion and six per thousand women die of abortion, most likely due to unsafe abortion (Likwa et al. 2009). Other studies show multiple factors that are associated with unsafe abortion and include: stigma associated with unwanted pregnancy and abortion; cultural values and religion; socio-economic status (wealth and place of residence); access to and availability of safe abortion and contraceptive services, especially among vulnerable groups of society; and, decision-making about choice of health services (Ministry of Health and Ipas 2008; CSO et al 2014).

Unsafe abortion has also been shown to have adverse economic consequences. The economic impact of unsafe abortion falls into two components – the direct costs of providing medical care for women who are hospitalized because of complications of unsafe abortion, and indirect costs to women, households, the community and society. Direct costs are generally highly subsidized by the public sector, although women and their families bear a proportion of these costs, and in some countries this can be a very large proportion. (Susheel Singh, Global Consequences of unsafe abortion a Review article, 2015) The economic cost of unsafe abortions in Zambia was studied in 2015. In a publication entitled “Cost of Abortion in Zambia: A comparison of safe abortion and post abortion Care,” Vwalika B et al found that PAC following an unsafe abortion can cost 2.5 times more than safe abortion care. The Zambian health system could save as much as US$0.4 million annually if those women currently treated for an unsafe abortion instead had a safe abortion.

Adolescent pregnancy is also recognized as a major demographic and public health challenge for Zambia. About three in ten (29%) adolescents aged 15-19 have experienced childbearing. Adolescent pregnancy is affected by early and illegal marriage practices which remain the norm for many Zambians. Age at first sex for both women and men is an important indicator of exposure to risk of pregnancy and STI, and is lower (<18 years) for females aged 18-24 years than males (CSO et al ZDHS 2014). For unmarried adolescents, pregnancies are likely to be unintended or unwanted.

Globally, 222 million women would like to prevent or delay pregnancy but have no access to contraception. Meeting this need would allow women to control their own fertility and reduce maternal deaths by one- third, with lasting benefits for their families and communities. (RCOG Leading Safe Choices Best Practice Paper in FP 2015). In Zambia, unmet need for family planning has declined from 27% in 2009 to 21% in 2014. 21 percent of currently married women have an unmet need for family planning, with 14 percent for spacing births, and 7 percent for limiting births. If all currently married women who say they want to space or limit their children were to use a family planning method, the contraceptive prevalence rate would increase to 70
percent. Currently, only 49 percent of the family planning needs of married women are being met (CSO at al ZDHS 2014).

There are existing policies and guidelines for the implementation of reproductive health services to prevent unwanted and unintended pregnancy in the country (Ministry of Health 2008; Ministry of Health 2006). The Zambian family planning Guidelines and Protocols (2016) Population Policy (2008), National Child Health Policy (2008), and Girl-Child Education Policy (1997) frameworks are legal instruments facilitating implementation of appropriate measures for the prevention of unintended and unwanted pregnancies.

The parental/guardian consent (authorization) for minors are ratified in the Convention on the Rights of the Child (CRC). Article 5 of the Convention provides that “parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention” (In WHO 2003:66). Article 3, which contains one of four guiding principles that govern the implementation of all articles of the Convention, states that, “in all actions concerning children (defined as every human being below the age of 18 years) whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interest of the child shall be a primary consideration”.

Health providers should encourage minors to consult parents or guardians about their pregnancy. If the minor indicates that consulting a parent is not possible (e.g. a parent is abusive) service providers should not insist on parental consent.

**Purpose**

This document provides the underlying principles and essential requirements for providing equitable access to, and adequate quality of, lawful comprehensive abortion care services. The purpose of these standards and guidelines is to ensure that women prevent unwanted pregnancies and those with unwanted/unintended/risky pregnancies get appropriate services to prevent the occurrence of unsafe abortion and associated morbidity and mortality: These guidelines are evidence-based recommendations for the delivery of safe comprehensive abortion care. They have been developed and updated with the intent of eliminating barriers to obtaining the highest attainable standard of sexual and reproductive health and reflect new evidence of best practices.

The document is directed to health providers, managers and policy makers involved in the provision of abortion related services. It contains guidance on what, how, by whom and in which facilities services can be provided.

It is hoped that all stakeholders working to reduce maternal mortality and morbidity resulting from unsafe abortion will find this document useful and will apply the principles behind it in their programs. More importantly, however, is that women who hitherto have been victims of unsafe abortion will no longer suffer preventable
morbidity and mortality irrespective of their social status or the part of the country where they come from because the guidelines will be institutionalized in both public and private health facilities all over the country.

**Structure of the document**

This document is organized into 4 sections. Section 1 deals with prevention of unwanted and unintended pregnancy, section 2 deals with management of unwanted/unintended and risky pregnancies, section 3 deals with Post Abortion Care and section 4 provides the monitoring and evaluation framework.

Each section contains medical practice norms broken down into standards and guidelines depending on the level of flexibility which is determined by the extent to which intervention evidence exists. When the outcomes are known, a practitioner has limited choices. On the other hand, when the outcomes of an intervention are uncertain or variable, practitioners must be given flexibility to tailor a policy to individual cases. The flexibility is thus dealt with by having two types of practice policies in the document: standards and guidelines.

- **Standards** are intended to be applied rigidly in almost every case, exceptions being rare and difficult to justify. For auditing purposes, standards are used to measure performance.
- **Guidelines** are recommendations for best practice. They are steering in nature. They do not have the same force as standards. When they are not applied, their justification must be rational, logical and documented. Each guideline specific to a standard is indented just under the standard. Broad guidelines that apply to many if not all standards are written at the end of a specific section.

**This document will be supplemented by protocols which give step by step guidance for every procedure.**

---

1 Protocols will be developed after adoption of guidelines.
Section 1 Prevention of unintended and unwanted pregnancy

Policy Statement: Individuals and families should have access to quality and affordable reproductive health services as a way of ensuring their physical, mental, emotional and social development throughout their lives. The provision of these services should be blind to age, colour, creed, religion, gender and mental or socio-economic status.

Contraception

Who Should Provide contraceptive services

Policy Statement: All stakeholders, from community to government, (Appendix 5) should play a role in preventing unwanted pregnancies and so involvement of all stakeholders regardless of creed and belief, is essential for successful interventions.

Standard 1: As recommended by FP guidelines and protocols of 2016, family planning services should be provided by trained providers at community and facility level e.g. medical officers, medical licentiates, nurse midwives, clinical officers, trained non-medical providers such as community based health workers/agents and traditional birth attendants.

Guidelines:

1. At appropriate level of care, providers must be adequately trained in the provision of both short term and long term methods of family planning.
2. Stakeholders such as the church, the media community, traditional leaders, school system should be involved in the prevention of unwanted pregnancy.
3. Community-based health workers/agents should integrate provision of information on pregnancy prevention, availability of safe abortion care and consequences of unsafe abortion into their work.
4. Community based health workers/agents should be supported to intensify their provision of contraceptives to the extent possible.

How should services be provided

Policy Statement: A holistic approach to contraception provision is beneficial to socio-economic development of the country and prevents pregnancy related morbidity and mortality.

Standard 1: All women, men and young people be provided with methods that prevent pregnancy upon request and as per their informed choice so long as the method meets the medical eligibility criteria, Contraceptive services should be based on the woman’s
voluntary informed choice without hindrance of personal opinions or pre-conceived biases of the service provider.

**Guidelines:**

1. Institutions shall ensure that a broad method mix is available onsite or through appropriate referral to allow for choice.
2. The choice of the client prevails above any other including that of the spouse or guardian or service provider. Services shall be provided with consent of the client only without need for notification or consent of a spouse or partner.

**Standard 2:** Service providers shall respect the client's rights in the provision of contraception services.

**Guidelines:**

1. Providers shall ensure that they:
   a) Communicate with clients effectively
   b) Treat all clients with respect and dignity
   c) Provide quality services in a way that does not infringe upon the client's rights
   d) Conduct profiling of the client appropriately
   e) Assure privacy and confidentiality

**Standard 3:** All providers should demonstrate counselling skills in line with the Family Planning Counselling Kit.

**Guidelines:**

1. The provider must ensure that the counselling is non-judgmental and empathetic.
2. Adequate information should be given to each client to enable clients make an informed choice.
3. The provider must ensure that they are responsive to client's concerns and circumstances.

**Standard 4:** All hospitals, health centres, clinics and community health structures should have space conducive for the provision of contraception services.

**Guidelines:**

1. Physical structures should be accessible to all including people who are differently-abled.
2. Physical facilities must ensure adequate privacy.
3. The district should ensure adequate provision of community based contraception services.
4. Trained mid-level providers should be used to provide contraceptive services wherever possible to increase access to services at community level.
Adolescent Contraceptive Services

Policy Statement: providing adolescents with quality contraceptive services reduces unwanted pregnancies, teenage fertility and risk of unsafe abortion thereby reducing morbidity and mortality

Standard 1: Youth friendly services should be available in all facilities providing Reproductive Health services including those at community level.

Guidelines:
1. Adolescents should be supported in accessing the method of contraception they need and there should be a supportive and friendly environment.
   a) Facilities should ensure availability of trained personnel in youth friendly services including psychosocial counselling, at all levels of health care.
   b) Facility should ensure adequate privacy and confidentiality including adequate infrastructure and arrangements that encourage young people to access contraceptive services.
   c) Facilities should sensitise the community on the availability and importance of youth friendly services.
   d) Youth Friendly Health Services should be available in the community.

Standard 2: All adolescents and youths, both in-school and out of school, should have access to comprehensive sexual and RH information and services.

Guidelines:
1. Information on types of contraceptives and how to access them should be included in the school curriculum as part of sexuality education.
2. Information and services should equip them with basic life skills with a view to enhancing their assertiveness, self-esteem, value clarification and decision making regarding issues that affect them.
3. Give active institutional support to IEC packages that are meant to address adolescent sexuality and reproductive health needs.
4. Ensure that cost of services does not hinder access of services for adolescents and youths.
5. Ensure active referrals of in school adolescents who need contraceptives to the nearest health facility or youth friendly space.

Standard 3: Facilities should ensure that adolescents and youths make informed and free decisions without coercion from interested parties.

