

COMPREHENSIVE ABORTION CARE (CAC)



INTEGRATED REFERENCE MANUAL
THIRD EDITION (2015)

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FOREWORD

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High maternal mortality has continued to be a public health concern for many developing countries including Nepal. The Government of Nepal (GoN) is committed to achieving the Millennium Development Goal of reducing Maternal Mortality Ratio (MMR) to 134 per 100000 live births by the end of 2015. As a result of various interventions by MoHP, Nepal has been able to successfully reduce MMR to 170 per 100000 live births in 2012. A recent study (Hendersen et al, 2013) assessing the changes in Nepal pre- and post- abortion legalization demonstrated that this policy change has contributed to a reduction in the national MMR. Expansion of safe abortion service was also highlighted as a major contributing factor for the declining trend in severe abortion complications. However, complications due to unsafe abortion still remain the third leading cause of maternal death (Pradhan et al, 2010). Improving access to safe abortion service while decreasing unsafe abortion is one of the major goals of reproductive health services in its effort to reduce maternal mortality and morbidity.

Following abortion legalization in 2002 by GoN, MoHP approved Nepal's safe abortion policy, and set norms and standards to implement the abortion law in the country in 2004. Comprehensive abortion care (CAC) services were first initiated at Paropakar Maternity and Women Hospital from March 2004. By 2006 safe abortion service with manual vacuum aspiration (MVA), a surgical method, was implemented in all district level hospitals and a CAC training manual was developed to train providers. Later on, medical abortion (MA) service was also implemented. The subsequent need for the integration of both MVA and MA training led to the drafting of the second edition of the training manual in 2011.

The 2012 update of the WHO manual (2003) "Safe Abortion Technical Guideline" prompted the Family Health Division and National Health Training Center to revise the CAC training manual a third time in order to WHO's new updates. This manual has undergone extensive review and

revision with CAC trainers, providers and other relevant experts. All first trimester providers will provide services as outlined in this protocol and will be certified only after they have demonstrated the required competencies during the training.

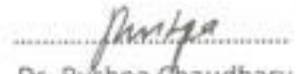
This manual would not have come to fruition without the expertise and commitment of the organizing and coordinating team of the Family Health Division and National health training center. We would like to express our sincere gratitude to all trainers and providers for providing valuable experiences and feedback in order to develop this manual. Similarly, we appreciate the effort taken by the Ipas team to facilitate the manual revision process, incorporating international standards adapted to our country context, and to provide technical and financial support required for the revision process and the printing of the manual.

We are hopeful that this manual will serve as guidance for reducing complications due to unsafe abortion and thus will contribute to the reduction of MMR in Nepal through the expansion of quality abortion services.



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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
BP	Blood Pressure
CAC	Comprehensive Abortion Care
COC	Combined Oral Contraceptives
COPE	Client Oriented Provider Efficiency
D and E	Dilatation and Evacuation
DMPA	Depo Medroxy Progesterone Acetate (Depo Provera)
EC	Emergency Contraception
EVA	Electric Vacuum Aspiration
FIGO	International Federation of Gynaecology and Obstetrics
FHD	Family Health Division
GoN	Government of Nepal
HLD	High Level Disinfection
HMIS	Health Management Information System
Hb	Hemoglobin
HBV	Hepatitis B Virus
Hct	Hematocrit
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IUCD	Intrauterine Contraceptive Device
IM	Intramuscular
IV	Intravenous
LARC	Long Acting Reversible Contraceptives
LMP	Last Menstrual Period
LSCS	Lower Segment Cesarean Section
MA	Medical Abortion
MoHP	Ministry of Health and Population
MVA	Manual Vacuum Aspiration
NSAIDs	Non-steroidal Anti-inflammatory Drugs
NSV	Non-scalpel Vasectomy
PAC	Post-abortion Care
PID	Pelvic Inflammatory Disease
POC	Products of Conception
QoC	Quality of Care
Rh	Rhesus
RTI	Reproductive Tract Infection
SAE	Severe Adverse Event
STIs	Sexually Transmitted Infections
USG	Ultrasonography
WHO	World Health Organization

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INTRODUCTION

Purpose

This Comprehensive Abortion Care (CAC) Reference Manual has been developed to provide participants the protocols and core contents required to learn CAC knowledge and skill to a specified standard of care.

CAC Training Goals

- To create positive attitudes among health workers regarding the provision of CAC services.
- To develop competence and confidence to provide high-quality, woman-centered CAC, which includes post abortion care

Learner Objectives

By the end of this training course, participants should be able to:

- Explain Nepali abortion law, procedural process, and policy.
- Describe the three key elements of CAC.
- Describe a woman's rights in an abortion-care setting.
- Perform a clinical assessment for abortion care.
- Provide abortion counseling and offer choice regarding manual vacuum aspiration (MVA) and medical abortion (MA) counseling and obtain informed consent.
- Offer post abortion family planning counseling and contraceptive services.
- Provide CAC to young women.
- Use and process properly the Ipas MVA Plus[®] aspirator and Ipas EasyGrip[®] cannulae.
- Develop an individualized pain management plan.
- Perform uterine evacuation using MVA.
- Describe the mechanism, regimens, route, and possible side effects of MA drugs.
- Identify steps to diagnose and manage complications during and after abortion.

- Provide post-procedure care and follow-up care after MVA and MA.
- Describe the steps for establishing an abortion care services monitoring system.
- Design an action plan to establish a CAC center in their setting.

MODULE 1:

INTRODUCTION TO COMPREHENSIVE ABORTION CARE

Key Topics:

1. Legal conditions for abortion care in Nepal.
2. How to provide woman-centered abortion care according to safe abortion policy in Nepal.
3. Women's reproductive rights.
4. Provider values and attitudes.
5. Recommended methods of first-trimester uterine evacuation.

1. Introduction: Abortion in Nepal

Background

Each year an estimated 46 million pregnancies end in induced abortion globally, nearly 22 million of these are estimated to be unsafe and nearly all unsafe abortions (98%) occur in developing countries. Deaths due to unsafe abortion remain close to 13% of all maternal deaths. Approximately 47,000 pregnancy-related deaths are due to complications of unsafe abortion (WHO 2012).

Before the legalization of abortion in 2002 in Nepal, women's health suffered because abortion was considered a crime. Women were imprisoned for up to five years for having an abortion. Abortion also went against social and cultural norms in Nepal, as well as religious beliefs. At that time, more than 50% of the hospital deaths were due to unsafe abortion. Similarly, 117 out of 1,000 women receiving unsafe abortion died from the abortion complication. A Maternal Mortality and Morbidity Study conducted in 1998 indicated that 54 % of the obstetrics and gynecology admissions in hospital were due to abortion complication. Another study conducted in 1997 revealed that 20% of the women detainees in prison were held due to charges of abortions or infanticides. To address these acute women health and right problem abortion was legalized under certain conditions in 2002.

Yet despite significant reduction of maternal deaths from 539/100,000 live births in 1996 to 281/100,000 live births in 2006 and 170/100,000 live births in 2010, maternal mortality remains unacceptably high in Nepal. The Nepal Maternal Mortality and Morbidity Study 2006/2007

indicates that 7% of the maternal deaths are due to complication of unsafe abortion, which remains the third leading cause of maternal death in Nepal.

Over a decade long multi-sectorial efforts, the liberalization of Nepal's abortion policy has benefited women's health, and likely contributes to falling maternal mortality in the country. In the 10-year post-legalization period, a greater number of women likely to obtain safe abortion and seek hospital care for complications, and a significant decline in serious abortion complication, have been observed. This decline suggests that liberalized safe abortion policy has contributed to reduce maternal mortality in Nepal.

Abortion Law of Nepal

His Majesty's Government amended the Nepal Criminal Civil Code (Muluki Ain) on 1st Chaitra 2058 (16th March 2002); Royal Assent was given to this amendment on 10th Asoj 2059 (27th September 2002). The Procedural Process for the Safe Abortion was approved by the cabinet on 10th Poush 2060 (25th December 2003) for the implementation of the Safe Abortion Law. The new law legalizes abortion under the following conditions:

- Up to 12 weeks of gestation with the request of the pregnant woman. The woman should give her consent and does not need to state the reason for which she is seeking abortion.
- Up to 18 weeks of gestation in case of rape or incest with the request and consent of the pregnant woman.
- At any gestation, if the pregnancy can cause harmful effect to the pregnant woman's physical or mental health or if the fetus is suffering from a severely debilitating or fatal deformity or disease, or intrauterine fetal death as certified by an expert physician.
- Only the pregnant woman holds the right to choose to continue or discontinue the pregnancy. If the pregnant woman is a minor (less than 16 years of age) or not in a position to give consent (mentally incompetent), the nearest guardian or relative can give consent for abortion services.
- The law prohibits termination of pregnancy of any gestation for the sole purpose of sex selection.

2. Woman-Centered, Comprehensive Abortion Care Services

What is Comprehensive Abortion Care (CAC) and why CAC services are needed?

Comprehensive abortion care (CAC) is an approach to providing abortion services that address the various aspects of the woman's health needs (both physical and emotional) and her personal circumstances along with her ability to access the services. The care should be affordable, acceptable and accessible to the woman and it should be linked with other reproductive health services, like contraceptive counseling and provision, and screening, prevention and treatment of sexually transmitted infections and reproductive tract infections. Appropriate referrals and linkage with other services should be an integral part of the abortion service center.

Though young women's need for safe abortion has long been recognized, this age group faces many difficulties in accessing any type of abortion while the consequences of failing to do so are typically more serious than for older woman. Service providers should be sensitive to the needs of this special group, and their other reproductive health needs need to be addressed together with abortion services.

Woman-Centered Abortion Care

Key elements to woman-centered abortion care include a range of medical and health related services that support women in exercising their sexual and reproductive rights. The three key elements of a woman-centered model for abortion care include:

1. Choice
2. Access
3. Quality

The services should be:

- Available, affordable, and timely
- Tailored to the medical and personal needs of the woman
- Safe and with confidentiality ensured
- Respectful of the right to information, privacy, and a range of choice
- Provided regardless of marital status, age, or other background factors

Choice

Choice means the right and opportunity to select between options. With regard to sexual and reproductive rights, it means that the woman herself should be able to choose and make her own decisions about her body and her health. The opportunity to choose, however, depends on various broad factors, including the policy environment, a well-functioning health system, social and cultural beliefs and practices, and economic resources.

With regard to pregnancy and abortion, choice means a woman's right to determine if and when to become pregnant; to continue or terminate a pregnancy; and to select among available abortion procedures, contraceptives, providers and facilities. She has the right to complete and accurate information about the procedures available, service providers and facility, personalized pain management, and referral facilities.

Many women needing abortion care are in vulnerable situations and may be at the mercy of family members or others who coerce them into having an abortion or continuing a pregnancy. In some settings, health providers may agree to provide an abortion only in exchange for high fees or insist that the woman use a particular contraceptive method, including sterilization. Such constrained or restricted choices compromise the concept of choice. These types of exploitive, coercive situations violate a woman's human rights and may place her health and well-being at risk. A woman-centered abortion care center addresses these issues and gives the woman appropriate choices.

Access

A woman's access to services is determined in part by the availability of trained and technically competent providers who:

- Use appropriate clinical technologies.
- Are easily reached—preferably in local communities.
- Have as many service-delivery points as possible.

A woman's access is hampered if the time and distance required to reach a designated health facility are excessive. To improve access to services, health systems can focus resources on training both public and private providers at the local level. Links between the public and private sectors can also offer a supportive network for providers.

A woman has better access when:

- Services are affordable and delivered in a timely manner without undue logistical and administrative obstacles.
- Emergency services are always available regardless of the woman's ability to pay.
- A woman is not denied services based on her economic or marital status, age, educational or social background, religious or political views, race or ethnic group, or sexual preference.
- Providers display respectful, caring, empathetic attitudes.

Access is also determined by cultural factors. In many societies, women have less access to education, health and social services than do men, which can lead to health-related disparities. Women are often dependent on others to provide financially for their health-care and other needs. For example, a woman who has little control over family resources may experience difficulty finding transportation to a health-care facility and paying for her visit.

Even in contexts where it is legal, abortion is often subject to legal or regulatory restrictions that may limit access. Health systems often interpret laws very narrowly, and providers or health systems may place tighter restrictions on abortion than are legally required or medically necessary in an overly cautious effort to protect themselves. In addition to narrow interpretation of the law, there are several restrictions that may affect a woman's access to abortion. These restrictions can be found in laws, regulations, policies, and practices. A few of these restrictions are:

- Lack of access to information on safe abortion
- Mandatory waiting periods
- Regulatory barriers to access to medicines
- Requirements that a woman report a rape to police or obtain a prosecution in order to access legal abortion
- Providers' conscientious refusal to provide abortion care
- Only permitting physicians and not midlevel providers to perform abortion, leading to provider shortages
- Requiring two or more physicians to certify the indication for abortion

These types of restrictions can be eliminated in part through the development and dissemination of national clinical standards and guidelines that help ensure service delivery to the full extent of the law.

Another common barrier to safe abortion and postabortion services is the use of outdated technology, specifically sharp curettage. This is problematic for two reasons:

- It denies women the benefits of safer and less painful methods.
- It increases the cost and complexity of services.

WHO recommends that health systems shift from using sharp curettage to MVA or medical methods for post-abortion care (PAC) and induced abortion services. To ensure availability and use of recommended technologies, health-care providers can:

- Commit to frequently updating their skills and encourage their colleagues to do the same.
- Train others to use newer technologies.

Community and service-provider linkages are key factors in preventing unwanted pregnancies and unsafe abortion, and increasing access to safe abortion services. These links can mobilize resources to help women receive appropriate and timely care for induced abortion or complications from abortion and can ensure that health services reflect and meet community expectations and needs—all factors that contribute to sustainability.