Guidelines:
1. Ensure respect of autonomy in decision making without third party authorization.
2. Ensure that the adolescent is adequately counselled in a way that she can understand the information provided to her.
3. Providers should act in good faith in the interest of the minor and this may involve leaving out parental or guardian consent where this is not mandated by policy.

Sexual Abuse and Violence

Policy Statement: The prevention and timely management of sexual violence reduces unwanted pregnancy, unsafe abortion and related morbidity and mortality.

Standard 1: Community and facility based SRH services should have information and services on prevention of sexual violence.

Guidelines:
1. Advocate for enforcement of laws pertaining to prosecutions against sexual and gender based violence (SGBV) for perpetrators. (Anti GBV Act 2011)
2. Create awareness about the health risks associated with sexual and gender based violence through media, community participation and other existing structures.

Standard 2: Facilities offering RH services should have protocols for providing services to survivors of sexual violence.

Guidelines:
1. Build capacity of all providers and institutions involved in handling victims of sexual abuse and violence.
2. Ensure provision of emergency contraception to eligible survivors.
3. RH providers should ensure that all victims of SGBV should be linked to other supportive services including prevention and management of STIs, HIV, unwanted pregnancy and need for Post Exposure Prophylaxis (PEP), psychosocial counselling and shelter.
4. Establish an effective referral systems through formalized agreements between stakeholders.
Termination of pregnancy

Legal Provisions and implementation guide for safe abortion services.

This section has been incorporated in the guideline with the aim of enabling all health workers, involved in the provision of abortion care, to be well informed on the law so that they may not only know when and how to apply the law but also inform and educate women and the community at large.

The Zambian legislative framework on the termination of pregnancies is defined by five principal Acts of Parliament. These are the Republican Constitution, the Penal Code, the Termination of Pregnancy Act, the Health Professionals Act and the Gender Equity and Equality Act. The Republican Constitution makes allowance for the termination of pregnancies, provided such is done within the laid down conditions of the law [See Article 12(2)]. On the other hand, the Penal Code makes provision for safe abortion by criminalizing unsafe and illegal abortion methods [See Sections 151 to 153]. The Gender Equity and Equality Act provides that a woman has the right to choose whether to have a child [see section 21(2)]

The Termination of Pregnancy Act is the principal legislative Act on the termination of pregnancy. It was enacted in 1972 with amendments in 1994. The Termination of pregnancy Act provides for the legal termination of pregnancies within defined spheres. The Act provides the general framework under which a pregnancy can be terminated. According to the Act, an abortion in Zambia can be conducted under the following circumstances:

i. Where the pregnancy constitutes a risk to the life of the pregnant woman

ii. Where the pregnancy constitutes a risk of injury to the physical or mental health of the pregnant woman

iii. Where the pregnancy constitutes a risk of injury to the physical or mental health of any existing children of the pregnant woman to such extent that the risk is greater than if the pregnancy were terminated

iv. Where the pregnancy constitutes a substantial risk so much that the child to be born would suffer from such physical or mental abnormalities as to be seriously handicapped
Amendments to the Penal Code

Due to the escalating number of Gender Based Violence cases, the Zambian Parliament in 2005 amended the Penal Code. Sections 151 to 153 dealing with abortion were amended to include terms as female child, rape and defilement.
Section 152[2] provides as follows:

"Any female child being pregnant who, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing or uses any force of any kind commits an offence and is liable to such community service or counseling as the Court may determine, in the best interest of the child"

Provided that where a female child is raped or defiled and becomes pregnant the pregnancy may be terminated in accordance with the Termination of Pregnancy Act

The following guide has been developed to help providers in applying the requirements of the Act.

1. Implementation Guide for Place for Termination of Pregnancy (section 2 & 3(3&4)

- Except as provided by subsection (4) any treatment for the termination of pregnancy must be carried out in a hospital

- The TOP Act provides that termination of pregnancy should be conducted only in hospitals. These “hospitals” can either be public or private health facilities, provided they meet the pre-set criteria as determined and licensed by the Health Professionals Council of Zambia (HPCZ).

- However, a termination of pregnancy can be carried out in any other “place” or health facility, if the termination was an emergency one necessary to save the life or prevent grave permanent injury to the physical or mental health of the pregnant woman [See Section 3(4) of TOP].

2. Implementation Guide for Section 3(1) of TOP

- Status of Termination of pregnancy

- Termination of pregnancies is legal, provided it is conducted by trained and skilled health care providers within the confines of the law.

- The health care provider must bear in mind that the Zambian law is premised on the sound assumption that the life of the mother is paramount to that of the unborn child.

- “Good faith” is premised within the tenets of medical ethics of preventing harm.
3. Implementation Guide for Section 3(1)(a)(i) of TOP

- Where the pregnancy constitutes risk to the life of the pregnant woman

- The health care provider must recommend or conduct termination of pregnancy where he/she forms the opinion that the continuance of the pregnancy poses risk to the life of the pregnant woman greater than if the pregnancy were terminated.

- The health care provider should, in all good faith, follow the knowledge of standard medical indications that necessitate termination of pregnancy to save the life or health of the pregnant woman.

- The health care provider must as an ethical consideration not expect the pregnant woman to request for the termination or that the pregnant woman should be in a state of ill health at the time of requesting safe abortion services. The health care provider must assess the pregnant woman’s conditions and recommend an opinion formed in good faith that the continuance of the pregnancy constitutes a risk to the life of the pregnant woman greater than if the pregnancy were terminated.

- The woman should not necessarily be in a state of ill health at the time of having TOP. It’s therefore the responsibility of the provider to assess the woman’s condition and determine whether there is a threat to her life.

4. Implementation guide for Section 3(1)(a)(ii) of TOP

- Risk of injury to the physical or mental health of the pregnant woman

- The health care provider should recommend or conduct termination of pregnancy where he/she forms opinion in good faith, that the continuance of the pregnancy constitutes a threat to the physical or mental health of the pregnant woman.

- The health care provider should recommend or conduct termination of pregnancy where he/she forms opinion in good faith, that the continuance of the pregnancy constitutes a risk to the physical or mental health of the pregnant woman. The World Health Organization (WHO) defined health in its broader sense in its 1948 constitution as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

- Risk of physical injury should be taken to mean that though no threat to the life of the pregnant woman exists, a threat to her physical wellbeing or limb exists [whose degree is irrelevant] by continuing with pregnancy or that the birth of the child endangers the pregnant woman’s mental wellbeing for psychological reasons or otherwise.
• Risk of Injury to the physical health means any such risk of a physical nature that would befall the woman whether actual or reasonably foreseeable environment. (See section 3(2). It up to the health provider to ascertain upon taking a history, making a physical or laboratory including genetic diagnosis/investigation of the pregnant woman.

• Risk to Mental health should be taken to mean any such injury to the pregnant woman premised upon psychological reasons taking into consideration the definition of mental health.

• Because mental health is not just absence of mental disorders, assessment need not be done by a psychiatrist.

5. Implementation Guide for Section 3(1)(a)(iii) of TOP

➢ Risk of injury to the physical or mental health of any existing children of the pregnant woman

• The health care provider shall recommend termination of pregnancy where s/he forms opinion that the birth of the child constitutes a risk of injury to the physical or mental health of any existing child/ren of the pregnant woman.

• It is enough that the birth of the unborn child shall constitute a threat to the physical or mental wellbeing of the existing child/ren of the pregnant woman that must be used as a basis for recommendation of the termination of pregnancy.

• The health care provider must only ascertain that the birth of the child shall endanger or threaten the physical or mental wellbeing of the existing child/ren of the pregnant woman.

6. Implementation Guide for Section 3(1)(b) of TOP

➢ Substantial risk that child would be born or suffer from physical or mental abnormalities as to be seriously handicapped

• Health care providers should recommend termination of pregnancy where s/he forms opinion that there exists a substantial risk that if the child were to born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

7. Implementation Guide for Section 3(2) of TOP
Woman’s actual or reasonably foreseeable environment

- To assess the environment the provider may consider the situation of the woman as regards
  - Medical
  - Economic situation
  - Social/cultural circumstance
  - Religious etc.

- If the woman’s actual or reasonably foreseeable environment as outlined above poses a risk to the successful completion of the pregnancy to term, the health provider may consider termination of pregnancy based on the woman’s free consent.

8. Implementation Guide for Section 4(1 & 2) of TOP

- Conscientious objection

- The Government of the Republic of Zambia respects the right of medical providers to conscientious objections in participating in the termination of pregnancy. However, the client’s right to information and access to health care services including termination of pregnancy must be respected.

- Though individuals have a right to their own belief and moral perspective on abortion, their personal objectives should not hinder access to care for others needing a service.

- If a health care provider feels uncomfortable in dealing with a client who requests termination of pregnancy, the client must be respectfully referred to a colleague who is willing to assist a client in obtaining services.

- No provider has the right to conscientious objection in an emergency in accordance with the TOP Act 1972 section 4 subsection (2).

- Public health care facilities are public domain. The management of all government health care facilities and facilities supported by government have the obligation to ensure that women have access to the services which they are legally entitled to, except those excluded through specific agreements with Government.

- Conscientious objection should only be dealt with when expressed by individual staff members and not as a group action nor as an institution.

- Conscientious objection only applies to the procedure and not broader services and only applies to the abortion provider and not support personnel.
9. Implementation Guide for Provision to Section 152 (2) of TOP

➢ Where the pregnancy is as result of rape or defilement

• Termination of pregnancy should be conducted within the wider meaning of Section 3(1)(a)(ii) of the TOP that there is risk of injury to the physical or mental health of the raped or defiled female child.

• Termination of pregnancy of a female child should be conducted as statutory right of the female child based on the request and the disclosure of the raped or defiled pregnant female child’s parent/s or guardian/s considering the devolving capacities of the female child to take part in decisions affecting her life. The pregnant female child’s word must be taken as a matter of fact and duly recorded as confidential and private and not subject to the health care provider’s subjective analysis.

• The health care provider must not demand of the pregnant woman to submit evidence of rape or defilement to have her pregnancy terminated.

General guide to TOP Act

Within the scope and framework of the TOP Act, management of unintended pregnancies would entail the termination of pregnancies such as those that pose risk of injury to the physical or mental health of any existing children of the pregnant woman or one that would have adverse effects on the foreseeable environment of the pregnant woman. It stands to logic that termination of pregnancy in Zambia can be justified by social and economic reasons.

Implementation guide to adoption

The Zambian legislative framework has provided for matters related to or incidental to adoption through the Adoption Act [Chapter 54].

Any person resident in Zambia, who for any reason might not be able to look after their child/children, can place such child/children under adoption with some people or registered adoption agencies.

Accordingly, for individual persons, Section 3(1) of the Adoption Act provides that the Court must on application of interested parties, make an order authorizing such applicant to adopt a child [Child defined as an infant below the age of 21 years, but does not include a person who is or has been married] if the following criteria is met that one of the applicants:

a) Has attained the age of twenty-five and is at least twenty-one years older than the infant; or
b) Has attained the age of twenty-one years and is a relative of the infant, or
c) Is the mother or father of the infant.

Societies or organizations that adopt children must be registered as an adoption society with the Commissioner of Juvenile Welfare.

**Who should provide Termination of pregnancy Services (TOP)**

**Policy statement:** TOP is a safe procedure when performed by skilled registered health practitioners.

**Standard 1:** According to the TOP act of 1972, pregnancy termination must be performed by registered medical practitioners trained in the provision of abortion care in accordance with state law.

**Guidelines**
1. Considering that medical practitioners may not be sufficiently available in all institutions, mid-level providers trained in the provision of CAC may provide termination of pregnancy as certified by or under supervision of a registered medical practitioner.

**Standard 2:** All providers² performing TOPs must receive training in the performance of abortions and in the prevention, recognition and management of complications.

**Where Can Pregnancy Termination Be Performed**

**Policy statement:** Termination of pregnancy is a safe procedure when performed under hygienic conditions with the right equipment by trained providers.

**Standard 1:** According to the Law, elective termination can only be performed in approved registered medical institutions, both public and private.

**Guidelines**
1. Public health facilities are legally obligated to provide abortion related services.
2. Private health facilities registered with HPCZ and offering other RH services can also offer abortion related services.

² To ensure equitable access to services even in the most disadvantaged areas where there might not be many doctors, the Minister may authorize other mid-level providers like Medical licentiates and midwives to provide abortion services through a statutory instrument as the law provides.
Standard 2: All institutions performing elective pregnancy termination should be guided by protocols based on prevailing clinical evidence.

Guidelines:

1. The method used to provide termination of pregnancy will determine the level of health system where the patient will be cared for
2. If a patient who requests pregnancy termination in a medical institution cannot undergo the procedure, she must be duly informed about the existing alternatives including referral to another facility, and this information must be documented.
3. Appropriate referrals should be available for patients who cannot be cared for in a particular facility

Standard 3: The procedure room must have emergency equipment and supplies to provide immediate management of expected emergencies.

Counselling and Informed Choice

Policy statement: A patient’s informed and free choice is essential for performing a quality pregnancy termination procedure

Standard 1: All women undergoing pregnancy termination must be appropriately and accurately informed about their choices in order to be able to make a decision

Guidelines:

1. Community-based health workers must inform women how to obtain safe, legal abortion care without any delay and refer women with complications of unsafe abortion for appropriate care.
2. Staff providing counselling must be empathetic and non-judgmental, particularly perceptive to and respectful of the state of the woman emotionally.

Standard 2: Accurate information on the risks and benefits of abortion must be given to all women undergoing termination of pregnancy.

Guidelines:

1. Information on the risks and benefits of abortion must include
   a) Alternatives to pregnancy termination such as adoption or carrying the pregnancy to term.
   b) Support that the woman is entitled to get by the law
   c) Institutions that may provide this support
   d) Pregnancy termination techniques and potential benefits and risks of each procedure
   e) Potential complications
2. Information about clinical procedures, aftercare should be given to patients.
3. Counselling should be in a language that the patient is able to understand and should be accompanied by written information where available

**Standard 3:** Contraceptive counselling and methods for those agreeable to contraception must be provided to all women undergoing Termination of pregnancy.

**Standard 4:** All women undergoing pregnancy termination must have certificate of opinion A or B completed not later than 24 hours after such termination in the case of certificate B

**Guidelines:**
1. Certificate A is to be completed for elective terminations and requires three signatories of doctors certifying their opinion formed in good faith.
2. Certificate B is for emergency terminations and requires the signature of only one doctor **who in good faith** certifies the procedure to save the life of the woman or to prevent grave permanent injury to the physical and mental health of the woman.
   a) A single doctor must assess what constitutes an emergency. In making such assessment, the practitioner will not only consider the present circumstances but would also consider the foreseeable circumstances including the risk of unsafe abortion and associated morbidity and mortality. The lack of other available doctors to certify a procedure as per certificate A is therefore an adequate reason for signing certificate B.
3. The certificate A or B shall be preserved by the practitioner who terminated the Pregnancy to which it relates for a period of three years beginning with the date of the termination and may then be destroyed. (TOP Regulation 217 of 1972)

**Standard 5:** All women undergoing pregnancy termination must sign an informed consent before undergoing the procedure.

**Guidelines:**
1. Informed consent should include the patient’s affirmation that she understands the procedure and its alternatives, potential risks, benefits and complications and that the decision is uncoerced and that she is prepared to have an abortion.
2. The health worker should determine whether the woman understands medical explanations before signing consent.
3. In the case of conflict between the woman and the partner/spouse, the woman’s decision takes precedence.

**Standard 6:** If the patient's age is below that of legal consent to a medical or surgical procedure (less than 18 years of age), the parents or legal guardian approval to terminate the pregnancy must be documented. The best interest of the minor will take precedence over that of the parents or guardian (HPCZ guidelines on Patients Informed Consent, 2016)

**Guidelines**

1. The best interest of the minor will take precedence over that of the parents or guardian.

2. Providers should recognize that pregnancy in a minor under 16 years of age is the result of statutory defilement. Such patients are entitled to services as provided by law (Penal Code Amendments No 15 of 2005 the provision to section 152 (2).

3. The confidentiality of the minor should be respected subject to the usual exceptions that apply to patient –provider confidentiality. No information about the minor should be disclosed to anyone other than the adult who provides consent.

4. The service provider should encourage minors to consult a parent or guardian if they have not already done so.

5. A parent or guardian can give consent on behalf of the minor and this must be documented.

**Standard 7:** All reasonable precautions must be taken to ensure the patient’s confidentiality

**Guidelines**

1. Counselling in abortion care does not require professional counsellors but can be provided by nurses, midwives, doctors, social workers including nurse assistants who have received appropriate training.

2. Supportive counselling may be necessary for:
   a) Adolescents
   b) Emotionally distressed women
   c) Women suffering complication of pregnancy
   d) Women having therapeutic termination of pregnancy
   e) Rape/incest victims
   f) Women infected with HIV
**Pre -Procedure Care**

**Standard 1:** For all patients, a pertinent medical history and physical examination including a bimanual examination must be obtained and documented.

*Guidelines:*
1. Vital signs e.g. blood pressure, pulse, temperature etc.) and physical exam should be done as indicated by medical history and or patient's symptoms and signs.

**Standard 2:** Confirmation of pregnancy must be documented

*Guidelines:*
1. Confirmation of pregnancy and gestation age can be done clinically using history, physical exam and pregnancy test where necessary. Where a variance occurs, ultrasound may be used to confirm gestational age, if available.

**Standard 3:** When a patient with a positive pregnancy test presents with vaginal bleeding and/or pelvic pain, ectopic pregnancy should be considered and ruled out urgently.

*Guidelines:*
1. Where necessary and available, the following tests could be done
   a) Pregnancy test to confirm pregnancy
   b) Hb if the patient is clinically anaemic
   c) Ultrasound scan to confirm gestation age, rule out abnormality where indicated, rule out ectopic pregnancy where there is suspicion and to confirm completeness of uterine evacuation where necessary.

**Standard 4:** Anti D where available should be offered to non-immunized RH negative women especially after the first trimester.

**Uterine Evacuation Procedures**

**Policy statement:** Pregnancy termination either by medical or surgical methods, is one of the safest procedures. The following standards and guidelines add to its safety.

**For pregnancies, up to 12-14 completed weeks of gestation**
Methods used for evacuation include:
- Surgical (manual vacuum aspiration (see appendix 6), electric vacuum aspiration)
- Medication (mifepristone combined with misoprostol, or misoprostol alone where mifepristone is not available)
Surgical methods

Standard 1: Vacuum aspiration (Manual MVA, is the preferred method for evacuating the uterus in the first trimester.

Guidelines:
1. The facility must have the appropriate and adequate equipment and supplies for termination of pregnancy

Standard 2: Pertinent medical history must be obtained and documented

Standard 3: Gestational age must be assessed clinically and documented

Standard 4: Patient comfort during the procedure must be considered

Guidelines:
1. Analgesics or other comfort measures should be offered

Standard 5: Appropriate dilatation of the cervix must be obtained.

Standard 6: All instruments entering the uterine cavity must be sterile or high level disinfected

Standard 7: All patients should receive prophylactic antibiotics within 2 hours before the procedure

Standard 8: Completion of the procedure must be verified by observing the products of conception for villi and/or gestational sac and this must be documented by the provider

Guidelines:
1. In most cases, completion should be verified on clinical grounds but where necessary or in doubt, ultrasound can be used for confirmation if available

Standard 9: Clinical protocols for post-operative care and follow-up must be followed.