Moreover, medical abortion (MA) has the potential to improve access to safe abortion and may be particularly beneficial in settings where uterine evacuation services are limited or not available. MA offers the following advantages in low-resource settings or in communities where access to safe abortion is restricted:

- MA is simple, easy to manage, and drugs used do not require refrigeration. It may be more easily accessed than EVA/MVA and may require less equipment, facilities, and staffing.
- Every clinician has the ability to provide information on MA to women even if they cannot dispense the drugs directly.
- Midlevel providers can be trained to provide MA.
- In settings where aspiration is the main method of uterine evacuation, MA provides an especially desirable alternative, eliminating the potential need for general anesthesia and a hospital stay.
- MA may be the safer, cheaper and perhaps only abortion option available in some clinical situations such as:
 - When a woman has uterine anomalies
 - When a woman cannot tolerate the procedure in the absence of anesthesia
 - MA may be cost-effective when compared with other methods. However, costs vary depending on the price of medications, number of clinic visits and specific clinical protocols.
 - Whenever MA is provided, linkage with back-up MVA services should be available.

Quality

A quality-of-care (QoC) framework for abortion gives a structure for the interaction between a woman having choices about abortion and having access to services, and those services being of specified standards. However, tailoring each woman's care to her social circumstances and individual needs as well as providing accurate, appropriate information and counseling that supports women in making fully informed choices are fundamental aspects of high-quality care.

High-quality care includes using internationally recommended medical technologies, particularly MVA and medical abortion, as well as appropriate clinical standards and protocols for infection prevention, pain management, management of complications, and other clinical components of care. Management and referral for complications of procedures and linkages to abortion care service facilities with surgical backup are critical components of the QoC framework, as well as competent post-procedure abortion recovery care. A hallmark of high-quality care is services that ensure confidentiality, privacy, respect and positive interactions between women and staff of the health facility.

The QoC framework must include wherever possible post-abortion contraceptive services, including emergency contraception, to help women prevent unwanted pregnancies, practice birth spacing, and avoid repeat abortions. Moreover, it should refer women to or provide reproductive and other health services, such as the screening, diagnosis and treatment of sexually transmitted infections (STIs); counseling on sexual violence; and/or special services for adolescents and young women. Finally, high-quality care must include the availability of information, education and communication (IEC) materials, giving easy to understand information on prevention of unsafe abortion and availability of safe abortion care services that are accessible and as comprehensive in choice whenever possible.

No woman should risk her life in order to exercise her reproductive choices. Woman-centered abortion care includes:

- Safe, affordable and timely services that are tailored to women's medical and personal needs
- Respectful and confidential care
- Ensured access to comprehensive information, privacy and a range of choices

3. Reproductive Rights

"Reproductive health is 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 system and to its functions and processes. Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human-rights documents."

This comprehensive definition of reproductive health and rights was agreed upon at the 1994 UN International Conference on Population and Development (ICPD). It provides a framework for legitimizing and protecting women's reproductive rights.

Upholding Women's Rights in an Abortion Care Setting

The International Planned Parenthood Federation (IPPF) has produced a formal statement declaring sexual and reproductive rights to be essential components of human rights. The 12 principles are as follows:

1. **The Right to Life.** No woman's life should be put at risk by reason of pregnancy.
2. **The Right to Liberty and Security of the Person.** No woman should be forced into pregnancy, sterilization or abortion.
3. **The Right to Equality and to Be Free from All Forms of Discrimination.** This extends to women's sexual and reproductive lives.
4. **The Right to Privacy.** All sexual and reproductive health-care services should be confidential. All women have the right to make independent reproductive choices.
5. **The Right to Freedom of Thought.** This includes freedom from the restrictive interpretation of religious beliefs and customs as tools to curtail freedom of thought on sexual- and reproductive-health care.
6. **The Right to Information and Education.** This includes information and education about sexual and reproductive health, access to full information, and free and informed consent.
7. **The Right to Choose Whether or Not to Marry and to Found and Plan a Family.**
8. **The Right to Decide Whether or When to Have Children.**
9. **The Right to Health Care and Health Protection.** This includes the right to the highest possible quality of care and freedom from traditional practices that are harmful to health.
10. **The Right to the Benefits of Scientific Progress.** This includes the right to new reproductive-health technologies that are safe, effective and acceptable.
11. **The Right to Freedom of Assembly and Political Participation.** This includes the right of all persons to seek to influence communities and governments to prioritize sexual and reproductive health and rights.
12. **The Right to Be Free From Torture and Ill-Treatment.** This includes the right to protection from violence, sexual exploitation, and abuse.

(Adapted from International Planned Parenthood Federation, 1996)

Conscientious Refusal of Care

Most countries permit abortion to save a woman's life, and women are legally entitled to care under those circumstances. Some health-care professionals refuse to provide induced abortion

based on personal objections. This is a barrier to access. Only health-care providers authorized to perform abortion have the right to decline to provide the procedure based on moral or religious reasons (as long as a woman's life is not in danger); however, they are ethically bound and should be legally required to ensure that women can access safe services at a nearby facility within a reasonable time period. Health care workers who are indirectly involved cannot refuse to perform their tasks by claiming conscientious objection. Furthermore, administrators of public-health facilities cannot invoke conscientious objection.

To ensure that refusal to provide services based on religious and moral reasons does not restrict women's access to care, health-care managers and providers can:

- Ensure that their facilities are offering abortion services based on standards and guidelines
- Affirm conscience-based provision of safe abortion care in their facilities
- Require that providers who refuse to provide service refer the client to another willing provider according to their facility's abortion protocols
- Create a list of providers who do or do not perform abortion
- Furnish a list of referral providers and facilities to providers who refuse to offer abortion care
- Create a protocol that stipulates sanctions to be taken against providers who refuse to provide referrals or to treat women whose lives are in danger

Providers are obligated to provide life-saving post abortion care to women who need treatment for abortion-related complications, and therefore cannot conscientiously refuse to offer these services.

4. Values, Attitudes, Empathy, and Respect

Health-care workers must separate their personal beliefs from their professional practices and treat all women equally, regardless of age or marital status. Health-care workers need to treat their clients with empathy, the ability to understand another person's feelings and point of view and to communicate this understanding.

Health-care workers' attitudes toward women have a strong influence. Positive encounters with empathetic, respectful health-care workers heighten women's satisfaction with their care, increase their adherence to medical-care instructions and make them more likely to trust health-care workers and seek appropriate medical care in the future. Positive encounters also are a foundation for good relationships between providers and the community they serve, which can create a supportive environment for their work.

- Comprehensive abortion-care service providers should strive to:
- Identify their values and attitudes regarding sexuality and reproductive-health, and be aware that their values about young women's sexuality may require special attention
- Separate their values from those of their clients

- Recognize how their attitudes can negatively or positively affect client interactions and quality of care
- Ensure that they are able to provide compassionate and empathetic care

Clinic managers can help establish and maintain an environment of sensitivity and respect for women's needs through training, supportive supervision, feedback from coworkers, and anonymous evaluations. For more information on effective communication, privacy and confidentiality, and informed consent. (See Module 3: *Counseling, Information, and Informed Consent*).

5. Uterine Evacuation Methods

Uterine evacuation is the removal of the contents of the uterus, also known as the products of conception (POC). The two recommended methods for accomplishing uterine evacuation in the first trimester are EVA/MVA and medications (pharmacological agents). Within these categories there are various techniques and agents that can be used, depending on the training and skills of the staff and the equipment and medical agents available. The woman's individual clinical situation, uterine size, length of pregnancy and personal preferences are also key factors in determining which method is most appropriate. Young women may use the same methods of uterine evacuation as adult women. Adolescent women seeking MA have similar or lower rates of adverse outcomes to adult women.

EVA/MVA is commonly referred to as a surgical method of uterine evacuation, but is increasingly referred to as an aspiration method. Methods of abortion that involve the administration of medications (pharmacological agents) are often referred to as medical methods. Those medications interfere with the continuation of pregnancy and cause uterine contractions, which expel the POC.

The World Health Organization (WHO) recommends EVA/MVA and MA over sharp curettage for uterine evacuation in the first trimester.

Manual Vacuum Aspiration (MVA)

WHO, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the World Bank, International Federation of Gynaecology and Obstetrics (FIGO), and the International Confederation of Midwives (ICM) all endorse MVA as an essential technology for uterine evacuation. MVA is considered an essential service by many national and international authorities. WHO and FIGO issued a joint statement in 1997

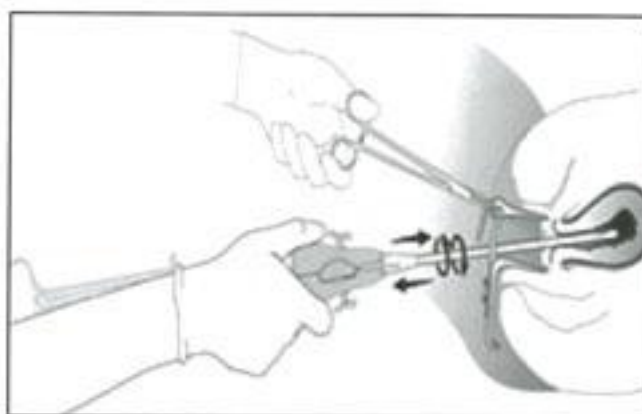


Figure: MVA Method

declaring: "Properly equipped hospitals should...adopt the aspiration method [of uterine

evacuation], selecting manual vacuum and/or electric vacuum according to the expertise available”.

MVA is safe and effective, can be performed by trained midlevel providers and, because it does not require electricity, can be used in decentralized, rural settings with intermittent electrical supplies. MVA services can be provided in a clinic setting on an ambulatory, outpatient basis, requiring fewer facility resources and reducing cost of care. Particularly in settings where instruments can be reused, the cost per procedure can be relatively low. Reduced waiting times and increased local availability of care also make this an acceptable method for many women. MVA creates little noise during the procedure, which some women find preferable. (See Module 6, Section 3: *Uterine Evacuation with Ipas MVA Plus** for more detailed information on MVA).

Description:



Figure: The Combi-pack of the MA drugs

MVA is a method by which the contents of the uterus are evacuated through a plastic or metal cannula that is attached to a vacuum source. The primary difference between electric vacuum aspiration (EVA) and MVA is the source of the vacuum. MVA uses a hand-held, portable aspirator, whereas EVA employs an electric pump. Although these sources provide equivalent suction at the initiation

of the procedure, the level of vacuum provided by the MVA aspirator decreases as the cylinder fills with blood and tissue. An electric pump provides a continuous and constant level of suction.

In an MVA procedure, a hand-held plastic 60 cc aspirator providing a vacuum source is attached to a cannula and hand-activated to suction out the uterine contents. To perform the MVA procedure, a cannula of the appropriate size, depending on uterine size, is inserted through the cervix into the uterus. The cannula is attached to a vacuum-charged aspirator. Then the vacuum is released by depressing the buttons on the aspirator. The cannula is then gently and slowly rotated while it is moved back and forth within the uterus. The aspirator serves as the source of vacuum to pull the POC through the cannula into the cylinder. Depending on the uterine size and amount of POC, the procedure takes from three to 10 minutes to complete.

Clinical safety and effectiveness:

MVA is extremely effective and safe, and is successful in 98% to 100% of cases, for both abortion and treatment of incomplete abortion. The method results in few complications, especially when performed up to 13 weeks since the LMP. Specific safety benefits of MVA, compared to sharp curettage, include significantly reduced risk of infection and of major and minor complications,

reduced amount of cervical dilatation required, decreased blood loss, shortened procedure time and hospital stay, reduced pain and reduced need for anesthesia.

Cost:

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

Acceptability to women:

MVA is well accepted by women, including young women. In most cases MVA requires lower levels of pain management than sharp curettage. Typically a local anesthesia (paracervical block), oral analgesics, verbal reassurance (Verbocaine) and, if desired, light sedation allow women to be awake and be aware what is happening to them during the procedure yet allow for adequate control of pain and anxiety. With lower levels of pain medication, abortion care can be provided in an outpatient setting, which is generally more acceptable to women than a hospital stay.

Cervical Dilatation

Dilatation of the cervix is required for most abortion procedures with MVA, except in cases of early pregnancy. Dilatation or cervical preparation may involve the use of mechanical dilators or the use progressively larger cannulae as dilators. Dilatation may also be accomplished by administering osmotic dilators such as laminaria or pharmacological agents such as misoprostol, where available.

Medical Abortion (MA)

Medication abortion has become more widely available using safe protocols based on various research trials. MA uses various medicines to bring about uterine evacuation. The use of medicines for uterine evacuation is recognized globally as essential for women's health. WHO has stated that "medical methods of abortion have been proved to be safe and effective" and in 2007 WHO added mifepristone and misoprostol for abortion to its Model List of Essential Medicines. Nepal also has added these medicines to the essential drug list.

In Nepal, MA can be used for pregnancies up to 9 weeks from last menstrual period (LMP), and studies have shown that the combined use of mifepristone and misoprostol is an effective method of uterine evacuation, with success rates of up to 95% for pregnancies up to and including 13 weeks. Researchers continue to study the optimal mechanisms, protocols, client eligibility, and dosages; thus, regimens and gestational age eligibility continue to evolve. Back-up services, preferably MVA either on site or by referral, are required in the event of a failed medication abortion.

Description:

Medical abortion uses various agents, most commonly mifepristone and misoprostol, to expel the contents of the uterus. Mifepristone blocks progesterone activity in the uterus, leading to detachment of the pregnancy. Mifepristone also causes the cervix to soften and the uterus to contract. Mifepristone used alone does not cause an abortion but works in combination with another prostaglandin like misoprostol.

Misoprostol is a synthetic prostaglandin, which softens the cervix and stimulates uterine contractions leading to expulsion of uterine contents. It is also used for cervical preparation before uterine evacuation, treatment for missed or incomplete abortion, induction of labor, and treatment of post-partum hemorrhage and gastric ulcer.