Medical methods

Standard 1: Either mifepristone and Misoprostol combined or Misoprostol alone, where mifepristone is not available, should be used per the local protocols. (see appendix 6)

Guidelines:
1. Allowing home use of mifepristone and misoprostol after counselling and clinical evaluation at a health care facility can improve the privacy, convenience and acceptability of services, without compromising on safety.
2. Medical abortion and in particular, use of misoprostol, for pregnancies over twelve weeks should be facility based to facilitate the need for repeated
doses of misoprostol as well as afford appropriate disposal of products of conception

**Standard 2:** Pertinent medical history must be obtained and documented

**Standard 3:** Gestational age must be clinically assessed and documented

**Standard 4:** The patient must be informed about the need for follow-up contact, if needed to ensure that she is no longer pregnant

**Standard 5:** The patient must be informed about the efficacy, side effects and risks with medications to be used.

**Guidelines:**
1. The patient must be informed that should medical abortion fail, surgical method may be needed.
2. The facility must provide an emergency contact on a 24-hour basis and must assure referral for uterine aspiration if indicated for patients self-administering misoprostol and/or mifepristone at home following clinical evaluation and counselling at a health care facility.

**Standard 6:** Patient’s instructions must include information about use of medication at home and symptoms of abortion complications and what to do in such cases.

**Standard 7:** Patient’s comfort level during the abortion procedure must be considered and appropriate pain management provided.

**Standard 8:** Completion of the abortion through clinical means and where necessary by ultrasound must be documented.

**Guidelines:**
1. If a patient has failed to return for follow up as planned, attempts should be made to locate her and this should be documented.

**After 12-14 weeks completed weeks of gestation**

**Surgical methods**
All cases of 12-14 weeks and above should only be managed in a unit staffed by a specialist or trained medical officer in consultation with a gynaecologist as it requires providers with special training and experience.

**Standard 1:** Medical abortion or Dilatation and evacuation (D&E) are the preferred methods for evacuating the uterus in the second trimester after cervical preparation/ripening/priming.

**Guidelines:**
1. Cervical preparation (ripening/priming) is recommended for:
a) Nulliparous women
b) Women less than 18 years old, and
c) All women at 12-14 weeks of gestation and above.

2. The facility must have the appropriate and adequate equipment and supplies for termination of pregnancy

**Standard 2:** Pertinent medical history must be obtained and documented

**Guidelines:**
1. Although abortion is safest when performed in the first trimester, health care providers should appreciate that late presentation is not necessarily the fault of the client/patient and access to safe services is critical to preventing her from using unsafe methods of termination.

**Standard 3:** Gestational age must be verified by history, clinically and if available by ultrasonography prior to termination of pregnancy

**Standard 4:** Patient comfort during the procedure must be considered and appropriate pain management provided

**Guidelines:**
1. Analgesics or other comfort measures should be offered

**Standard 5:** Appropriate dilatation of the cervix must be achieved.

**Standard 6:** All instruments entering the uterine cavity must be sterile

**Standard 7:** All patients must receive prophylactic antibiotics

**Standard 8:** Completion of the procedure must be verified and documented by the provider

**Guidelines:**
1. In most cases, completion should be verified on clinical grounds and though Not necessary if in doubt, ultrasound (if available) can be used for confirmation

**Standard 9:** Clinical protocols for post-operative care must be followed.

*Medical methods*
Standard 1: Either mifepristone and Misoprostol combined or Misoprostol alone can be used according to the local protocols. (see appendix 6) Women shall remain in the facility until expulsion of the pregnancy is complete.

Standard 2: Pertinent medical history must be obtained and documented.

Standard 3: Pregnancy must be confirmed and gestational age clinically assessed and documented.

Standard 4: The patient must be informed where indicated, about the need for follow-up contact to ensure that she is no longer pregnant and her abortion is complete.

Standard 5: The patient must be informed about the efficacy, side effects and risks with medications to be used.

Standard 6: Patient’s comfort level during the abortion procedure must be considered and appropriate pain management provided.

Standard 7: Patients must be advised that administration of prostaglandins may precipitate rapid onset of uterine contractions and expulsion.

Standard 8: Once regular contractions have been confirmed, patients must be monitored regularly until expulsion of products of conception.

Standard 9: Completion of abortion should be verified on clinical grounds and if available by ultrasound and must be documented.

Guidelines:
1. Expulsion of a live foetus is a possibility which fact must be discussed with patients.

Standard 10: A skilled medical personnel must be accessible for emergency care when need arises.

Guidelines:
1. Patients suspected of having post abortion complications must be evaluated by a trained clinician so that appropriate care can be determined.
2. The patient must be informed that should medical abortion fail; surgical method may have to be used.

Late second trimester terminations (Therapeutic)

Policy statement: Termination of pregnancy in late second trimester is sometimes necessary.
Standard 1: termination done in late second trimester should be done in obstetrics and gynaecology sections of hospital.

Standard 2: All facilities should have clear and evidence-based protocols for termination of pregnancy in the late second trimester.

Standard 3: Hospitalisation is required for all patients having termination of pregnancy in the late second trimester abortion

**Guidelines:**
1. Patient must be informed that should medical methods fail surgical methods such as Dilatation and Evacuation may be needed and with a possibility of hysterectomy.
2. Expulsion of a live foetus is a possibility which fact must be discussed with a patient.

Standard 4: Bereavement counselling should be offered to all women undergoing TOP in late second trimester

**Pain Management in Termination of Pregnancy**

**Policy statement:** Client satisfaction can be enhanced through minimizing pain and anxiety during pregnancy termination procedures.

Standard 1. All patients undergoing uterine evacuation should be provided pain management regardless of type of procedure used.

**Guidelines:**
1. Client centred care reduces anxiety and perception of pain
2. Pain management should include psychological support and non-pharmacological methods.
3. Pain management should include pharmacological methods in all cases.
4. All women undergoing MVA for induced abortion must be offered paracervical block (see Appendix 11)
5. Appropriate systemic analgesics need to be provided to all women before performing an MVA
6. Appropriate systemic analgesics should be provided to all women undergoing medical methods of induced abortion prior to the procedure.
7. Social support person may be needed to compliment pain management during the procedure to the extent that this does not breach a patient privacy and confidentiality.

Standard 2: Uterine Aspiration is safer when performed under local anaesthesia than when performed under general anaesthesia.

**Guidelines:**
General anaesthesia should be used only if indicated and this should be carefully documented. GA must be provided only in the presence of qualified anaesthesia personnel in the room to monitor the patient and provide anaesthesia care. GA is given only at facilities that are equipped to manage complications arising out of GA

**Standard 3:** When conscious sedation,⁴ deep sedation⁵ or general anaesthesia is used, monitoring of the patient’s level of consciousness and vital signs must be documented as per protocol.

**Use of Peri-Procedure Antibiotics**

**Standard 1:** Routine prophylactic use of antibiotics is recommended for all surgical abortion procedures.

*Guidelines:*
1. Where antibiotics are not available the procedure can still be performed. The risk of infection is low if strict aseptic techniques are observed
2. Facility based protocols will be used for the choice of specific antibiotics

**Immediate Post Procedural Care (For all surgical and late second trimester Terminations)**

**Policy statement:** Most serious abortion complications are detectable in the immediate post procedure period. Appropriate and accessible immediate and follow up care is essential to patient’s well-being.

**Standard 1:** Completion of the termination process must be verified and documented in accordance with local protocols

**Standard 2:** Until medically stable, all patients must be observed and clinically monitored during the recovery period by a health provider trained in post procedure care.

**Standard 3:** Prior to discharge the patient must be conscious and coherent, ambulatory with a stable blood pressure and pulse and well controlled pain and vaginal bleeding

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⁴ A minimal depressed level of consciousness that retains the patient’s ability to maintain a patent airway independently and continuously to be easily aroused and to respond appropriately to physical stimuli and verbal commands
⁵ A controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes including inability to maintain a patent airway independently and/or to respond purposively to physical stimulation or verbal commands. It can result from sedative and analgesic administration intended to produce only conscious sedation.
Standard 4: The patient must be given instructions outlining the danger signs and symptoms of post procedure complications.

Guidelines:
1. Discharge instructions must be explicit and well understood by the woman before she leaves
2. Discharge instructions should be provided in writing in the local language wherever possible
3. Instructions should include:
   a) Danger signs requiring immediate medical care
   b) What to do and where to go if complications arise
   c) Side effects to be expected
   d) Instructions for taking medication that have been prescribed
   e) After care including personal hygiene
4. A return visit may be mandatory or at the discretion of the woman and the provider depending on type of TOP provided and gestational age.

Standard 5: Before leaving the facility, all patients must be informed and counselled on existing contraceptive options and provided with their chosen method on site unless the method is contraindicated

Standard 6: All women needing other Reproductive health services must be appropriately referred and the action documented.

Guidelines:
1. All patients must be observed for at least an hour after the surgical procedure is completed if there are no complications.

Management of Complications of Procedure

Policy statement: Prompt recognition and optimal management of complications related to pregnancy termination, reduces morbidity and mortality.

Standard 1: Functioning equipment and appropriate medication must be available on site to handle medical emergencies.

Standard 2: Surgical evacuation of the uterus is recommended in cases of failed or incomplete abortion.

Standard 3: When there is excessive bleeding, the surgeon must first resuscitate and then institute measures to identify the cause and control it.

Standard 4: The patient must be referred to a higher level of care when the bleeding does not respond to therapeutic measures or when the patient is hemodynamically unstable or otherwise critically ill e.g. sepsis.
Standard 5: if perforation or rupture of the uterus is suspected patient must be stabilized and promptly referred to a higher level for appropriate management.

Standard 6: If infection sets in, prompt treatment with appropriate antibiotics is required. Clients with septicaemia must be referred for appropriate management.

Guidelines
1. Facility should have a specified area for emergency equipment to include oxygen, emergency medications and supplies
2. Emergency training and mock-drill protocols should be in place to ensure ongoing preparedness of staff in managing medical emergencies
Who Can Provide PAC

Policy Statement: quality PAC services reduce morbidity and mortality from complications of abortion when provided by trained and certified health care providers.

Standard 1: PAC should be provided by trained and certified health care providers.

Guidelines:
1. Providers include doctors, medical licentiate, clinical officers, Nurse Midwives and nurses.
2. All providers that have been certified should be able to provide emergency evacuation of the uterus size up to 12 to 14 weeks' gestation.
3. Training can be done pre-service or in-service centrally or using the On the Job Training (OJT) national curriculum.

Where Can PAC be Provided

Policy Statement: PAC is safe when provided by a trained provider in an environment with adequate hygiene and suitable equipment.