Other medications that have been used for abortion include methotrexate and various other prostaglandins, but clinical evidence currently supports the combined use of misoprostol and mifepristone as the most effective in stimulating complete abortion. Misoprostol alone may be useful where mifepristone is not available.

Clinical safety and effectiveness:

Combined regimens using mifepristone and misoprostol through nine weeks since the LMP have been widely studied and safely used by millions of women in many countries. Studies to date indicate that the combination of mifepristone plus misoprostol is more effective in stimulating complete abortion than either drug used alone. Research protocols for pregnancies up to and including nine weeks since the LMP report success rates up to 97%. Studies investigating the use of misoprostol alone for first-trimester abortion indicate that there is potential for some regimens resulting in complete abortion in approximately 85% of cases. The effects of medication abortion are similar to those associated with spontaneous abortion and include some amount of abdominal cramping, a little bit more than menstrual-like bleeding and expulsion of small fleshy mass. Other possible side effects, depending on dosage and route of administration, include vomiting, nausea, diarrhea, chills, and fever. Some studies suggest that misoprostol can cause birth defects in a small number of cases; so a woman's decision on treatment of continued pregnancies after taking misoprostol should include this information. If a woman decides to continue a pregnancy after unsuccessful MA, her health-care provider should respect her decision.

Cost:

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

Acceptability to women:

MA is highly acceptable to women in a variety of settings, including where resources are limited. Studies consistently show that 85 to 95 percent of women are satisfied or highly satisfied with

the method, and would be willing to use it again or recommend it to a friend if needed. Women who choose MA are more satisfied with it than those who are randomly assigned to either method. The non-invasive aspect of MA, as opposed to a VA procedure, is often mentioned as a significant benefit. Some women perceive MA as a more private and natural method. Women may take the medications at home, which gives them more control over the conditions under which they have the abortion. Young women show similar preferences around MA and participation in the decision-making process.

6. Considerations for Post-abortion Care

For women who present to the clinic with a spontaneous, threatened, missed or incomplete abortion; complications from a safe or unsafe induced abortion; or complications from previous post-abortion care:

- According to WHO recommendations, if uterine size at the time of treatment is equivalent to a pregnancy of gestational age 13 weeks or less, either MVA or treatment with misoprostol is recommended for women with incomplete abortion.
- Uterine size may be smaller than the woman's report of her gestational age because some of the uterine contents have already been expelled. A woman's eligibility for uterine evacuation method for PAC should be guided by uterine size rather than LMP.
- Wherever possible, women should be given a choice of uterine evacuation methods based on her eligibility.
- Both MVA and misoprostol are clinically effective, safe and economical and highly acceptable to women and providers.

7. Summary

- Woman-centered CAC includes: induced abortion to the full extent of the law; treatment of incomplete, missed or unsafe abortion; compassionate counseling; contraceptive services; related sexual and reproductive health services provided on site or via referrals to accessible facilities and community-service provider partnerships.
- Choice, access, and quality are three key elements of woman-centered CAC.
- Women's choices must be informed by complete and accurate information.
- Health-care workers should explain the woman's condition and options to her in non-technical language and obtain her voluntary, informed consent prior to initiating care.
- Health-care workers should exhibit empathy and respect for women and ensure privacy and confidentiality.
- Health-care workers must be trained, technically competent, and use appropriate clinical technologies in order to provide high-quality care.
- All women, including young women, have the right to high-quality, CAC.
- Health-care workers must understand the concept of women's rights in order to conduct professional interactions and to provide compassionate, high-quality care.

- Only health-care providers authorized to perform abortion have the right to decline to provide the procedure based on moral or religious reasons (as long as a woman's life is not in danger); however, they are ethically bound and should be legally required to ensure that women can access safe services at a nearby facility within a reasonable time period.
- Providers should examine their personal beliefs, values and potential biases so that they do not affect provision of high-quality care.
- The two recommended methods of first-trimester uterine evacuation used in our country are MVA and MA (pharmacological agents).
- Providers need to take the following factors into consideration when determining which uterine evacuation method to use: the woman's clinical condition; her personal preferences; availability of equipment, supplies and skilled staff; and currently available scientific and medical evidence.
- MVA for first-trimester abortion and PAC are safe and acceptable, including for young women, and it is successful in 98-100 percent of cases.
- MA for first-trimester abortion is safe and acceptable, including for young women, and is successful in at least 95 percent of cases using mifepristone plus misoprostol, and 85 percent of cases using misoprostol only.
- Mifepristone followed by misoprostol is the most effective available MA regimen for medical abortion up to nine weeks since LMP.

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MODULE 2:

CLINICAL ASSESSMENT

Key topics

1. How to take relevant history of women seeking abortion services.
2. How to perform complete physical examination of women seeking abortion services.
3. How to determine the duration of pregnancy and any special precautions needed for providing abortion care, including special consideration for young women.

1. Introduction

The first step in providing abortion care is to establish that the woman is indeed pregnant and, if so, to estimate the duration of the pregnancy and confirm that the pregnancy is intrauterine. This module describes how to conduct a complete clinical assessment before an abortion procedure, how to address pre-existing conditions which can affect abortion care and how to consider the needs of special populations.

Prior to performing an abortion procedure, it is essential to assess a woman's condition. This allows the provider to properly diagnose the woman's clinical status and help determine the best options for her. It sometimes reveals specific pre-existing conditions that may require special attention or management. The assessment should be conducted in private. A clinical assessment can generally be organized into four main components:

- Client history
- Physical examination including pelvic examination
- Psycho-social assessment
- Investigations

Appendix A: *Clinical Assessment Skills Checklist* can serve as a tool to evaluate a provider's ability to perform a full clinical assessment.

2. Client History

It is important that the provider takes a woman's complete clinical history. This will help determine the length of the pregnancy and identify any known conditions such as use of medications,

allergies or other medical diseases. All components of history specified in HMIS 11 should be filled correctly. In addition to estimating the duration of pregnancy, clinical history taking should serve to identify contraindications to the different uterine evacuation methods and to identify risk factors for complications of treatment. Finally, the clinical history should provide information that will help the provider meet the woman's other reproductive and sexual health needs.

Ask the woman about and record her clinical history, including:

- Age, occupation, and address
- First day of LMP
- Signs and symptoms of pregnancy
- Whether she had a pregnancy test or ultrasound and the results of the test
- Whether she has had any bleeding or spotting during the pregnancy
- Sexual history, such as number of partners or recent new partners
- Obstetric and gynecologic history including number of previous pregnancies, live births, miscarriages or abortions, menstrual history, fibroids, or infections, previous ectopic pregnancy or tubal surgeries
- Any recent abortion related care
- Recent abortion medications taken including misoprostol or herbal medications
- Physical or cognitive disabilities or mental illness
- Previous medical and surgical history
- Any bleeding tendencies or disorders
- History of/presence of sexually transmitted infections (STIs)
- Drugs allergies especially of xylocaine and prostaglandins
- Any symptoms of domestic violence or coercion
- HIV status (presence of HIV infection in a woman undergoing abortion, HIV testing may be offered but is not mandatory)
- History of contraceptive use
- Alcohol, tobacco, drug use or substance abuse.
- Other relevant history

Physical Examination

Accurately determining the length of pregnancy is a critical factor in both selecting an abortion method and preventing complications. Therefore, before beginning any uterine evacuation procedure, it is critical to estimate the uterine size as accurately as possible.

General Health Examination:

Before starting the physical examination, the provider should explain to the woman of the steps of Physical examination and why it is being done and what she can expect. This is especially important if this is the woman's first pelvic exam, which is most likely in young or nulliparous women.

- Check vital signs – pulse, BP, temperature, respiratory rate
- General health – weakness, lethargy, malnourishment, anemia, jaundice, edema, cyanosis, petechial/purpuric rashes
- Check for any signs of Sexually Transmitted Infections/Reproductive Tract Infections (RTIs)
- Check the heart and lung sounds
- Abdominal examination includes checking for uterine size (height of the uterus above the pubic symphysis), any other mass or organomegaly

Abdominal and Bimanual Pelvic Examination:

Confirmation of the length of pregnancy is of utmost importance while providing abortion services. The woman should empty her bladder before pelvic examination to determine the uterine size. Underestimation of gestational age can lead to serious complications. The confirmation of gestational age is necessary for legal limits of abortion and for the skill and competency of the provider as well.



Figure: Positioning the woman for examination

Positioning the woman:

- Help the woman move into the lithotomy position.
- Use drapes or linens to make sure her privacy is protected.
- Attend to any special anatomical or physical needs, including disability, arthritis, or injuries.
- Ensure that she feels as comfortable as possible.

Per speculum examination is done to rule out any local lesions like polyps, cancers, double cervix, vaginal septa etc. Any evidence of infections like purulent discharge, ulcers, bleeding, foreign bodies also require management simultaneously.

The provider should perform a bimanual examination to assess the size, consistency and position of the uterus and adnexa. Signs of pregnancy, including softening of the cervix and softening and enlargement of the uterus, are detectable during the bimanual examination as early as six to eight weeks since the LMP. Pelvic masses, adnexal pain, masses, or tenderness on moving the cervical excitation can also be detected.



Figure: Bimanual Examination

To assess the uterus and adnexa, the clinician places two fingers into the vagina and then palpates the abdomen with the other hand. The size of the uterus is then compared with the history of amenorrhea. After 6 weeks gestation, the uterus increases in size by approximately 1 centimeter per week and takes on a roundish shape. Assessing the uterus in early pregnancy can be challenging and requires a great deal of practice.

Table: Guide to Uterine Size Determination

Gestational date	Uterine size
6 weeks	Hen's egg
8 weeks	Cricket ball
10 weeks	Asian pear (<i>Naspati</i>)
12 weeks	Fundus just palpable above symphysis pubis

If the **uterus is smaller than expected**, consider one of the following conditions:

- The woman is not pregnant
- Inaccurate menstrual dating
- Ectopic pregnancy
- Spontaneous or incomplete abortion, missed abortion, or abnormal intrauterine pregnancy, such as molar pregnancy
- Normal variation between women at a given length of pregnancy
- Acutely retroverted uterus

If the **uterus is larger than expected**, consider one of the following conditions:

- Inaccurate menstrual dating
- Multiple pregnancies
- Uterine anomalies such as fibroids or bicornuate uterus
- Gestational trophoblastic neoplasm/molar pregnancy (although the uterus can sometimes

be smaller also)

- Normal variation between women at a given length of pregnancy
- Full bladder

Situations that make it difficult to accurately assess uterine size include fibroids, retroverted position of the uterus, obesity, full bladder or the woman contracting abdominal muscles (not relaxing her abdomen). If uncertain about the size of the uterus, or if there is a discrepancy between size and gestational age determined by LMP, it may be helpful to use an ultrasound, if available, or to ask another experienced clinician to check the uterine size by bimanual examination.

Table: Diagnosis and treatment of types of abortion

Probable Diagnosis and Definition	Signs and Symptoms	Management Options
Threatened abortion: vaginal bleeding in woman with a viable intrauterine pregnancy	<ul style="list-style-type: none"> • Light PV bleeding • Slight pain • Closed cervix • Uterine size corresponds to LMP 	<ul style="list-style-type: none"> • Reassurance • Expectant management • If continued bleeding, further clinical assessment
Incomplete abortion: an abortion – whether spontaneous or induced – in which some pregnancy tissue passes out of the uterus but some remains	<ul style="list-style-type: none"> • Light to heavy bleeding • Cramping/pain • Open cervix • May see tissue at the cervical os • Uterine size is usually smaller than gestational age 	<ul style="list-style-type: none"> • Depending on the clinical condition and the woman's preference, she may be offered misoprostol or MVA • Antibiotics if indicated • Pain control
Missed abortion: a kind of miscarriage; the pregnancy ends, but the tissue remains in the uterus	<ul style="list-style-type: none"> • Light to no bleeding • Cramping/pain • Closed cervix • Uterine size smaller than gestational age • Diagnosis may be made on ultrasound 	<ul style="list-style-type: none"> • Depending on the clinical condition and the woman's preference, she may be offered misoprostol or MVA
Complete abortion: all POC have been expelled from the uterus and the os is closed	<ul style="list-style-type: none"> • Light bleeding • Cramping/pain • Closed cervix • Uterine size smaller than gestational age 	<ul style="list-style-type: none"> • Expectant management • Antibiotics if indicated • Pain control

Psychosocial Assessment

The contact that the provider and assistant have with the woman while taking her clinical history and performing a general physical examination provides an ideal opportunity to assess her emotional and psychosocial well-being. During the assessment, providers can evaluate a woman's current emotional state, relevant relationship and family circumstances, and support systems, as they have a direct bearing on her clinical experience. Although many women will be emotionally stable and comfortable with their decision, some women may show signs of nervousness or distress. The team members should exhibit nonjudgmental behavior and display a sense of concern and confidentiality. Because of social and cultural issues the woman may not want to disclose full information about the pregnancy. Open, supportive communication and a gentle, reassuring manner help ensure that the team members are able to obtain all relevant information needed to determine the best possible care for the women.

It is also important to note any cognitive disabilities, mental illness or indication that the woman has been subjected to violence. At this time the women should be encouraged to discuss the circumstances that led to her seeking abortion care. If any such psychosocial issues are discovered, the woman may need to be referred for appropriate care after the abortion services.

Women who have experienced violence may be afraid or feel uncomfortable about being touched. There are often no physical signs of violence against women. However, providers should be alert to the following signs, while understanding that these signs can also be present outside the context of violence:

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

These signs may indicate the need for further discussion and screening for violence by providers to determine if a woman is in a dangerous situation. If this proves to be the case, providers should do what they can to help the woman before she leaves the facility, as many women may not return for follow-up appointments. A provider can refer a woman to a one-stop crisis center (where available) or to a women's cell.