Standard 1: All institutions offering PAC services should be registered by appropriate regulatory authorities.

Guidelines:
1. PAC can be provided from health levels as low as the health post (depending on available skills and clients condition) up to tertiary level. (See appendix 5)

Standard 2: All institutions providing PAC should be guided by local protocols.

Standard 3: All procedure rooms providing PAC must have equipment and supplies to deal with medical emergencies (see appendix 5).

Guidelines:
1. Emergency preparedness should be available in all facilities providing PAC. All facilities should be able to stabilize, treat or refer patients with post abortion complications.
2. The equipment and supplies needed will, to some extent, depend on the type of services offered at the facility.

Standard 4: All institutions providing PAC must have strong referral linkages to the next level of care.
Guidelines:
1. Each institution providing PAC should be aware of the next level of care that can treat complicated cases of PAC.

Standard 5: Appropriate infrastructure, Equipment and supplies needed for treatment of serious complications should be available at the referral institutions.

Emergency Treatment

Pre-Procedural
Policy Statement: Prompt clinical assessment reduces morbidity and mortality associated with abortion related complications.

Standard 1. All patients with abortion related complications should have a rapid assessment for presence of life threatening conditions and managed accordingly.

Guidelines:
1. Assessment should include assessment of vital signs and indication of how clinically stable the patient is.

2. Any patient discovered with a life-threatening condition such as shock, ectopic pregnancy, sepsis or haemorrhage should have resuscitative measures instituted immediately.

Standard 2: A pertinent medical history must be obtained and documented together with physical examination and laboratory findings.

Guidelines:
1. Physical examination should include a pelvic examination noting any vaginal discharge, vaginal bleeding, uterine size and presence of retained products of conception (RPOCs). Signs of infection including fever, foul smelling discharge, and tender uterus should also be documented.

2. If infection is suspected, appropriate laboratory specimens should be taken but should not delay initiation of treatment.

3. Appropriate laboratory tests such as HB, blood grouping and cross matching and any other tests indicated by the medical condition of the patient should be done.

Standard 3: Time of arrival of patient and attendance must be documented.

Guidelines:
1. The time of arrival should be when she is getting registered at the facility (getting hospital card/file)
2. The time she is first attended to is the time when she is in contact with a health care provider who may be a nurse or clinician.

**Standard 4:** All patients should undergo counselling about the procedure, pain management, risks, benefits and alternatives. This must be tailored according to the urgency of the clinical condition

**Guidelines:**
1. Pre-procedure counselling should include
   a) Options of management either using MVA or Misoprostol for PAC (MPAC)
   b) Counselling about the proposed treatment plan
   c) Contraceptive counselling

2. Lifesaving procedures should not be delayed by counselling as this can be completed after the procedure.

**Standard 5:** An informed consent should be obtained from all patients undergoing a surgical procedure.

**Guidelines:**
1. In an emergency, consent maybe given by, next of kin or head of the health facility 2.
2. In an emergency, where consent cannot be obtained, health practitioners should provide medical treatment to anyone who needs it, provided the treatment is limited to what is immediately necessary to save life or avoid significant deterioration in the patient’s health.

**Standard 6:** Resuscitation, stabilisation and prompt referral of the patient is essential if necessary equipment and supplies for treatment is absent or infrastructure is inadequate or staff is not trained in management of the complication/s.

**Guidelines:**
1. Basic elements of resuscitation should include
   a) management of airways, breathing and circulation
   b) control of bleeding
   c) intravenous fluid replacement
   d) control of pain and infection

**Procedures**

*Surgical procedure*

**Standard 1:** The preferred method of uterine evacuation up to 12 weeks’ uterine size is MVA.
Guidelines:
1. Where MVA is not available, then the uterus may be evacuated by dilatation and or evacuation

Standard 2: For uteruses above 12 weeks’ evacuation should be completed by dilation and evacuation (usually by use of ovum forceps and MVA)

Standard 3: Patient comfort and pain management should be considered during the procedure.

Standard 4: All instruments entering the uterus must be sterile.

Guidelines:
1. Before re-use cannulae need to be sterilized or high level disinfected

2. MVA syringes must be sterilized or high level disinfected in between patients, but they do not need to be sterile at the time of use and can therefore be stored in a clean rather than a sterile environment.

Standard 5: Completion of the procedure must be verified and documented.

Standard 6: Routine prophylactic use of antibiotics is recommended for surgical abortion procedures.

Guidelines:
1. Where antibiotics are not available the procedure can still be performed. The risk of infection is low if strict aseptic infection prevention techniques are observed.

2. Facility based protocols will be used for the choice of specific antibiotics.

Medical method (Use of Misoprostol for Post Abortion Care - MPAC)

Standard 1: Misoprostol should be offered to all patients who qualify for medical management of incomplete abortion.

Guidelines:
1. To qualify, the patient must have uterine size less than 12 weeks and not having any contraindications to Misoprostol e.g. allergy.

Standard 2: The efficacy and side effects of Misoprostol must be explained to all patients.

Guideline:
1. Patients should be made aware that if Misoprostol fails then surgical evacuation is necessary.

Standard 3: All facilities should follow protocols on follow-up of patients with MPAC.
Management of other complications

Policy Statement: Prompt recognition coupled with optimal management of complications related to abortion, reduces morbidity and mortality.

Standard 1: Functioning equipment and appropriate medication with staff trained to use them appropriately must be available on site to handle medical emergencies.

Guidelines:
1. Facility should have emergency equipment to include oxygen, emergency medications and supplies.
2. Adequate trained staff available to manage other complications.
3. Emergency drill protocols should be in place to ensure ongoing preparedness of staff in managing emergencies.

Standard 2: Every facility should be able to stabilize and, or treat or refer a woman with any complication as quickly as possible.

Guidelines:
1. All patients should have IV access and facilities need to have crystalloids and plasma expanders at all times.

Haemorrhage

Policy Statement: Timely treatment of excessive blood loss is critical as delays in controlling blood loss and replacing fluid or blood volume can be fatal.

Standard 1: For any client presenting with haemorrhage, measures should be undertaken to identify the cause of the bleeding and control it.

Guidelines:
1. Blood loss can be assessed by measuring blood pressure, pulse rate and urine output.
2. The cause of haemorrhage should be established and managed accordingly. Haemorrhage can be caused by retained products of conception (RPOCs), trauma to the vagina or damage to the cervix or uterine perforation or uterine atony or bleeding disorders
3. Uterotonic agents should be administered if excessive bleeding is caused by atony.
Standard 2: All patients presenting with shock should be referred to a higher-level facility after stabilization.

Standard 3: All facilities must ensure that appropriate precautions are taken in screening and transfusion of blood.

Infection (Septic Abortion)

Policy Statement: Patients suspected with sepsis must be promptly treated with therapeutic doses of broad spectrum antibiotics.

Standard 1: All patients with symptoms of infection should be assessed for shock, causes and managed accordingly.

Guidelines:
1. Assessment of infection should include ruling out retained products of conception (RPOCS,) and perforation of uterus and/or injury to abdominal organs.
2. Patients with suspected perforation may need laparotomy.
3. Accurate diagnosis of septic shock may require insertion of a central venous line and appropriate referral.

Standard 2: Patient with septic shock should be referred to 1st level hospital or higher after stabilization.

Standard 3: Patients with post-abortal sepsis should have broad spectrum antibiotics intravenously.

Guideline:
1. Facilities should follow local protocols on which antibiotics to use.

Standard 4: All patients with sepsis due to RPOCs should receive broad spectrum IV antibiotics within 2 hours prior to evacuation with MVA.

Management of toxic and chemical reactions

Patients may occasionally present with poisoning secondary to substances used to procure an abortion.

Standard 1: In all cases of poisoning, measures should be undertaken to establish the causative substance and an antidote administered accordingly.

Standard 2: All patients with poisoning should be referred appropriately

Guidelines:
1. Patients may need ventilation support or specialist care (renal or any other organ failure) and so should be referred to institutions where these services are available.

2. Resuscitative measures and other supportive therapy should be instituted before referral.

**Post Abortion Contraception**

**Policy Statement:** Post abortion contraceptive counselling and provision after an abortion reduces and, or prevents repeat abortions and should be made available to all women

**Standard 1:** All women receiving PAC should be offered family planning counselling and services.

**Guidelines:**
1. Counselling should be profiled to the patient's needs and situation (*refer to the Zambia FP protocols and guidelines 2016*).

2. Counselling can be provided individually or in group basis bearing in mind individual needs of each patient and upholding the patient's privacy and confidentiality.

**Standard 2:** All facilities offering PAC should be able to provide a broad mix of contraceptives, according to the level of care and health care provider skills.

**Guidelines:**
1. Patients should be referred appropriately to the next level of care if chosen method is not available or if the health care provider has no skills to give patient the method.

2. Almost all methods can be given to women after an abortion per the eligibility criteria.

**Standard 3:** The health care provider must ensure documentation of the woman's informed choice of contraception.

**Guidelines:**
1. Whether the woman opts not to have any contraception or opts for a method, this should be documented.

2. If a method is chosen, information on the method and follow-up should be communicated to the patient to ensure correct and continued usage of the method.
Linkages to Other RH services

**Standard 1:** All women should be referred to other reproductive health services according to their needs.

**Guidelines:**
1. These services may include cervical cancer screening, STI including HIV screening. Women who have had a spontaneous abortion and desire to have a child should be referred to a specialist for assessment. Other services should include psychosocial counselling in cases of rape, defilement or incest.

**Follow up**

**Standard 1:** All women must have follow up instructions according to the protocols. This should include clear instructions on emergency follow-up.
Confirmation of Foetal tissue

Policy Statement: Identification of products of conception helps confirm diagnosis of intrauterine pregnancy and reduces and or prevents complications of abortion.

Standard 1: All evacuated uterine contents must be examined visually before the woman leaves the facility.

Guidelines:
1. When insufficient tissue or incomplete products of conception are obtained, the patient must be re-evaluated and re-evacuation should be considered.
2. The presence of ectopic pregnancy should be considered and ruled out if there are no products of conception.
3. Formal histopathology examination maybe required when there are copious amounts and grapelike products of conception to rule out Molar pregnancy. If confirmed it should be managed accordingly at appropriate levels.