Laboratory Tests

No laboratory test is needed for CAC procedure. In most cases, providers only require the information obtained from the women's history and from physical examination to confirm the pregnancy and its length. Some special situations where lab test can be considered are:

- Urine pregnancy test: To confirm pregnancy. This is needed when typical signs of pregnancy are not clearly present and the provider is unsure whether the woman is pregnant.

- Haemoglobin/hematocrit: If there is concern about anemia.
- The need for routine Rhesus (Rh) immunization for Rh negative women undergoing early abortion has not been proven by clinical studies and Rh testing is not required to provide abortion services. Where Rh immunoglobulin is available and routinely provided to Rh-negative women, this protocol should also be applied for women undergoing abortion. It should be administered at the time of the procedure when performing MVA and, in the case of MA, when the first pill of the abortion regimen is taken.
- This is an opportunity to screen for other reproductive health issues including cervical dysplasia and cancer and reproductive tract infections. These services may be offered to women if they are available but are not required to provide abortion care.
- Ultrasonography (USG): USG can be used when there is difficulty assessing gestational age based on history and exam, to assess abortion completion, and to diagnose other conditions requiring treatment, such as ectopic pregnancy. USG is not routinely required and its use may increase the cost of the procedure and the likelihood of unnecessary or premature intervention using MVA in the case of MA.

Recommended Regimen for Management of RTI/STIs in Nepal

Therapeutic antibiotics should be administered to all women who are suspected of or who have been diagnosed with an infection. If possible, women at high risk should be screened and treated for RTIs/STIs in addition to receiving prophylactic antibiotics. Women who are screened for STIs do not need to wait for results before having the procedure. Treat giving the first dose of antibiotics just before carrying out the procedure. Management of an RTI/STI should be carried out as below and both partners need to be treated.

Syndromic Diagnosis	Main Causative organisms	Medication/Dosage
Vaginitis	Candida albicans Trichomonas Vaginalis Bacterial Vaginosis	Tinidazole 2 gm Single dose OR Metronidazole 400 mg XTDS X 7days Plus Fluconazole 150 mg oral single dose OR Clotrimazole 200 mg Vaginally X 3 nights locally

Syndromic Diagnosis	Main Causative organisms	Medication/Dosage
Cervicitis	Neisseria Gonorrhoea Chlamydia Trichomatis	Azythromycin 1 gm oral single dose OR Doxycycline 100 mg oral twice daily for 7 days Plus Cefixime 400 mg oral single dose OR Ceftriaxone 250 mg IM single dose OR Spectinomycin 2 gm IM single dose
Genital ulcer disease Syndrome (GUD)	Treponema Pallidum (syphilis) Haemophilus Ducreyi (chancroid) Herpes Simplex virus (HSV)-genital Klebsiella granulomatis- granuloma inguinale	Treatment for Syphilis: Injection Benzathine Penicillin 1.2 million I.U deep IM at each buttock (total 2.4 million I.U) single dose PLUS Treatment for Chancroid: Azithromycin 1 gm orally as a single dose PLUS Treatment for Genital Herpes: Acyclovir 400 mg X PO XTDS X 7 days (if there is clinical evidence of genital herpes)
Lower Abdominal Pain Syndrome	Neisseria gonorrhoea Chlamydia trachomatis Anaerobic bacteria	For mild to moderate PID (outpatient treatment): Cefixime 400 mg oral stat OR Ceftriaxone 250 mg IM stat PLUS Doxycycline 100 mg oral X BDS X 14 days PLUS Metronidazole 400 mg XTDS X 14 days Follow up in 3-7 days, if not improved refer For severe PID (inpatient treatment): Ceftriaxone or other third generation Cephalosporin IV (dose & duration to be determined on the basis of severity & clinical judgment) PLUS Doxycycline 100 mg oral xBDSx14 days Plus Metronidazole 400 mgxTDSx14 days

Prophylactic Antibiotic Regimen

If possible, prophylactic antibiotics to prevent post-procedure infection should be given at least 30 minutes before the MVA procedure. Regimen: Doxycycline 100 mg orally two times daily for five days. Infection rates after MA are very low. WHO guidelines do not recommend routine use of antibiotics with MA.

Pre-Existing Conditions

If any of the following conditions are found, it may be necessary to refer the woman to higher facility or be prepared to act according to the woman's special needs. These pre-existing conditions could trigger or exacerbate certain complications or interfere with care in other ways.

Pre-Existing Condition	Comments
Hypertension	<ul style="list-style-type: none"> • Methergine, an ergotamine derivative, should NOT be used in women with hypertension for treatment of postabortion atony. • It should be avoided in women with blood pressure greater than 140/80 or 150/90 mmHg.
Seizure disorder	<ul style="list-style-type: none"> • The woman should take her usual dose of anti-seizure medication on the day of the abortion procedure. • Benzodiazepine sedative may be administered before performing an abortion. • Several anti-epileptic drugs like Phenytoin interfere with all forms of combined hormonal contraception; review contraceptive options carefully. • May require intensive medical support for uterine evacuation procedure, and will depend on the severity of the disease.
Anemia	<ul style="list-style-type: none"> • If hematocrit or hemoglobin very low, be prepared to treat appropriately or refer to higher center. • Average blood loss in MA may be more than in MVA.
Blood-clotting disorders	<ul style="list-style-type: none"> • If the woman has an active clotting disorder, proceed with caution, preferably in a facility that is able to treat women who are hemorrhaging. • Vacuum aspiration in a facility with blood products (if possible) may be a safer option for a woman with a known clotting disorder than MA, as uterine atony and hemorrhagic events may not present in the immediate period following misoprostol administration.
Diabetes	<ul style="list-style-type: none"> • No changes in diet or medication regimen are necessary for MVA under local anesthesia. • High blood-glucose levels are preferable to low blood glucose levels prior to a procedure, but ketoacidosis should be avoided.

Pre-Existing Condition	Comments
Heart disease	<ul style="list-style-type: none"> • If symptomatic or severe disease, MVA may be performed in an operating room and monitored with the assistance of an anesthesiologist. • Caution and clinical judgment are required when using MA.
Asthma	<ul style="list-style-type: none"> • Women with mild or well controlled asthma may have either a MVA or MA. • Women with an acute asthma attack or poorly controlled asthma may need to have delayed care until asthma is under control. • Some prostaglandins (PGF2 alpha—hemabate) should be used with caution in asthmatics in case of postabortal atony; PGE1 and PGE2 (Prostin) can still be given. • Misoprostol is a type of prostaglandin that promotes bronchodilation, decreasing inflammation and increasing oxygen flow and is thus safe to use in asthmatics.
Long-term corticosteroid therapy	<ul style="list-style-type: none"> • No evidence exists regarding use of mifepristone in steroid-dependent women. • Providers must use clinical judgment if no other alternatives to safe abortion exist. • Increase steroid dose for 3-4 days and monitor the woman very closely. • Conditions such as poorly controlled asthma may still be worsened.
Molar pregnancy	<ul style="list-style-type: none"> • In most cases, molar pregnancy will not be diagnosed prior to abortion in early pregnancy. • Women with known or suspected molar pregnancy should have an abortion using vacuum aspiration with confirmation of tissue diagnosis and appropriate follow up.
Suspected ectopic pregnancy	<ul style="list-style-type: none"> • Known or suspected ectopic pregnancy is a contraindication to MA. • An ectopic is a life-threatening emergency that requires treatment. • Evaluate, treat or refer according to local protocol.
Cervical stenosis	<ul style="list-style-type: none"> • Consider performing MVA under ultrasound guidance, using an agent such as misoprostol to prepare the cervix prior to procedure. • MA may be preferred.

Pre-Existing Condition	Comments
Uterine malformation	<ul style="list-style-type: none"> • A woman can have a choice of MA or MVA. MVA and D & E should only be performed by an experienced provider with caution, and consideration given to an ultrasound-guided procedure. <p>If uterine malformations are present, medical abortion is the preferred method. A woman can have a choice of MA or MVA. MVA and D & E should only be performed by an experienced provider with caution, and consideration given to an ultrasound-guided procedure.</p>
Smoking	<ul style="list-style-type: none"> • There is no evidence of increased risk of abortion among smokers. • Smoking contributes to cardiovascular risk factor and should be considered when assessing a women's overall suitability for MA or anesthesia with a uterine evacuation procedure.
Alcohol or drug abuse	<ul style="list-style-type: none"> • Be prepared for low pain threshold. • Consider use of narcotic analgesic and parenteral sedative.
Prolapsed uterus	<ul style="list-style-type: none"> • Women with prolapsed uterus can use misoprostol sublingually instead of vaginally if there is concern that the misoprostol would not stay in place.
STIs (Sexually Transmitted Infection)	<ul style="list-style-type: none"> • If a woman is assessed to have an STI at the time she requests MA, the STI treatment may be started on the same day she receives mifepristone. In MVA the treatment can be started ½ hr before the procedure.
HIV/AIDS	<ul style="list-style-type: none"> • HIV-positive women may use MA or MVA. Theoretically, HIV-positive women may be at higher risk of reproductive tract infections after a uterine evacuation procedure but this has not been studied. • Women with HIV/AIDS may be at risk for anemia, especially if they have malaria or are taking certain antiretroviral therapies. As with any woman, if heavy bleeding occurs, provide prompt treatment with uterine evacuation.

There are other pre-existing conditions that should not interfere with the provision of MVA or MA. These include:

Pre-Existing Condition	Comments
Age	<ul style="list-style-type: none"> Neither adolescent nor older age is a contraindication for abortion. Special care should be taken to provide youth-friendly service.
Obesity	<ul style="list-style-type: none"> There is no evidence that the failure rate of MA is increased or that a different dosage regimen is required.
Hyper- or Hypothyroidism	<ul style="list-style-type: none"> There is no evidence that the failure rate of MA is increased or that a different dosage regimen is required.
Breastfeeding	<ul style="list-style-type: none"> It is likely that mifepristone passes into breast milk, though clinical implications are likely to be minimal. Small amounts of misoprostol enter the breast milk soon after administration, but the clinical implications are likely to be minimal. It is recommended that misoprostol to be taken immediately after a feed and the next feed be given 4-6 hrs later.
Multiple pregnancy	<ul style="list-style-type: none"> The failure rates of MA are NOT increased. A different MA dosage/regimen is NOT required. Careful tissue examination necessary after MVA/EVA.

3. Considerations for Post abortion Care

- Women who are pregnant and present with vaginal bleeding and/or lower abdominal pain or cramping may have a threatened abortion, a spontaneous, missed or incomplete abortion, complications from a safe, self-induced or unsafe abortion, or complications resulting from previous PAC.
- Clinical assessment should focus on the health status of the woman and whether she has suffered any abortion-related complications.
- Women presenting for post abortion care may show a range of symptoms from mild to severe including:
 - Light to moderate vaginal bleeding
 - Severe vaginal bleeding/hemorrhage
 - Pelvic infection/sepsis
 - Intra-abdominal injury
- Women who present for post abortion care need to have a rapid initial assessment for shock. Women who are unstable due to hemorrhage or sepsis need to be stabilized and treatment started immediately. Treatment may require immediate uterine evacuation.
- Once a woman has been stabilized, the clinical assessment should focus on the type of abortion (incomplete or missed), whether there are complications that need attention and her eligibility for methods of uterine evacuation.

- For post abortion care, the uterus should be smaller than the woman's report of her LMP.
- Management of the abortion depends on:
 - Type of abortion (missed abortion or incomplete abortion)
 - Size of uterus
 - Medical eligibility
 - Availability of equipment and supplies
 - Woman's preference

Appendix B: *Clinical Assessment for Postabortion Care Skills Checklist* can be used to evaluate and improve a provider's performance of a clinical assessment for post abortion care.

4. Summary

- During the clinical assessment, the provider should meet with the woman in private to discuss her information and perform an examination.
- Clinical assessment for abortion should include taking a client history, conducting a physical examination, psychosocial assessment, and, if needed, collection of specimens and ordering of any lab tests.
- Client history helps determine the woman's gestational age and eligibility for MA or MVA, and provides information to help the provider meet her other reproductive and sexual health needs.
- The physical examination involves assessing the woman's general health and performing a pelvic exam.
- Laboratory testing and ultrasound are not required for routine abortion services but may be helpful if a woman's pregnancy status and dating are unclear.
- Where possible, prophylactic antibiotics should be administered prior to MVA to help reduce women's risk of post- procedure infections. Prophylactic antibiotics are not needed for medical methods of uterine evacuation. Lack of access to antibiotics should not be a barrier to abortion care.

MODULE 3:

COUNSELING, INFORMATION, AND INFORMED CONSENT

Key topics

- Essential knowledge, skills and attitudes regarding counseling for abortion service.
- Effective counseling to woman seeking abortion (before, during and after the abortion procedure).
- Informed consent of the woman seeking abortion services.
- Post abortion contraceptive counseling and method provision.
- Counseling and abortion care for young women.

1. Introduction

Many women have made a decision to have an abortion before coming for care. This decision should be respected and pregnancy options counseling should not be required or serve as a barrier to receiving abortion care. If she has questions about her pregnancy options, providers can discuss them with her. They include:

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

By providing any information needed and supporting a woman's decision, providers can help women feel confident and comfortable that they are making the decision about their pregnancy that is best for themselves and other important people in their lives. Staff should ensure that she can make a decision free from coercion. If a woman desires counseling, it should be voluntary and confidential.

Counseling is a structured interaction in which a person voluntarily receives emotional support and guidance from a trained person in an environment that is conducive to openly sharing thoughts, feelings and perceptions. Therefore counseling is:

- Respectful, empathetic, supportive, confidential, and interactive.
- Accepting the woman's perceptions and feelings.

- Focused on the woman's needs.
- Supporting the woman's voluntary decisions.

Counseling should be done at each step of abortion care, after history taking and physical examination when the woman can decide to choose abortion or continue her pregnancy. If she wants abortion service, she can choose between the appropriate uterine evacuation procedures understanding the process, risks and benefits, drugs to be taken at home, pain management options, recovery, and PAC. If both MVA and MA are available, the counselor should explain the differences between them and help the woman explore which option is best for her. As long as the different methods are clinically appropriate, providers should refrain from inserting their own method preferences into the discussion and support a woman's decision. She should be counseled regarding post abortion contraceptives and she can choose the contraceptive appropriate for her. If the need arises she should be counseled regarding other reproductive health issues like domestic violence, sexual violence, safe sex practices, etc. The provider should link her to other necessary services besides abortion care, e.g. psychological counselor, substance abuse rehabilitation, safe shelter homes, etc.

The provision of information is an essential part of good quality abortion services. Every pregnant woman who is contemplating abortion should receive adequate relevant information and be offered counseling from trained health care personnel with comprehensive knowledge and experience of different methods of abortion and contraceptives. Because many facilities do not have full-time counseling positions, existing staff members can be trained to provide basic abortion counseling. In cases where clinicians also function as counselors, they must remain mindful that client-counselor dynamics may differ from client-clinician relations. Whether or not they have formal counseling responsibilities, clinicians should possess counseling knowledge, an affirming, non-judgmental attitude, and caring and supportive behaviors.

Information, counseling and abortion services should be provided as promptly as possible without undue delay. The woman and provider may have different values, social circumstances, cultures, and speak different languages, which can create barriers to understanding. It is the provider's responsibility to recognize and positively address these barriers to be able to reach empathy and understanding. Service providers should be trained to inform, counsel and treat adolescents and young women according to their evolving capacities to understand the treatment and care options being offered, and not according to an arbitrary age cut-off. With correct information and support, young people are capable and have the right to make health-care decisions and provide informed consent for themselves. They should support minors (below the age of 16 years) to identify what is in their best interest, including counseling parents or other trusted adults about their pregnancy, without bias, discrimination or coercion, with the consent of the minor. The counselor talks with the woman to explain the procedure, answers the questions, discusses what to expect and obtains informed consent.

Providers can refer to Appendix C: *Counseling Skills Checklist* to review all necessary components of a counseling session. This tool can be used to evaluate a provider's skills around counseling for abortion service.

2. Privacy and Confidentiality

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

At the beginning of the counseling session, the provider should inform the woman that any medical and personal information discussed during counseling is confidential, and then ensure that this information is not released without the woman's voluntary authorization.

When confidentiality and privacy is not maintained, the scene is set for deterring many women, particularly adolescents and unmarried young women from seeking safe, legal abortion services, and may drive them to clandestine unsafe abortion services. Confidentiality is a key principle of medical ethics and an aspect of the right to privacy, which must be guaranteed at all times.

3. Informed and Voluntary Decision-Making, and Consent

Providing information and offering counseling is vital in helping the woman consider her options and ensuring that she can make a decision that is free from coercion. Many women have made a decision to have an abortion before seeking care, and this decision should be respected. Informed consent involves an important discussion between the counselor and the client in which the client understands her clinical condition, understands the risk and benefits of the various clinical options, and decides freely what course of action to take.

Provision of counseling to a woman who desires it should be voluntary, confidential, and non-directive and by trained personnel. The empathetic counselor should listen attentively, understand the woman's feelings, show caring behavior, responds honestly and respectfully, is friendly and helpful and uses simple, non-technical language.

Providers should remain mindful of any circumstances that may limit a woman's ability to make autonomous decisions, such as:

- Pressure from her partner or family members to have an abortion
- Difficulty communicating due to language barriers or because she is hard of hearing or deaf
- Cognitive disability or mental illness
- Mental immaturity
- A traumatic event (such as violence or an unsafe abortion)



Figure: Counseling session

4. Counseling

Counselors should strive to create a safe environment in which women can explore and validate their feelings.

Effective counselors remain open and non-judgmental even when their personal beliefs differ from those of their clients. Counselors should practice empathy, the ability to understand another person's feelings and point of view and to communicate this understanding. Counselors should never insist that a woman talk or reveal information that she is not comfortable sharing. Counseling always involves two-way communication between the health-care provider and the woman. Each person spends time talking, listening, and asking and answering questions.

Counselors who practice effective communication:

- Stay attentive and focused on the woman and her needs
- Use non-verbal cues to convey interest in and concern for the woman and observe her nonverbal cues
- Ask open-ended questions and use encouraging words to help the woman talk openly
- Let her talk before providing information
- Follow up with appropriate feedback
- Use words and language that are easily understandable, including for young women
- Are warm and without bias, anger or judgment, including body language

Counselors who do not practice effective communication:

- Make judgments about a woman's behaviors
- Make assumptions about the woman and her needs, or focus on their own priorities
- Indicate a lack of interest through nonverbal cues and do not pay attention to the woman's nonverbal cues
- Ask only close-ended questions
- Do not listen carefully, or show distraction

- Interrupt or speak over the woman
- Use medical terms or language that is difficult for women to understand
- Do not check to make sure that the woman has understood their questions
- Allow interruptions such as telephone calls or people coming into the counseling space
- Feel they know what is best for the woman, better than the woman herself

Initial Counseling: Rapport Building

- Establish and maintain a warm and cordial relationship.
- Establish a formal but friendly interaction. Encourage the client to talk and help them to talk comfortably. A friendly environment with a warm and friendly facial expression can ease the women to communicate easily and honestly.
- Call the client by her name.
- Assure privacy and confidentiality.
- Demonstrate interest in what the client tells you.
- Establish eye contact with the client.
- Show support and understanding without judgment.
- Explores the circumstances that led to the need for an abortion.

Pre-Procedure Counseling

Before proceeding to the pre-procedure counseling, inform the women of the examination findings. Counsel the client regarding her abortion options depending on gestational age or preference (MVA versus MA).

At a minimum, a woman must be **given information on:**

- What will be done before, during and after the procedure;
- Eligibility, effectiveness, regimen, and protocol;
- What she is likely to experience (e.g. menstrual-like cramps, pain, and bleeding);
- How long the procedure or process may take; What pain management can be made available to her;
- Side effects, risks, and complications associated with the methods

The counselor needs to **be cautious so as not to frighten** the women while providing this information:

- Warning signs and when to seek help;
- When she will be able to resume her normal activities, including sexual intercourse; and
- Postabortion contraceptive methods and follow-up care.

A provider should not:

- Provide information that is not relevant to the woman's particular situation
- Tell the woman what they think is best
- Try to influence attitudes, beliefs, and behaviors by persuading or threatening

Obtained client's consent in the client personnel profile once she decides on her preferred methods of abortion.

Counseling during Procedure

The anxiety and discomfort of the women can be addressed by continuous emotional support and counseling provided by the provider and the assistant during the procedure. The support provided through counseling may reduce a woman's fear and perception of pain.

- Communicate with the woman constantly during the procedure.
- Explain what to expect, periodically reassuring and encouraging her.

Post-Procedure Counseling

When the procedure is completed, provide information on:

- How long she will rest at the facility.
- The amount of bleeding and cramping that will probably occur in the days immediately after the abortion.
- How to identify signs of potential complications and when/how and who/where to contact if complications do occur.
- Whether follow up visit is needed or not.
- When she will be able to resume her normal activities, including sexual intercourse.
- Her method of post-abortion contraception, if she has decided to use one. Check to make sure that the woman is happy with the method she selected prior to the procedure. If she has changed her mind, provide additional contraceptive counseling to find another method.

Referrals

If a provider is unable to adequately address the woman's needs, it is best to refer her to other appropriate individuals or services. Providers need to be aware of high-quality, affordable resources available in their area and know how to refer women to them. For young women, referrals should be made to providers and services that are known to offer appropriate care for young women. Referral protocols and resource lists that provide simple, accurate, and up-to-date information are essential components of an effective referral system. Providers should track referrals in the logbook.

Closing a Counseling Session

When closing a counseling session, the counselor should:

- Provide a short summary of the key concepts discussed
- Ask the woman if she has any additional questions
- Ensure that the woman understands any verbal instructions or referrals, if appropriate
- Provide the woman written or pictorial instructions or referrals, if appropriate and desired
- Explain what to expect during the remainder of the clinic visit

Special Considerations: Counseling for Specific Populations

Women with multiple abortions:

If a woman does not desire pregnancy yet has experienced multiple unwanted pregnancies, the counselor can talk with her about why this is occurring. If the reason is that she chooses not to use contraception, some women will not have an explanation as to why they choose this. In some cases, there may be an underlying issue that prevents the woman from adequately protecting herself from unwanted pregnancy, including myths about contraception, coercive sex, abusive sexual relationships, or unresolved emotional conflicts. Women with severe emotional issues should be referred to longer-term, professional mental-health services, if available.

Women who have experienced violence:

It is likely that providers will encounter women who have experienced sexual violence. Women who have experienced such violence – which includes rape, sexual assault, coercive sex, incest, and involuntary sex work – will often experience related health conditions, such as physical injury, sexually transmitted infections (STIs), psychological distress or unplanned pregnancy. Physical or psychological violence during pregnancy may also contribute to miscarriage or the desire for an abortion.

Abortion care visits may be the only contact that women who have experienced violence have with the health-care system. Counselors should develop a standard method for asking all clients about violence in their lives and incorporate those questions into routine counseling. Health workers must be cognizant of their own limitations in assisting women experiencing violence and, when possible, refer women to others who are specialized in addressing these women's needs.

- Special violence-related counseling considerations include:
- An unwanted pregnancy may be the result of rape or incest
- A spontaneous abortion could have been caused by physical abuse
- The pregnancy could have been wanted
- A woman may face further violence if her abortion or use of contraception is not kept confidential
- A woman may have been forced or coerced into having an abortion

Women with cognitive and developmental disabilities and/or mental illness:

Cognitive and developmental disabilities and mental illness vary widely, and some women will need more assistance than others. Women may come to the clinic with their partner, caregiver, parent, friend, or relative. While it may be helpful to engage the companion in discussions about the woman's needs, condition, informed consent, choices about care, and contraceptive options, it is critical that the counselor address the woman directly.

A common misperception is that women with cognitive and developmental disabilities and/or mental illnesses are not sexually active. Many women with these conditions are able to engage in safe, consensual sexual relationships. It is important to note, however, that women with these conditions are at an increased risk for sexual violence and coercive sexual activity, potentially by

their caregivers. If sexual violence is suspected, the counselor should speak with the woman in private and refer her to appropriate community services.

Communication with a woman who has a cognitive disability may take some extra time and effort on the counselor's part.

The woman may or may not be her own guardian, which can affect her ability to give informed consent. If she is able to make decisions about her own care, the counselor should make an extra effort to ensure that the woman clearly understands what she is consenting to and what her choices are. Women with cognitive disabilities may be quick to agree or to answer yes before they fully understand a situation.

Considerations for Post abortion Care

- In cases of shock or other life-threatening conditions, a complete clinical assessment and voluntary, informed consent may be deferred until after the woman is stabilized.
- If a woman is in extreme pain or emotional distress, counseling should be offered when she is stable and able to comprehend and communicate.
- Women have a right to privacy and confidentiality. In a legally restricted environment, women who have self-induced or obtained a clandestine abortion may be particularly fearful that information will be reported to authorities. Providers should inform the woman that medical and personal information will not be released without her voluntary authorization, except when it is legally required.
- Providers should be able to respond to questions about safe, legal abortion and where women can access such services.
- Providers should consider that this may have been a wanted pregnancy.

5. Post abortion Contraceptive Counseling

International organizations recognize that access to contraception is a basic human right, fundamental to reproductive and sexual health. The WHO recommends all women should receive contraceptive information and be offered counseling for and methods of postabortion contraception, including emergency contraception, before leaving the health-care facility.

The goal of contraceptive counseling is to help a woman decide if she wants to prevent pregnancy in the short or long term and to assist her in choosing an appropriate and acceptable contraceptive method. Within the context of abortion care, contraceptive counseling and provision allows a woman to begin her chosen method immediately following the abortion, thereby increasing the likelihood that she will continue its correct and consistent use and avoid unintended pregnancies in the future. This will increase the likelihood that she will continue its correct and consistent use as it helps the woman avoid unintended pregnancies in the future.

Provision of contraceptive information and services is an essential part of abortion care as it helps the woman avoid unintended pregnancies in the future. Every woman should be informed that on average, a women will ovulate within 20 days of MA with mifepristone and misoprostol but

can ovulate as early as 8 days which is not significantly different after MVA. This puts her at risk of pregnancy unless an effective contraceptive method is used. She should be given accurate information to assist her in choosing the most appropriate contraceptive method to meet her needs. The final selection of a method, however, must be the woman's alone. A woman's acceptance of a contraceptive method must never be a precondition for providing her an abortion.

Preferably on site, the woman should be offered contraceptive counseling and given the method of her choice. If referral services are needed, a woman should be provided with an interim method of contraception such as condoms or birth control pills until she can access her chosen method.

Appendix D: *Contraceptive Counseling Checklist* has been provided as a tool to evaluate and improve a provider's postabortion contraceptive counseling skills.

Contraceptive Failure

Providers will encounter women who have terminated unwanted pregnancies that resulted from contraceptive failure. Contraceptive failure happens for several reasons:

Failure of the contraceptive

- No method is 100 percent effective. Even when a modern method of contraception is used correctly and consistently, some women will become pregnant.