Foetal Tissue Disposal

Policy Statement: Proper disposal of foetal tissue reduces spread of infectious disease and stigmatisation of abortion services. For this reason, procedures on disposal of tissue should be available.

Standards 1: Foetal tissue must be considered biohazard and be disposed in accordance with protocols.

Guidelines:
1. Universal precautions must be observed by all personnel handling foetal tissue

Standard 2: All foetuses born dead before or after 28 weeks should be notified and disposed of per the local regulations and wishes of the patient.

Guidelines:
1. Foetuses expelled before 28 weeks may be incinerated or buried if the patient so wishes.
2. Before incineration a consent form is signed by the patient or next of kin where appropriate.
3. In case of a foetus born alive in an unwanted pregnancy, efforts should be made to preserve its life with a view of facilitating appropriate social services.

**Emotional support for health care providers**

**Policy Statement:** Provision of emotional support to providers of abortion services enhances quality of care.

**Standard 1:** Facilities should draw up protocols to address emotional needs of staff providing abortion services.

**Guidelines:**
1. Regular meetings to share experiences and value clarification exercises should be held.
Policy Statement: Monitoring and evaluation ensures highest possible quality of care. A system should be created and implemented to audit, monitor and evaluate services in accordance with these standards and guidelines.

Monitoring and evaluating (M&E) can be achieved using three approaches; Routine service statistics, periodic evaluation (internal & external) and patient information. (see appendix 8) This can be done at all levels- facility, regional and national levels:

Routine service statistics involves:
1. Regular monitoring and evaluation (M/E) at the facility level are key to maintaining and improving the quality of services delivered.
2. Facility managers/staff supervisors are needed to provide supportive supervision in routine monitoring and give appropriate recommendations to improve quality of care. This can be achieved through:
3. Analysis of patterns or problems in services using service statistics
4. Proportion of women seeking repeat abortion.
5. Observation of counselling and clinical services to assess quality of interaction with the woman throughout the process, to correct any shortfalls in adherence to technical standards, or other practices that jeopardize quality of care (e.g. judgmental attitudes, imposition of "informal charges").
6. Functioning of logistics system to ensure regular supply of equipment and consumables.
7. Regular aggregation of data from facility level upwards.
8. Utilisation of aggregated data by the facility for service improvement.
9. Assessment of progress to remedy problems identified in routine monitoring.
10. Engaging staff in a participatory process to implement recommendations for service delivery improvement.
11. Clinical incident reviews and learning

Periodic evaluation:
1. Client based exit interviews, observations and questionnaires
2. Provider based surveys looking at, among others;
3. Skills and competencies of providers
4. Perception
5. Application of theory to practice
6. Supportive systems in the delivery of the health services
7. Facility level: case reviews, registers, observation, checklists, facility surveys and maternal death audits.

Patient information must include:
1. Total number of clients seen, their demographic information
2. A record of abortions provided, methods used, pain management provided
3. Women seen but not provided with services,
4. Women referred to higher levels of care,
5. Treatment of complications of abortion
6. Contraceptive methods accepted and initiated.
7. Feed-back mechanism for all referrals provided confidentiality is maintained at all levels

The facility Manager should ensure good supervision of services, including monitoring and evaluation of quality of care. Monitoring data should be used to make decisions about changes or improvements necessary in services, as well as to provide performance feedback to providers and staff.

Each facility should periodically review their own statistics with a view of improving their quality of care. Selected data should be sent routinely to higher levels to enable cross monitoring of facilities and geographic areas and be used at national level for policy formulation and planning. These data will be used to monitor costs to health facilities of providing legal abortion and of treating complications of unsafe abortion.

Evaluation should be based on core measurable indicators, and there should be some consequence for the findings, such as awards for high quality services

**Standard 1**: All abortion procedures must be documented.

*Guideline:*
1. Records should be accurate, complete and well organized while ensuring confidentiality.

**Standard 2**: All levels of care are encouraged to conduct regular audit of the care they provide and below are some examples of audits that can be performed.

*Organisation of services*
- Assess whether decision-to appointment intervals fall within acceptable guideline target
- Assess case notes of women undergoing abortion to determine percentage performed as day cases

*Information for women*
- Audit the extent to which they provide accurate and unbiased information regarding induced abortion especially with regard to potential sequelae using patient surveys.

*Pre-abortion management*
- Assess proportion of surgical abortion clients being given antibiotic prophylaxis.
- Assess proportion of patients having documented evidence of being screened for other medical conditions to ensure eligibility.
Abortion procedures

- Case note review could be conducted to see which prostaglandin/s is being used for abortion procedures and the protocol used.
- Percentage of women accepting local anaesthesia could be reviewed.
- Proportion of providers offering services who have been formally trained.

Post procedure care

- Assess percentage of women receiving information on danger signs post operatively.
- Audit number of women who end up with complications following elective termination.
- Proportion of terminations being reported.

Standard 3: All termination of pregnancy services must be reported as required by the law.

Guidelines:
1. Complete certificates A or B should be sent to the Permanent Secretary
2. Monitoring and evaluation of comprehensive abortion care services should be integrated in the existing HIMS.

Standard 4: All deaths resulting from abortions must be reviewed according to local nationally accepted maternal death review protocols. Lessons learned must be shared anonymously.

Standard 5: Managers must ensure inventory control and maintenance of equipment.

Guidelines:
1. In planning, inventory control and maintenance system; include:
   a) The quantity and types of equipment and supplies to be in stock
   b) Adequate storage facilities
   c) Monitor of stock levels
   d) Re-ordering of stock
   e) Security of stock
   f) Procedure for re-supply
   g) Routine maintenance and repair of equipment
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15. Nurses and Midwives Act no 31 of the laws of Zambia, GRZ 2007


23. The care of women requesting induced abortion, Evidence-based Clinical Guideline number, RCOG 2011


Appendices

Appendix 1: The Zambian TOP Act of 1972

CHAPTER 304
TERMINATION OF PREGNANCY

An Act to amend and clarify the law relating to termination of pregnancy by registered medical practitioners; and to provide for matters incidental thereto and connected therewith.

[13th October, 1972]

1. This Act may be cited as the Termination of Pregnancy Act. Short title

2. In this Act, unless the context otherwise requires- Interpretation

"hospital" means any institution run as such by the Government or any other institution approved in writing for the purposes of this Act by the Permanent Secretary, Ministry of Health;

"the law relating to abortion" means sections one hundred and fifty-one, Cap. 87 one hundred and fifty-two and one hundred and fifty-three of the Penal Code, and includes any written law or rule of law relating to the procurement of abortion;

"registered medical practitioner" means a medical practitioner registered as such under the provisions of the Medical and Allied Professions Act.

3. (1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if he and medical termination of pregnancy
two other registered medical practitioners, one of whom has specialised in the branch of medicine in which the patient is specifically required to be examined before a conclusion could be reached that the abortion should be recommended, are of the opinion, formed in good faith-

(a) that the continuance of the pregnancy would involve-

(i) risk to the life of the pregnant woman; or

(ii) risk of injury to the physical or mental health of the pregnant woman; or

(iii) risk of injury to the physical or mental health of any existing children of the pregnant woman;

greater than if the pregnancy were terminated; or

(b) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

(2) In determining whether the continuance of a pregnancy would involve such risk as is mentioned in paragraph (a) of subsection (1), account may be taken of the pregnant woman's actual or reasonably foreseeable environment or of her age.

(3) Except as provided by subsection (4), any treatment for the termination of pregnancy must be carried out in a hospital.

(4) Subsection (3) and so much of subsection (1) as relates to the opinion of two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of the opinion, formed in good faith, that the termination of pregnancy is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman.

4. (1) Subject to subsection (2), no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection:

Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.
(2) Nothing in subsection (1) shall affect any duty to participate in any treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.

(3) In any proceedings before a court, a statement on oath by any person to the effect that he has a conscientious objection to participating in any treatment authorised by this Act shall be sufficient evidence for the purpose of discharging the burden of proof imposed upon him by subsection (1).

5. (1) The Minister may, by statutory instrument, make regulations for the better carrying out of the provisions of this Act and, without prejudice to the generality of the foregoing, such regulations may make provision for-

(a) anything which is to be or which may be prescribed under this Act;

(b) requiring any such opinion as is referred to in section three to be certified by the registered medical practitioner concerned in such form and at such time as may be prescribed by the regulations;

(c) the preservation and disposal of certificates made pursuant to the regulations;

(d) requiring any registered medical practitioner who terminates a pregnancy to give notice of the termination of pregnancy and such other information relating to the termination of pregnancy as may be prescribed;

(e) prohibiting the disclosure, except to such persons or for such purposes as may be prescribed, of notices given or information furnished pursuant to the regulations.

(2) The information furnished in pursuance of regulations made by virtue of paragraph (d) of subsection (1) shall be notified solely to the Permanent Secretary, Ministry of Health.

(3) Any person who wilfully contravenes or wilfully fails to comply with the requirements of regulations made under subsection (1) shall be guilty of an offence and on conviction shall be liable to a fine not exceeding two thousand penalty units.

(As amended by Act No. 13 of 1994)
6. For the purpose of law relating to abortion, anything done with Supplementary intent to procure the miscarriage of a woman is unlawfully done unless provisions it is done in accordance with the provisions of this Act.

SUBSIDIARY LEGISLATION

TERMINATION OF PREGNANCY

SECTION 5-THE TERMINATION OF PREGNANCY REGULATIONS

Regulations by the Minister

Statutory Instrument 219 of 1972

1. These Regulations may be cited as the Termination of Pregnancy Regulations.

2. (1) Any opinion to which section three of the Act refers shall be certified in the appropriate form set out in the First Schedule. Certificate of opinion

(2) Any certificate of an opinion referred to in subsection (1) of section three of the Act shall be given before the commencement of the treatment for the termination of pregnancy to which it relates.

(3) Any certificate of an opinion referred to in subsection (1) of section three shall be given before the commencement of the treatment for the termination of pregnancy to which it relates or, if that is not reasonably practicable, not later than twenty-four hours after such termination.