Failure to use the method or failure to use it correctly or consistently for various reasons such as:

Forgetting to use a method consistently

- Not being able to afford contraceptives on a regular basis
- Stopping use due to unexpected side effects or misunderstandings about effects on fertility or health
- Disapproval of husband/partner, mother-in-law, other family members, religious leaders or other influential people
- Sex was non-consensual
- Concerns about being stigmatized due to cultural attitudes that equate contraceptive use with promiscuity

There are also health-system-related failures that can result in women not being able to access or correctly use contraceptive methods, including:

- Provider did not adequately explain how to use the method
- National reproductive-health policies limit access to contraception for certain women, such as young or unmarried women
- Contraceptive methods are too expensive

- Family planning clinics do not reliably stock the woman's preferred methods
- Contraceptive service locations and times are not convenient
- Contraceptive service protocols limit re-supply; for example, dispensing only one-month supply at a time

A woman's ability to use contraception successfully may not always be in her control. Providers should empathetically help each woman assess her own situation, consider which method might help her prevent a future unwanted pregnancy, and discuss possible solutions to challenges she may have using contraception. In some cases, discreet long-acting methods that do not require daily adherence such as IUCDs or implants may be more effective and may help increase her successful use of contraception. Providers need to avoid blaming women for not preventing past unwanted pregnancies, as this can lead to women's reluctance to seek services in the future. Providers should also be aware of cultural attitudes and beliefs that may influence a woman's use of contraception, particularly young women.

Involvement of Partners

The woman should be asked whether or not she wants her partner included in contraceptive counseling. In some cases, inclusion of partners in contraceptive counseling can increase the effectiveness of the counseling. Male partners' support of contraception is a strong predictor of contraceptive use. Counseling male partners can increase their awareness and use of male contraceptive methods, such as male condoms and vasectomy.

If the woman's partner wants to be included in the contraceptive counseling process, the provider should first meet alone with the woman to determine if she wants the partner involved. If a woman does not want her partner involved, she should be counseled and given the method privately and no information from the visit should be shared with her partner.

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

Essential Steps for Contraceptive Counseling

A provider who counsels effectively does more than describe the various contraceptive methods available; he or she establishes trust with the woman, comes to understand her needs and tailors the counseling session to meet those needs. Contraceptive counseling requires an open exchange of information that can only occur in an atmosphere of mutual respect.

The following steps have been adapted from the GATHER technique, a widely used approach in contraceptive services.

Greet and establish rapport

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

Ask the woman

- Ask the woman about her needs. Using open-ended questions, discuss the factors that led to the abortion and determine if the pregnancy was unplanned.
- If she was using contraception, ask her to explain how failure occurred. Explain human reproduction, if necessary. Some women who seek an abortion may not fully understand basic information on how they became pregnant or how contraception prevents pregnancy. This may be particularly true for young women.
- The woman may have needed a therapeutic abortion where future pregnancies may pose health risks, or the pregnancy may have been terminated due to fetal abnormalities.
- Ask the woman if she desires to delay or prevent future pregnancy. Some women may not be interested in delaying pregnancy. For these women, contraceptive counseling and information on the benefits of spacing children may still be useful for future reference, or if a delay in pregnancy is medically recommended. Many women desire contraception to prevent or delay another pregnancy.
- Consider the woman's clinical condition and her personal situation.

Tell the woman about characteristics of available methods

- Determine which contraceptive methods are available and accessible at the facility and in the community.
- Explain characteristics, side effects and effectiveness of the methods available, and direct her to accessible places to obtain them.

Help the woman choose her method

- Support the woman in selecting the contraceptive method that best suits her and her partner.
- Solicit follow-up questions, explaining the characteristics of different methods and exploring resupply issues, including where contraceptives may be available in her community
- Discuss potential barriers to successful use of contraception and ways to overcome them.

Explain how the method works

- Ensure she understands how the method works.
- Help her develop a plan for continued use.

Return for follow-up care and refer to other resources

- Encourage her to return if she has concerns or problems with her method or the method becomes unacceptable. She should also return if she wants to change methods, if she needs resupply or if she wishes to stop using contraception.
- Discussions about contraception may reveal other factors affecting a woman's sexual and reproductive health, such as violence or commercial sex work.
- Providers should have resource lists available.

Key points about contraceptive counseling include:

- She could become pregnant as early as 8 days following abortion.
- She can delay or prevent another pregnancy by using contraception.
- Emergency contraception can be used within 120 hours (5 days) of unprotected sexual intercourse to prevent pregnancy, although the sooner it is used, the more effective it is.
- Correct, consistent use of male or female condoms protects against HIV and other sexually transmitted infections.
- Discuss her medical eligibility for each method, including any contra-indication.
- Explain characteristics, use, side effects, and effectiveness of the methods available.
- Explains the need for follow up for the method chosen.
- Inform where to obtain regular supply of the next dose of the contraceptive methods.

Special Contraceptive Counseling Considerations***Women with multiple abortions:***

If a woman does not want to become pregnant and has experienced multiple unwanted pregnancies and abortions, the provider should help the woman identify any difficulties she may have using or accessing contraception and work with her to resolve those difficulties.

When discussing contraception with a woman who has had multiple abortions:

- Explore with the woman her history of contraceptive use. If she has not been using contraception, ask her about this, using non-judgmental language.
- If she has been using contraception, identify and resolve any difficulties she has experienced with her chosen method or help her select a method that may be more appropriate for her.

- If resupply of her chosen method has been problematic, help her identify a method that she can obtain more consistently.
- Advise the woman about how to access and use emergency contraception (EC) if she has unprotected intercourse or if contraceptive failure occurs. If possible, provide her with a supply of emergency contraceptive pills (ECPs).

Women who have experienced violence:

When helping a woman who has experienced violence, select an appropriate contraceptive method and ask her to consider whether there is a connection between the violence and her contraceptive use. If the violence is a result of her contraceptive use, help her consider a method that cannot be detected by others. If the woman cannot control the circumstances of her sexual activity, advise her on using methods that do not require partner participation such as injectable, intrauterine devices and implants and also how to access and use EC. It may be beneficial to provide ECPs in advance.

Women with cognitive and developmental disabilities and/or mental illness:

The provider should begin by assessing what knowledge and experience the woman already has regarding contraception. The provider can then assist her in determining which method is most suitable for her by asking who she has sex with and under what circumstances.

The following information should be considered when discussing contraception with women who have cognitive disabilities and/or mental illness:

- The woman may have difficulty remembering how or when to use certain methods, such as taking a pill every day; however, these methods may still be a good option if instructions are given clearly and the woman has a caregiver who can help remind her and establish the method as part of her daily or monthly routine.
- Some women with developmental disabilities may have trouble with fine motor skills; in such cases, certain methods, such as diaphragms, may not be advisable.
- Women in this population should be instructed on how to use and negotiate barrier methods, and providers should emphasize that they must be used every time she engages in intercourse if she wants to prevent pregnancy and STIs.
- The provider should demonstrate the method—using actual condoms, diaphragms or cervical caps—and/or use illustrative instructions.
- Providers should also give the woman written and/or illustrative instructions to take home or other helpful tools such as a calendar.
- It is probable that many women in this population do not know in advance when they will engage in sexual intercourse. For this reason, the advance provision of EC pills, with specific instructions, may be advisable.
- Under no circumstances should any method be performed or provided without the woman's explicit consent. Women with cognitive disabilities and/or mental illness have the same right as other women to make choices regarding childbearing.

- Regarding informed consent, providers should be aware that the woman may or may not be her own guardian. If the woman is indeed able to make decisions about her own care, the provider should make an extra effort to ensure that she clearly understands what she is consenting to and what her choices are.

Medical Eligibility for Contraceptive Use after a Uterine Evacuation

If a woman is eligible and has been counseled and consented to the method, all methods of contraception – including intrauterine devices (IUCDs) and female sterilization – may be started at the same time as a MVA. Most methods of contraception, including modern hormonal methods (contraceptive pills, implants, injectable) may be started on the day a woman is given mifepristone. IUCDs may be inserted at the follow-up visit when it is determined that the woman is no longer pregnant; meanwhile, an interim method of contraception should be offered.

When providing contraception to a woman, her medical eligibility for each method must be considered.

Table: Medical Eligibility Criteria for Contraceptive Use: Quick Reference Chart (WHO)

KEY	
	Category 1: There are no restrictions for use
	Category 2: Generally use; some follow-up may be needed
	Category 3: Usually not recommended; clinical judgment and continuing access to clinical services are required for use
	Category 4: The method should not be used
I/C	Initiation/Continuation: A woman may fall into either one category or another, depending on whether she is initiating or continuing to use a method. Where I/C is not marked, the category is the same for initiation and continuation.
NA	Not Applicable: Women who are pregnant do not require contraception
NC	Not Classified: The condition is not part of the WHO classification for this method.
*	Other risk factors for VTE include: previous VTE, thrombophilia, immobility, transfusion at delivery, BMI > 30 kg/m ² , postpartum hemorrhage, immediately post-caesarian delivery, pre-eclampsia, and smoking
**	Evaluation of an undiagnosed mass should be pursued as soon as possible
***	Anticonvulsants include: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine, and lamotrigine. Lamotrigine is a category 1 for implants.

CONDITION		COC	DMPA	Implants	IUCD
Pregnancy		NA	NA	NA	
Breastfeeding	Less than 6 weeks postpartum				NC
	6 weeks to < 6 months postpartum				
	6 months postpartum or more				
Postpartum (non-breast-feeding)	< 21 days				NC
	< 21 days with other risk factors for VTE*				
	≥ 21 to 42 days with other risk factors for VTE*				
VTE= venous thromboembolism	< 48 hours including immediate post-placental	NC	NC	NC	
	≥ 48 hours to less than 4 weeks				
	Puerperal sepsis				
Postabortion	Immediate post-septic				
Smoking	Age ≥ 35 years, < 15 cigarettes/day				
	Age ≥ 35 years, ≥ 15 cigarettes/day				
Multiple risk factors for cardiovascular disease					
Hypertension	History of (where BP cannot be evaluated)				
	BP is controlled and can be evaluated				
	Elevated BP (systolic 140 – 159 or diastolic 90-99)				
	Elevated BP (systolic ≥ 160 or diastolic ≥ 100)				
	Vascular disease				
Deep venous thrombosis (DVT) and pulmonary embolism (PE)	History of DVT/PE				
	Acute DVT/PE				
	DVT/PE, established on anticoagulant therapy				
	Major surgery with prolonged immobilization				
Known thrombogenic mutations					
Ischemic heart disease (current or history of) or stroke (history of)				I	C
Known hyperlipidemias					
Complicated valvular heart disease					
Systemic lupus erythematosus	Positive or unknown anti-phospholipid antibodies				
	Severe thrombocytopenia		I	C	I C
	Immunosuppressive treatment				I C

CONDITION		COC		DMPA		Implants		IUCD	
Headaches	Non-migrainous (mild or severe)	I	C						
	Migraine without aura (age < 35 years)	I	C						
	Migraine without aura (age ≥ 35 years)	I	C						
	Migraines with aura (at any age)			I	C	I	C		
Unexplained vaginal bleeding (prior to evaluation)								I	C
Gestational trophoblastic disease	Regressing or undetectable β-hCG levels								
	Persistently elevated β-hCG levels or malignant disease								
Cancers	Cervical (awaiting treatment)							I	C
	Endometrial							I	C
	Ovarian							I	C
Breast disease	Undiagnosed mass	**	**	**	**	**	**		
	Current cancer								
	Past with no evidence of current disease for 5 years								
Uterine distortion due to fibroids or anatomical abnormalities									
STIs/PID	Current purulent cervicitis, chlamydia, gonorrhea							I	C
	Vaginitis								
	Current pelvic inflammatory disease (PID)							I	C
	Other STIs (excluding HIV/hepatitis)								
	Increased risk of STIs								
	Very high individual risk of exposure to STIs							I	C
Pelvic tuberculosis								I	C
Diabetes	Nephropathy/retinopathy/neuropathy								
	Diabetes for > 20 years								
Symptomatic gall bladder disease (currently or medically treated)									
Cholestasis (history of)	Related to pregnancy								
	Related to oral contraceptives								
Hepatitis	Acute or flare	I	C						
	Chronic or client is a carrier								
Cirrhosis	Mild								
	Severe								
Liver tumors (hepatocellular adenoma and malignant hepatoma)									

CONDITION		COC	DMPA	Implants	IUCD
HIV	High risk of HIV or HIV-infected				
AIDS	No antiretroviral therapy (ARV)				I C
	Clinically well on ARV therapy	See drug interactions			
	Not clinically well on ARV therapy	See drug interactions			I C
Drug interactions, including use of:	Nucleoside reverse transcriptase inhibitors				
	Non-nucleoside reverse transcriptase inhibitors				
	Ritonavir, ritonavir-boosted protease inhibitors				
	Rifampicin or rifabutin				
	Anticonvulsant therapy***				

In general, all modern contraceptive methods can be used immediately following abortion provided that:

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

If a woman has a complication during or after an abortion, it should be taken into consideration when communicating about contraception. Complications are usually temporary conditions and if a complication does not allow a woman to start her desired method, then a temporary or “bridging” method can be started in the interim until it is safe to start her desired method. For example, if the woman has an infection after MVA and desires a post-abortion IUCD, then she could use oral contraceptives until she recovers and can receive her IUCD.

All modern methods can be used by young or nulliparous women. Long-acting reversible contraceptives (LARC) have many advantages and should be offered as an option for women of all ages and regardless of her marital status.