(4) Any such certificate as is referred to in sub-regulations (2) and (3) shall be preserved by the practitioner who terminated the pregnancy to which it relates for a period of three years beginning with the date of such termination and may then be destroyed.

3. (1) Any registered medical practitioner who terminates a pregnancy anywhere in Zambia shall, within seven days of the termination, give notice to the Permanent Secretary, Ministry of Health, notice thereof and the other information relating to the termination in the form set out in the Second Schedule.

(2) Any such notice and information as is referred to in sub-regulation
(1) shall be sent in a sealed envelope marked "Confidential" to the Permanent Secretary, Ministry of Health, P.O. Box 30205, Lusaka.

4. A notice given or any information furnished to the Permanent Secretary, Ministry of Health, in pursuance of these Regulations shall not be disclosed except that disclosures may be made:

(a) for the purposes of carrying out his duties, to an officer of the Ministry of Health authorised by the Permanent Secretary, Ministry of Health; or

(b) for the purposes of carrying out his duties in relation to offences against the Act or the law relating to abortion, to the Director of Public Prosecutions or a member of his staff authorised by him; or

(c) for the purposes of investigating whether an offence has been committed against the Act or the law relating to abortion, to a police officer not below the rank of Assistant Superintendent or a person authorised by him; or

(d) for the purposes of criminal proceedings which have begun; or

(e) for the purposes of bona fide scientific research; or

(f) to the registered medical practitioner who terminated the pregnancy; or

(g) to a registered medical practitioner, with the consent in writing of the woman whose pregnancy was terminated.
FIRST SCHEDULE (Regulation 2)

IN CONFIDENCE CERTIFICATE A
(Not to be destroyed within three years of the date of operation)
THE TERMINATION OF PREGNANCY ACT

CERTIFICATE TO BE COMPLETED BEFORE A TERMINATION OF PREGNANCY IS PERFORMED UNDER SECTION 3 (1) OF THE ACT

I, ........................................................................................................................................... .
(name and qualifications of practitioner in block capitals)
of. .............................................................................................................................................. .
(full address of practitioner)
and I, ........................................................................................................................................... .
(name and qualifications of practitioner in block capitals)
of. .............................................................................................................................................. .
(full address of practitioner)
and I, ........................................................................................................................................... .
(name and qualifications of practitioner in block capitals)
of. .............................................................................................................................................. .
(full address of practitioner)
hereby certify that we are of the opinion, formed in good faith, that in the case of
(full name of pregnant woman in block capitals)
of. .............................................................................................................................................. .
(usual place of residence of pregnant woman in block capitals)
1. The continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated;
2. The continuance of the pregnancy would involve risk of injury to the physical or mental health of the pregnant woman greater than if the pregnancy were terminated;
3. The continuance of the pregnancy would involve risk of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman greater than if the pregnancy were terminated;
4. There is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped
[Ring appropriate number(s)] This certificate of opinion is given before the commencement of the treatment for the termination of pregnancy to which it refers.

SIGNED...........................................................................................................................................
DATE...............................................................................................................................................
SIGNED...........................................................................................................................................
DATE...............................................................................................................................................
SIGNED...........................................................................................................................................
DATE...............................................................................................................................................

59
IN CONFIDENCE CERTIFICATE B

(Not to be destroyed within three years of the date of operation)

THE TERMINATION OF PREGNANCY ACT

CERTIFICATE TO BE COMPLETED IN RELATION TO TERMINATION OF PREGNANCY IN EMERGENCY UNDER SECTION 3 (4) OF THE ACT

1, ........................................................................................................................................... .
(name and qualifications of practitioner in block capitals)

of. ......................................................................................................................................... .
(full address of practitioner)

Hereby certify that I *am/was of the opinion formed in good faith that it *is/was necessary immediately to terminate the pregnancy

of. ......................................................................................................................................... .
(full name of pregnant woman in block capitals)

of. ......................................................................................................................................... .
(usual place of residence of pregnant woman in block capitals)

in order
1. to save the life of the pregnant woman; or
2. to prevent grave permanent injury to the physical or mental health of the pregnant woman.
(Ring appropriate number)

This certificate of opinion is given
A. before the commencement of the treatment for the termination of the pregnancy to which it relates; or
B. not later than 24 hours after such termination.

SIGNED ....................................................................................................................................

DATE ....................................................................................................................................

*Delete as appropriate
Appendix 2: Chapter 87, The Penal Code (Amendment) Act of 2005

151. Any person who, with intent to procure the miscarriage of a woman or female child, 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 whatsoever, commits a felony and is liable, upon conviction, to imprisonment for a term not exceeding seven years.

Attempts to procure abortion
(As repealed and replaced by Act No. 15 of 2005)

152. (1) Every woman being pregnant who, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used, commits a felony and is liable, upon conviction, to imprisonment for a term of fourteen years.

(2) Any female child being pregnant who, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing or uses any force of any kind commits an offence and is liable to such community service or counseling as the court may determine, in the best interests of the child: Provided that where a female child is raped or defiled and becomes pregnant, the pregnancy may be terminated in accordance with the Termination of Pregnancy Act.
(As repealed and replaced by Act No. 15 of 2005)

Abortion by pregnant woman or female child Cap. 304

153. Any person who unlawfully supplies to or procures for any person anything whatsoever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman or female child, whether she is or is not with child, commits a felony and is liable, upon conviction, to imprisonment for a term not exceeding fourteen years.

Supplying drugs or instruments to procure abortion

(As repealed and replaced by Act No. 15 of 2005)
Appendix 3: Sample of consent form

Informed Consent form for legal abortion procedure

I, the undersigned, wish to undergo the procedure for safe termination of pregnancy, and understand the following:

1. I have received comprehensive counselling about all of my options regarding the current pregnancy.

2. Like many medical procedures, there are some risks and side effects, the details of which have been thoroughly explained to me.

3. I have applied for the procedure of my own free will without coercion or inducement.

4. All of the above information has been explained to me in a language I understand.

Client’s name (print)  Client’s signature/thumb print

Date

Name of provider  Signature of provider

_In loco parentis, as applicable:_

Name  Signature
Appendix 4: Instruments and Supplies for manual vacuum aspiration (MVA)

Basic Supplies
- Intravenous infusion set and fluids (sodium lactate, glucose, saline)
- Aspiration (syringes) (5, 10 and 20ml)
- Needles (22-gauge spinal for paracervical block; 21 gauge for drug administration)
- Sterile gloves (small, medium, large)
- Cotton swab or gauze sponges
- Water based antiseptic solution (not alcohol-based)
- Detergent or soap
- Clean water
- Chlorine or glutaraldehyde for disinfection/decontamination
- High level disinfection or sterilization agent.

Instruments and Equipment
- Vaginal speculum
- Tenaculum
- Sponge (ring) forceps or uterine packing forceps
- Pratt or Dennison dilators: sizes 13 to 27 French
- Container for antiseptic solution.
- Strainer (metal, glass, or gauze)
- Clear glass dish for tissue inspection.

Medications
- Analgesia medication (e.g. ibuprofen or pethidine)
- Anti-anxiety medication (e.g. diazepam)
- Anaesthetic- chloroprocaine (1-2%) or lidocaine (0.5-2%) without epinephrine.
- Oxytocin 10units or ergometrine 0.2mg.

MVA Instruments
- Vacuum aspirator
- Flexible cannulae of different sizes
- Adapters, if needed
- Silicone for lubricating syringes, if needed.
# Appendix 5: Abortion services & Equipment by level of care

<table>
<thead>
<tr>
<th>Level of care</th>
<th>Type of health personnel available</th>
<th>Abortion related services</th>
<th>Equipment /drugs</th>
</tr>
</thead>
</table>
| Community           | Community residents with basic health training  
• Traditional birth attendants (TBAs)  
• Community health workers (CHWs)  
• Community based distributors (CBDs)  
• Safe motherhood action groups (SMAGs) | • Recognize signs and symptoms of pregnancy  
• Recognize signs and symptoms of abortion and its complications  
• Provide RH education, including FP and the risks of unsafe abortion  
• Distribute appropriate contraceptives including emergency contraception  
• Inform communities and women on the legal provisions for safe abortion.  
• Timely referral of women to formal care for PAC or safe abortion | • Some contraceptives (OCP, Condoms, spermicide, EC etc.) as prescribed to be dispensed  
• Health education material  
• IEC  
• Referral/communication links |
| Health posts/stations | Frontline health workers  
• Nurses | The above activities plus;  
• Check vital signs  
• Provide pain medication  
• Diagnosis of stage of abortion and PAC (depending on training)  
• Initial resuscitation (depending on training)  
• Referral to next level | Depends on skill available  
Syphigmanometer, Stethoscopes, Thermometers  
Examination couch with light source  
Vaginal specula  
Protective clothing including Gloves  
IP Supplies  
Standard emergency kit  
Essential drugs  
Misoprostol  
Essential drugs  
Some Contraceptives  
Transport for referral  
MVA and Infection prevention supplies & equipment |
| Health centres      |  
• Doctors  
• Clinical officers  
• Midwives and nurses,  
**Supportive staff** | The above activities plus;  
• Counselling (FP, Options)  
• PAC  
• Vacuum aspiration up to 12 completed weeks | Sphygmanometer, Stethoscopes, Thermometers  
Examination couch with light source  
Vaginal specula  
Protective clothing including Gloves  
Infection Prevention Supplies |
<table>
<thead>
<tr>
<th>Level</th>
<th>Responsibilities</th>
</tr>
</thead>
</table>
| **laboratory technicians** | - Medical abortion up to nine completed weeks of pregnancy  
- Administer antibiotics and IV fluids  
- Resuscitation and initial treatment  
- Simple Laboratory tests like Hb  
- Orient and supervise community level workers  
- Refer as needed  
- Local anaesthesia  |
| **Environmental Health Technician** | - Standard emergency equipment and supplies for resuscitation  
- Essential drugs  
- Misoprostol  
- Essential drugs including oxytocin  
- Contraceptives including long term methods  
- Laboratory equipment & supplies  
- Oral and parenteral antibiotics  
- Radio communication (? telephone?)  
- Transport  
- MVA  
- Sterilisation equipment  
- Disinfectants Local anaesthesia  
- Sedatives  
- Analgesics  
- Needles and syringes  
- IV fluids and equipment |
| **District hospital** | - Same as above, plus GMOs, with or without an obstetrician-gynaecologist  
- The above activities plus;  
- Uterine evacuation for second trimester abortion  
- Induction of labour (IOL)  
- Treatment of most complications  
- Blood cross-matching and transfusion  
- Local and general anaesthesia  
- Laparotomy and indicated surgery  
- Diagnosis and referral for serious complication such as peritonitis and renal failure  
- Train all cadres of health professionals (pre- and in-service)  
- Refer as needed |
| **2nd level and** | - Same as above plus obstetrician-
- The above activities plus;  
- All those above plus |
| Referral hospitals | gynaecologists | • Treatment of severe complication (including bowel injury, tetanus, renal failure, gas gangrene, severe sepsis)  
• Therapeutic terminations  
• Treatment of Coagulopathy | ICU facility  
Neonatal ICU  
Specialized X ray equipment  
Sonographic equipment  
Minimally invasive surgical equipment and supplies  
Blood bank  
Cytotoxic |