Table: Guidelines for Selection of Contraception by Methods

Method	Timing After Abortion	Advantages	Remarks
Condoms	May be used immediately after abortion	<ul style="list-style-type: none"> • No method-related health risks • Inexpensive • Good interim method if initiation of another method must be postponed • No medical supervision required • Provide protection against RTIs and STIs (HBV and HIV/AIDS) • Easily discontinued • Effective immediately • Can be provided by non-physicians 	<ul style="list-style-type: none"> • In typical use, much less effective than IUCD or hormonal methods • Requires use with each act of intercourse • Requires continued motivation • Resupply must be available • May interfere with intercourse
Oral Contraceptives Combined (Nilocon white/ Sunaulo Gulaf) and progestin-only (mini pill)	May be used immediately after abortion or on the same day as the first dose of MA drugs	<ul style="list-style-type: none"> • Highly effective • Can be started immediately, even if infection is present • Can be provided by non-physicians 	<ul style="list-style-type: none"> • Requires continued motivation and daily use • Resupply must be available • No protection against STIs/HIV • Effectiveness may be lowered with long-term use of certain medications, including rifampin, dilantin and griseofulvin

Method	Timing After Abortion	Advantages	Remarks
Emergency Contraceptive Pills (E-con)	May be used immediately after abortion	<ul style="list-style-type: none"> • Important back-up method when contraception fails (for example, condom breaks), when no method is used or when sex is forced 	<ul style="list-style-type: none"> • Providing emergency contraceptive pills in advance as a back-up method may help prevent future unwanted pregnancies • No protection against STIs/HIV • Generally less effective than other contraceptive methods • May have side effects such as nausea and vomiting
Progestin-Only Injectable (Depo-Provera)	May be given immediately after abortion or on the same day as the first dose of MA drugs	<ul style="list-style-type: none"> • Highly effective • Can be started immediately, even if infection is present • Can be provided by non-physician • Not user-dependent, except for remembering to get the injection every three months • No supplies needed by user 	<ul style="list-style-type: none"> • May cause heavy and/or irregular bleeding initially, especially for the first few months; then most women have light or no periods • Delayed return to fertility after stopping use • Must receive injections every three months • No protection against STIs/HIV
Progestin-Only Implants (Jadelle/Indo-plant)	May be inserted immediately after abortion or on the same day as the first dose of MA drugs	<ul style="list-style-type: none"> • Highly effective Long-term contraception (Jadelle is for 5 years and Indo-plant is for 3 years) • Immediate return to fertility on removal • No supplies needed by user • High satisfaction and continuation 	<ul style="list-style-type: none"> • May cause irregular bleeding, especially spotting, or amenorrhea • Trained provider required to insert and remove • No protection against STIs/HIV

Method	Timing After Abortion	Advantages	Remarks
IUCD (Cu T-380 A)	IUCD can be inserted after MVA, provided the risk or presence of infection can be ruled out. After MA, IUCDs can be inserted as soon as reasonably sure woman is no longer pregnant.	<ul style="list-style-type: none"> • Highly effective • Long-term contraception; effective for 12 years. • Immediate return of fertility following removal • Does not interfere with intercourse • High satisfaction and continuation • No supplies needed by user • Requires only monthly checking for strings by user • Only one follow-up visit needed unless there are problems 	<ul style="list-style-type: none"> • May increase menstrual bleeding and cramping during the first few months • Complications include uterine perforation during insertion, which is rare, and expulsion • May increase risk of pelvic inflammatory disease (PID) and subsequent infertility for women at risk for RTIs and STIs (HBV and HIV/AIDS) • Trained provider required to insert and remove
Voluntary Sterilization (VS) (Female VS and Male No-Scalpel Vasectomy (NSV))	FVS can be performed after uncomplicated MVA. After MA, FVS may be performed as soon as it is reasonably certain a woman is no longer pregnant. Consider bridging with a short-term method if there is a delay.	<ul style="list-style-type: none"> • Permanent method • Highly effective • Once completed, no further action required • No change in sexual function • No long-term side effects • Female VS immediately effective 	<ul style="list-style-type: none"> • Adequate counseling and fully informed consent are required before VS procedures to minimize risk of regret • Slight possibility of surgical complications • Requires trained staff and appropriate equipment • No protection against STIs/HIV • Male VS requires an interim method

Method	Timing After Abortion	Advantages	Remarks
Fertility awareness (natural family planning)	Not recommended for immediate use, as the first ovulation after an abortion will be difficult to predict and the method is unreliable until a regular menstrual pattern has returned. In women who have had regular menstrual periods prior to the abortion, signs of ovulation can typically be discerned after at least one postabortion menstrual period has taken place.	<ul style="list-style-type: none"> • No cost associated with method • No method-related health risks • No medical supervision required • Easily discontinued • Effective immediately 	<ul style="list-style-type: none"> • Unreliable immediately after abortion • Less effective than hormonal contraceptives, condoms or IUCD • Alternative methods recommended until resumption of normal cycle • Requires extensive instruction and counseling • Requires continued motivation and a thorough understanding by the woman and her partner of how to use the method • Does not protect against STIs/HIV

Use of Contraception in Abortion with Complications

Infection:

In cases where pelvic an infection is evident or presumed, the provider should advise the woman to avoid intercourse until the infection is resolved or ruled out. When complete abstinence is not realistic, certain methods are not recommended.

Female sterilization is not appropriate until infection is either ruled out or resolved, as the presence of infection may increase the risk of post-surgical infection. Intrauterine methods are not appropriate until infection is resolved because insertion may substantially worsen the condition. Use of a shorter acting method like pills or DMPA can be safely used during this time to provide a “bridging” method until the infection has been cleared and a woman can undergo her sterilization or IUCD placement.

Genital Injury:

Genital injury includes uterine perforations, cervical tears, vaginal trauma and lacerations. These injuries may require a delay in the use of certain contraceptive methods depending on the location and severity of the injury. Methods that may be temporarily restricted include female

sterilization and IUCD. In these cases, the provider must make a clinical judgment about which methods to recommend for interim use.

Excessive Blood Loss:

Excessive blood loss may require a delay in the use of female sterilization and IUCDs, depending on the severity of the loss. For sterilization, delay is recommended if laboratory tests or clinical signs indicate anemia.

Emergency Contraception

Emergency contraception (EC) is a particularly important option for preventing pregnancy after unprotected intercourse or contraceptive failure. For women receiving abortion services, providing EC pills in advance as a back-up method may help prevent future unwanted pregnancies; however, the use of EC will not terminate or interfere with a pregnancy once it is established.

Types of EC:

1. Intrauterine contraceptive device (IUCD): When inserted within five to seven days after unprotected intercourse, a copper IUCD is 99 % effective in preventing pregnancy.
2. Emergency contraceptive pills (ECPs): It is 75 to 95 % effective when used within five days after unprotected intercourse (22). To be most effective, ECPs should be started as soon as possible after unprotected intercourse.

Although either progestin-only pills (POPs) or combined estrogen-progestin oral pills (COCs) may be used, POPs are more effective and produce fewer side effects. When taken within 24 hours of unprotected intercourse, progestin-only ECPs have been found to reduce the risk of pregnancy by 95 %. When taken within 120 hours of unprotected intercourse, EC reduces the risk of pregnancy by 60-94%.

EC Protocol: Dosages of EC pills

In some settings, pills specifically packaged for EC are available. Where packaged ECPs are not available, taking a specific dose of commonly packaged oral contraceptives is acceptable. Recommended dosages depend on the formulation of the particular pills used. The following are examples of ECP regimens:

- POPs: Single dose of 1.5 mg of levonorgestrel taken within five days of unprotected intercourse.
 - Where pills containing 1.5 mg of levonorgestrel are not available, two pills of 0.75 mg can be taken together.
 - Other POPs with levonorgestrel can also be used but, depending on the pill composition, women will need to take the number of pills equal to 1.5 mg of levonorgestrel.

- Women should be advised that the progestin-only regimen has the highest effectiveness and fewest side effects.
- COCs: Two doses of 0.1 mg (100 mcg) of ethinyl estradiol plus either 0.5 mg of levonorgestrel or 1.0 mg of norgestrel taken 12 hours apart but within 120 hours after unprotected intercourse.

Considerations for Postabortion Care

- Eligibility for contraception after PAC is the same as after induced abortion.
- If PAC is uncomplicated, all methods of contraception may be offered and provided to the woman as long as she is medically eligible, understands the methods and gives informed consent.
- If a woman has signs and symptoms of infection, IUCD placement or female sterilization should be delayed until the infection has resolved.

6. Summary

- Pregnancy options counseling should not be required or serve as a barrier to receiving abortion care.
- Young women are capable of making the decision to terminate a pregnancy, and may need more information to aid their decision-making and informed consent process.
- Counseling should be conducted in an area where no one else can see or overhear. Information provided by the woman is confidential and should not be released without her voluntary authorization.
- To give voluntary informed consent, women must know all their options and their benefits and risks. They must also be able to choose without pressure or coercion.
- Clients respond best to counselors who provide compassionate, non-judgmental support; convey empathy; and create a safe environment in which the woman is comfortable exploring her feelings.
- Woman-centered counseling is structured completely around each woman's needs and concerns, such as those of young women and other special considerations.
- Woman-centered counseling includes such techniques as active listening, open-ended questioning, reflecting feelings and attention to non-verbal communication.
- If both MVA and MA are available, the counselor should explain the differences between them and help the woman explore which option is best for her.
- Referral protocols and resource lists that provide simple, accurate, up-to-date information are essential components of an effective referral service.
- Counseling should conclude with summarizing key concepts discussed, what to expect, and ensuring that the woman understood what was discussed and her needs were addressed.

- Every woman receiving abortion care, including young women, should be offered contraceptive counseling and, if she desires, a contraceptive method.
- Providing contraceptive services at the same time and in the same location as abortion care can help ensure that a woman receives a contraceptive method before leaving the facility.
- Inclusion of partners in contraceptive counseling may increase the effectiveness of the counseling, but should only be done if the woman, during a one-to-one conversation with the provider, indicates that she wants her partner involved. If not, she should be counseled and given the method privately and no information should be shared with the partner.
- Providers should understand that women may have special situations in their lives that will affect their contraceptive needs and use, and should be prepared to address those situations.
- Providers need to be knowledgeable about the range of contraceptive methods and consider each woman's medical eligibility for various methods, including EC.

MODULE 4:

YOUNG WOMEN AND ABORTION CARE

Key topics:

1. Definition of the term “young woman” and the context of young women in Nepal.
2. Provision of abortion care to young women.
3. Need of young women for contraceptives and referral.

1. Introduction: Why Focus on Young Women?

Young women face unique vulnerabilities and barriers to safe abortion care. Social, economic, logistical, policy, and health system barriers to safe abortion care for young women, explain why young women often find no alternative than to resort to unsafe abortion, even in settings where safe abortion is legal.

Stigma and negative attitudes, fear of negative repercussions, lack of access to comprehensive sexuality education, limited financial resources, cost of care, transportation, involvement laws and concerns over privacy and confidentiality are many of the reasons why young women who obtain abortion care tend to access it later in the pregnancy than adults, and why they are more likely to delay seeking help for abortion-related complications than adults.

The disproportionately high number of young women who resort to unsafe abortion makes it critical to ensure that young women, independent of marital status, have access to safe abortion as a part of comprehensive health-care services.

Defining Young Women

People in the developmental stage between the onset of puberty and a culturally determined entrance to adulthood are called adolescents, youth, and young people. People aged 10-19 are widely accepted as “adolescents”, while “youth” are 15-24 years of age and “young people” encompasses both age ranges, ages 10-24. In this context, the term “young women” refers to women between the ages of 10-24 years old. It is important to remember that age alone cannot define young women or help us understand their needs. Young women are diverse and their circumstances, including marital, educational and socioeconomic status and living conditions are all important factors to consider when serving and working with this population.

The Context of Young Women in Nepal

- In Nepal, adolescents and youth (A&Ys) account for 33 percent of the total population of Nepal. Young people aged 10-14 years constitute 13.51%, 15-19 years constitute (10.97%) and 20-24 years constitute (8.36%).
- Marriage at an early age is very common in Nepal. By the age of 20-24 years, more than two-thirds of young women have gotten married. Early marriage starts child bearing at an early age with potential risk to the reproductive health of young women. Eighteen percent of all births are attributed to women less than 20 years of age. About 37 percent of young women under 15 years of age will contribute to population growth and migration in the country (NDHS 2011).
- The contraceptive prevalence rate in Nepal for currently married women aged 15-49 years using any method of family planning increased from 3% to 50% during the last 30 years [against the Millennium Development Goals (MDGs) target of 67 percent by 2015]. In Nepal, the major known contraceptive methods among female adolescents and youth are: condom (96%), pills (80%), injectable (85%), female and male sterilization (63% and 58% respectively), emergency contraception (16%), withdrawal (9%) and other methods (19%). Fourteen percent of married adolescents 15-19 years report using a modern contraceptive method, while the unmet need is 41%.

2. Making Abortion Care Appropriate for Young Women

Below is a summary of the issues in abortion care for young women. Each of these issues will be described in greater detail in subsequent sections.

The Critical Importance of Effective Youth-Specific Counseling:

- Young women should be allowed to make a free, informed decision and that decision should be respected.
- Providers should be able to provide supportive and non-judgmental counseling. Because young women face so many barriers to accessing safe abortion care, it is critical that providers build skills in gaining young people's trust and honoring that trust. Respond to questions fully and honestly, in a way that respects a young woman's decisions even if it is not the choice the provider would want her to make.
- Young women may be uncomfortable talking about topics related to sex and sexuality, requiring the provider to spend more time building rapport and trust. If possible (and true), providers should try to normalize the conversation by saying, "I have treated a number of young women with the same concern you have." Providers should give young women opportunities to express what she already knows and her opinions, through open, or as a last resort, leading questions, before providing more information.
- Sexual coercion or violence, STIs, and emergency contraception are especially important counseling topics to cover with young women.