**Approved Private facilities:**

| Lower clinics | • Staffed by nurses and Clinical officers | • Perform function described under health posts/stations |
| Medium clinics | • Staffed by a health officer or GMO and a team of other health workers | • Perform function described under health centres |
| Higher clinics/hospitals | • supported by a specialist and a team of other health workers with hospitalization facilities | • Perform function described under district Hospital |
| Higher hospitals | • Staffed by specialist (obstetricians/gynaecologists), and a team of other health workers | • Perform function described under 2\textsuperscript{nd} level and referral hospitals depending on status |
## APPENDIX 6 - Summary of Uterine Evacuation Methods: Medical and Surgical abortion

<table>
<thead>
<tr>
<th>Medical abortion</th>
<th>UP to 9 WEEKS (63 Days)</th>
<th>9–12 WEEKS (63–84 Days)</th>
<th>&gt;12 WEEKS (84days)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mifepristone and misoprostol</strong></td>
<td>- Mifepristone 200 mg, Oral, Single dose</td>
<td>- Mifepristone 800 μg, then 400 μg vaginal, then vaginal or sublingual OR - Misoprostol 800 μg, then 400 μg vaginal, then vaginal or sublingual - Every 3 hours up to 5 doses - Start 36–48 hours after taking mifepristone</td>
<td>- Misoprostol 800 μg, then 400 μg vaginal, then vaginal or sublingual OR - Misoprostol 400 μg, then 400μg oral, then vaginal or sublingual - Every 3 hours up to 5 doses - Start use 36–48 hours after taking mifepristone - Misoprostol 400 μg - Vaginal or sublingual - Every 3 hours up to 5 doses For pregnancies beyond 24 weeks, the dose of misoprostol should be reduced, owing to the greater sensitivity of the uterus to prostaglandins, but the lack of clinical studies precludes specific dosing recommendations.</td>
</tr>
<tr>
<td><strong>Misoprostol alone</strong></td>
<td>- Misoprostol 800 μg, Vaginal or sublingual, Every 3-12 hours up to 3 doses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Surgical Abortion</th>
<th>≤12–14weeks</th>
<th>&gt;12–14 Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vacuum aspiration</strong></td>
<td>Methods of vacuum aspiration include:</td>
<td>Dilatation and evacuation (D&amp;E)</td>
</tr>
<tr>
<td></td>
<td>- manual vacuum aspiration (MVA)</td>
<td>D&amp;E is the surgical method for abortion &gt;12–14 weeks of pregnancy.</td>
</tr>
<tr>
<td></td>
<td>- electric vacuum aspiration (EVA)</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from WHO (2014) Clinical Practice Handbook
**Appendix 7: Post-abortion contraception**


Based on Medical Eligibility criteria for Contraceptives, 4th ed., Geneva, WHO 2009

Generally, almost all methods of contraception can be initiated immediately following a surgical or medical abortion. Immediate start of contraception after surgical abortion refers to the same day as the procedure, and for medical abortion refers to the day the first pill of a medical abortion regimen is taken. As with the initiation of any method of contraception, the woman’s medical eligibility for a method should be verified.

**Post-abortion medical eligibility recommendations for hormonal contraceptives, intrauterine devices and barrier contraceptive methods**

<table>
<thead>
<tr>
<th>POST-ABORTION CONDITION</th>
<th>FIRST TRIMESTER</th>
<th>SECOND TRIMESTER</th>
<th>IMMEDIATE POST-SEPTICABORTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>COC</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>POP</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>DMPA, NET-EN</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>LNG/ENG implants</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Copper-bearing IUD</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>LNG-releasing IUD</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Condom</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Spermicide</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

COC, combined oral contraceptive; DMPA/NET-EN, progestogen-only injectables; LNG, levonorgestrel; POP, progestogen-only pill.

**Definition of categories**

1: a condition for which there is no restriction for the use of the contraceptive method.

2: a condition where the advantages of using the method generally outweigh the theoretical or proven risks.

3: a condition where the theoretical or proven risks usually outweigh the advantages of using the method.

4: a condition that represents an unacceptable health risk if the contraceptive method is used.
Appendix 8. Suggested data sources and indicators for monitoring and evaluating abortion services

Routine service statistics
- Number of abortions provided, by completed week of pregnancy and by type of procedure.
- Time between first consultation and abortion.
- Number of women referred elsewhere, by reason.
- Number of women seen but not provided with services, by reason.
- Number of women treated for complications, by type of abortion procedure.
- Contraceptive provided, by type.
- Referrals for contraceptive.

Periodic Evaluation.
- Percentage of service delivery points offering abortion care and their distribution by geographic and level of the health care system, and patterns of utilization.
- Number of providers performing abortion and their distribution by geographical area and level of health system.
- Number of health workers trained, by type; assessment of quality of training.
- Costs of abortion services and of treating the complications of abortion, by type of procedure and type of provider and any fees charged.
- Periodic special studies (client satisfaction, proximity of women to facilities, costs, impact, etc)
- Number of staff needing in-service training and numbers trained.

Patient Information (kept in patient file)
- Age, parity, marital status.
- Reason(s) for referral
- Reason(s) for refusal
- Follow-up care given
- Contraceptive methods chosen
- Fee charged, if any
Appendix 9. UNIVERSAL PRECAUTIONS and Instrument Processing

Health care workers involved in providing abortion services should follow these universal precaution measures to prevent the transmission of infections from providers to patient, from patient to providers, and to the community.

- Wash hands thoroughly with soap and water immediately before and after contact with each patient.
- Use high level disinfected or sterile gloves, replacing them between patients and procedures.
- Never use gloved hands to open and close doors or to process instruments.
- Wear clean gowns, apron, goggles and masks.
- Clean floors, beds, toilets, walls and rubber draw sheets with detergents and hot water. If they are soaked with blood or body fluid, use a 0.5% chlorine solution.
- Wear heavy duty gloves when cleaning surfaces and washing bed sheets spilled with blood and body fluids and when processing equipment for reuse.
- Dispose of waste contaminated with blood, body fluids, laboratory specimens or body tissues safely, following facility protocols.
- Avoid recapping needles whenever possible. If necessary, use the scoop method.
- Dispose of sharps in puncture-resistant containers and bury or incinerate them.
- All reusable instruments should be soaked in 0.5% chlorine solution and cleaned with soap and water immediately after use and sterilize or high level disinfect.
Appendix 10: Monitoring tool

<table>
<thead>
<tr>
<th>Province</th>
<th>District</th>
<th>Facility Name</th>
<th>Number of women who received abortion care</th>
<th>Safe abortion</th>
<th>Post abortion Care</th>
<th>Possibly unsafe/illegal</th>
<th>spontaneous</th>
<th>Third trimester termination</th>
<th>Total</th>
</tr>
</thead>
</table>

**Age of women**

- < 18 years
- 18 - 30
- > 30 years

**Occupation**

- Student
- Unemployed
- Informal employment
- Formally employed

**Marital status**

- Married
- Single
- Divorced
- Widow

**Completed gestation weeks**

- Less than 9 weeks
- 9 - 12 weeks
- Greater than 12 weeks
- Greater than 28 weeks

**Type of procedure**

- Vacuum Aspiration
- D & C
- Medical methods
- Other (specify)

**Women who received a contraceptive**

**Type of contraceptive**

- COC
- POP
- IUD
- Implants
- BTL/vasectomy
- Condoms

**Women with major complications**

- Bleeding
- Perforation
- Infection
- Other specify

**Women who died from procedure complications**

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Appendix 11. PARACERVICAL BLOCK TECHNIQUE

1. Prepare lidocaine syringe.
   - Use 20mL of 1% lidocaine OR 10mL of 2% lidocaine.
   - Do not exceed the lidocaine maximum dose of 4.5mg/kg or 200mg total.

2. Attach needle to the syringe.
   - A needle 3cm in length is recommended to facilitate deep injection.

3. Place the speculum and perform cervical antiseptic prep.

4. Inject small amount of lidocaine superficially into the anterior lip of the cervix at the
   site where the tenaculum will be placed (12 o'clock).
   - Inject 2mL if using 20mL of 1% lidocaine.
   - Inject 1mL if using 10mL of 2% lidocaine.

5. Grasp cervix with the tenaculum at 12 o'clock.

6. Inject remaining lidocaine in equal amounts at the cervicovaginal junction, at 2, 4, 8
   and 10 o'clock.
   - Injections should be 3cm (1in) deep.
   - Aspirate before injecting to prevent intravascular injection.

PRACTICE TIPS

- Deep injection of lidocaine (3cm or 1in) provides more effective pain relief than
  superficial (1.5cm) injection

- Possible side effects seen with intravascular injection include peri-oral tingling,
  tinnitus, metallic taste, dizziness, or irregular/slow pulse.

- Midlevel providers trained to provide paracervical block demonstrate similar safety
  and efficacy rates as physicians.

- Serious adverse events related to paracervical block are rare

Adapted from Ipas Clinical Updates in reproductive Health, CURH, 2017