- Young people may use different words for various terms than the ones providers use. Providers should ask the young women what word she uses, and ask what they mean. The provider should then explain the meaning of common medical term such as vagina, vulva, sexual intercourse, abortion and then use those words during counseling.
- Young women may require that the same information be provided more than once, perhaps in different ways. This is likely to make the counseling session longer than one with older women. Use clear and understandable language to convey all relevant information on the implications of each treatment option.
- Providers are often seen as authority figures and young women may be intimidated and afraid to ask for more information, options, or additional services; or may accept the provider's recommendation even if these make them uncomfortable. Providers should encourage young women to ask questions, and solicit opinion before making any suggestions. Avoiding lecturing or scolding.
- Providers should use multiple ways to communicate support, including positive, open body language by facing her, removing any physical barriers such as a desk, leaning, slightly forward, making appropriate eye contact and nodding.

A counselor who works effectively with young people:

- Has the ability to build rapport with young women and earn their trust
- Respects their different life circumstances
- Has excellent communication skills
- Using clear and understandable language
- Avoiding lecturing or scolding.
- Using multiple ways to communicate support, including positive, open body language by facing her, removing any physical barriers such as a desk, leaning, slightly forward, making appropriate eye contact and nodding.
- Understands that young people sometimes communicate differently than adults
- Has accurate knowledge of sexual and reproductive health and local guidelines, laws and cultural benefits

Evolving Capacities and the Principle of Capability

- While there are no universally accepted definitions of young people's capacity to make decisions, it is widely recognized that this capacity is evolving, and is not linked directly to chronological age. Young people of a given age can have a wide range of decision-making capacities.
- The Convention on the Rights of the Child affirms children's and young people's right to independent decision-making in accordance with their capacities. This international convention recognizes that support and guidance can be helpful for any young person, but parents and guardians should provide direction only "in a manner consistent with" the young person's capacities. No adult should attempt to direct a young person's decision-making if s/he has the capacity to make a decision.

- Most young people can understand the risks and benefits of medical procedures as well as adults, and are able to make decisions about their medical care independently. When local laws and policies allow, providers should assume a young person's capacity to make a decision, unless counseling reveals the young woman desires the support of a guardian in decision-making.
- Because determining capacity (or incapacity) remains subjective, a useful principle of capability has been provided: Young people who understand that they need to protect their reproductive health, and who request reproductive health services to that end, can be considered capable of receiving reproductive health counseling and services without parental oversight. The same principle of capability can be applied to abortion care for young women.

Supporting Young Women's Needs and Wishes When a Third Party is Involved

- In Nepal, a young woman who is less than 16 years old must be accompanied by someone who can give consent for the procedure. This may be a family member, friend, or her partner. If the young woman is 16 years of age or older, her consent alone is enough to proceed with the procedure.
- If a third party is involved in the counseling, providers should ask the client in private first if she wants to involve the third party in her decision-making. If she says yes, but appears nervous, they can help her decide how to discuss her feelings with the third party. If she says no, her decision to not include the third party should be accepted. If the young woman must, by law, notify or get consent from a third party, and she is not eligible for any exemption or alternative, providers should explain this obligation and offer to help her talk to the third party.
- Decision making on abortion often takes place mostly outside the clinic setting, and a young woman may be particularly susceptible to adults' influence, especially from a partner or someone who has power over her. Providers should ask questions to ensure that she has not been pressured or coerced by anyone, including a partner, family, community or friends, to make her decision.

To make sure that her decision is fully hers:

- Meet alone with the young woman first to have a private conversation free from other people's influence.
- Ask her to carefully explain her decision, paying attention to any personal views or desires she expresses.
- Listen for language that can indicate other people's influence in her decision-making, such as, "My boyfriend thinks I should..." or "My mother wants me to..."
- She may be influenced by other people's views and desires, but she needs to understand that her own life will be most directly affected by her decision and that the decision is hers to make.

Confidentiality:

- Explanation and enforcement of confidentiality are crucial elements of appropriate care for young women.
- Begin the counseling and consultation session by reassuring the young woman that all of the information exchanged and care she receives are confidential and will not be shared without her permission.
- Administrators and providers need to have strong confidentiality policies and uphold them so young women feel secure seeking services, knowing their privacy will be respected. It is useful to explain to the young woman the specific ways in which the staff protects confidentiality in the facility.

Supportive and Non-Judgmental Attitude

- Young women have a right to make a free, informed decision about their pregnancy and that decision must be respected. Studies show that providers are more likely to respect a decision with which they agree, but it is important for providers to respect a young woman's decision even if they do not agree with it. If information is requested, providers should make sure that a young pregnant woman understands all of her options, helps her examine how her decision will affect her and the people important to her, and support her decisions.
- Individual providers can mitigate the impact of social barriers and help young people to get the care they need by providing health care in an environment in which preconceived notions of gender, age, sexuality and abortion have been thoughtfully examined, and by recognizing and respecting that young women have the right to life and health, to accurate information and to the highest attainable standard of health care.
- Providers should make a conscious effort to keep personal beliefs from limiting their ability to give the best care possible to young women. Providers often hold a range of attitudes—both conscious and unconscious—about young people's sexuality, which can have a significant impact on the content and quality of abortion-related care for young women.

First Obstetric Event

- Providers should recognize that this may be the young woman's first obstetric event, and she may be nervous or afraid.
- Clinical provision of abortion care for young woman should focus on their specific needs and issues. Any provider dealing with young women should focus on their specific needs besides the general service delivery. Key clinical considerations specific to young women include: For all physical examinations, ensure that there is visual and preferably auditory privacy before proceeding with pelvic examination; explain each step to the young woman, including what she can expect before and during the examination.
- Do not begin to examine her until receiving her consent even if an adult has legally consented on her behalf.
- When the pelvic examination begins, ask permission before touching her with a hand or speculum.

Pain Threshold

- Young age and null parity are risk factors for experiencing more pain. Young women may also have difficulty imagining the level of pain associated with the abortion or complications, so examples of comparisons are needed. Non-pharmacological methods in addition to pharmacological methods for pain management should be utilized and explained in relevant and easy to understand terms when applicable.

Cervical Dilatation

- A young, particularly nulliparous, woman's cervix may be more difficult to dilate than that of an older woman and thus may require a slower and/or longer dilation process. The dilation process can be facilitated by starting with a smaller dilator than is required by women with one or more children.

Countering Misinformation

- A young woman may fear that an abortion will harm her, based on misinformation from adults or peers, or anti-choice campaigns and messages.
- Providers should be prepared to counteract misinformation by providing factual evidence-based information. Studies show that many young women seeking an abortion fear that the pregnancy is their only chance to bear a child because of myths that an abortion causes infertility. Providers should be aware of this and be able to answer any concerns about safety accurately and completely.

Risks versus Benefits:

- Providers should give complete information about possible complications and side effects, as they may be the only source of accurate information; omitting information betrays the women's trust.
- The provider can help a young woman weigh the potential risks against the benefits she has identified to help her make an informed decision. It may be helpful to compare the risks of a safe abortion or a given contraceptive method to carrying a pregnancy to term or to other non-reproductive health medical procedures (for example, an appendectomy).
- When different treatment options are available for uterine evacuation and/or pain management, providers should respect the young woman's informed decision about the treatment she prefers.

Post abortion Contraception for Young Women

- It is important to ask rather than assume what the young woman's immediate and longer-term reproductive plans are and structure the discussion around those plans.
- Clinical eligibility guidelines for post abortion contraceptives for young women are the same as for adult women.

- As with abortion, young women may have concerns about the safety or efficacy of contraceptive methods, which may be based on misinformation.
- Young women may not know how pregnancy occurs or is prevented. For example, they may have heard that pregnancy won't occur if they have intercourse in certain positions, in water or during menstruation. Because of misinformation like this, it is important that providers explain how a contraceptives works, including efficacy, potential side effects such as change in menstruation (less/more) weight changes or breast tenderness and their incidence, and the long-term clinical implications of any such side effects. Providers can ask indirect questions such as, "What are some things your friends say about how you can and can't get pregnant?" and "What are some things you heard about this method?" to find out whether a young woman is misinformed.
- Providers should learn from the young woman what barriers she may face in using different contraceptive methods and help the young woman identify the most appropriate option for her. A young woman's privacy needs can also influence her selection of contraceptives method; for example, an injectable may suit a young woman with high privacy needs, even if her preferred method might otherwise be something else.
- They may have increased needs for a discreet method of birth control that does not need regular resupply like long-term, reversible family planning methods. These young women should be provided with correct information about these methods.
- The use of emergency contraceptive method is equally important. In case of unprotected sex or contraceptive failure, if available young women should be offered to leave the facility with at least one dose of emergency contraception or a prescription to obtain it from a pharmacy.
- Young women should be informed about where to obtain a regular supply of a chosen contraceptive method, if appropriate.

Key points to be emphasized to young women about each contraceptive method include:

- She could become pregnant soon following her abortion, even prior to return of periods
- She can delay or prevent another pregnancy by using contraceptives.
- Emergency contraception (EC) can be used within 120 hours (5 days) of unprotected sexual intercourse to prevent pregnancy, although the sooner it is used, the more effective it is. It should be used as soon as possible i.e. within 72 hours or 120 hours in case of hormonal tablets. IUCD as EC can be inserted up to 7 days of unprotected intercourse.
- Correct, consistent use of male or female condoms protects against HIV and other sexually transmitted infections.
- Discuss her medical eligibility for each method, including any contraindication.
- Explain characteristics, use, side effects, and effectiveness of the methods available.
- Explains the need for follow up for the method chosen.
- Inform her of where to obtain the next dose of her preferred contraceptive method.

Referrals

- Because of the barriers they face in accessing health-care services, young women may use services less than adult woman. Providers should seize the opportunity to provide or refer young women to any other health-related information and services they may need. These can include services related to age-appropriate physical and psychosocial development, physical and sexual abuse, substance abuse, nutritional status, vision, sexually transmitted infections and tuberculosis. Providers should know where to refer young women for services that cannot be provided at their facility, and make sure that the referrals are made to knowledgeable providers who serve young women with respect.

3. Summary

- Young women have a right to make a free, informed decision about their pregnancy and that decision must be respected.
- Providers need to provide youth-specific counseling and make abortion care appropriate for young women.
- Providers need to offer youth-specific post abortion contraceptive counseling and method provision.
- Providers should provide young women with health-related information and services they may need, or refer them if appropriate.

MODULE 5:

INFECTION PREVENTION

Key Topics

1. Infection prevention and transmission routes in the abortion care setting.
2. Essential elements of infection prevention, including standard precautions.
3. Procedures for managing occupational exposure to blood and body fluids.
4. Processing contaminated instruments, and safely disposing of contaminated wastes including disposal of POC.

1. Infection Transmission

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

Since abortion procedures and care involve contact with blood and other body fluids, all abortion service providers, assistants and support staff in all facilities should understand and apply standard precautions for infection prevention and control. It is a health-care worker's responsibility to take correct and consistent measures to guard against the spread of infection, using appropriate hygiene and infection prevention techniques and behaviors. Appendix K: *Infection Prevention Action Plan Worksheet* provides an opportunity for facility staff to improve their infection prevention methods.

Key points

- Blood-borne pathogens can cause incurable infections such as HIV and HBV, HCV, etc.
- Health facilities are common setting for disease transmission.
- Infectious agents are transmitted through cuts or openings in skin and through mucous membranes.
- Most common transmission involves injuries from sharp instruments, such as needle sticks, or splashes of blood on non-intact skin or mucous membranes.
- Infection prevention practices protect clients, providers, assistants, co-workers and our communities against blood-borne pathogens.

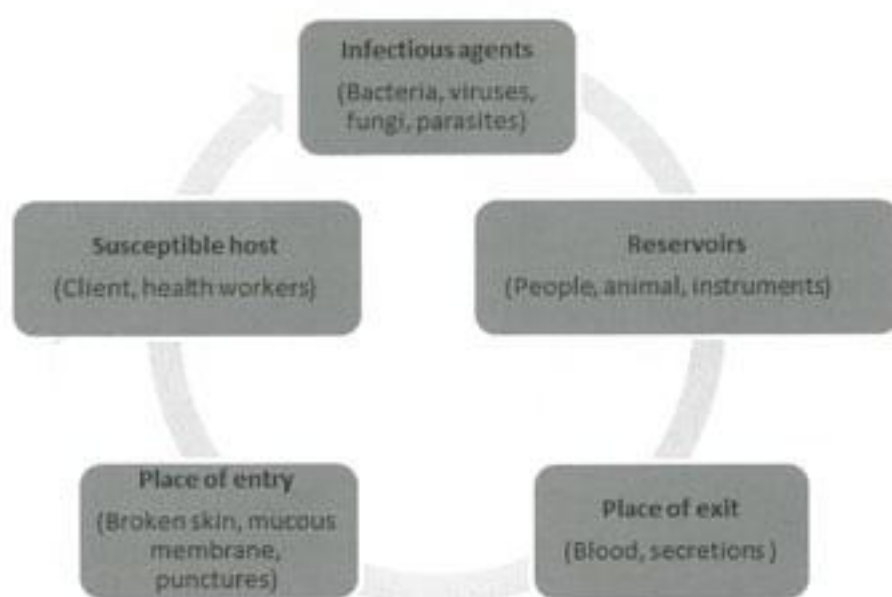


Figure: Mode of Transmission (Direct or Indirect Transmission)

2. Standard Precautions

Standard precautions are simple infection-control practices that should be used in the care of all patients and staff, at all times, to reduce the risk of transmission of blood-borne infections. Remember that a person can carry infection without showing any noticeable signs or symptoms.

Key points:

- Treating all clients with the same precautions is called “standard precautions” and was formerly called “universal precautions.”
- Properly handle blood and body fluids and use appropriate prevention techniques with all clients and staff at all times, regardless of their actual or perceived health status.
- Apply infection-control measures designed to block transmission between the person and potentially infectious bodily fluids, including washing hands and wearing barriers such as gowns, gloves, aprons, masks, eyewear, and footwear.

- Consider all blood and other body fluids from every person to be infectious.
- Wash hands immediately before and after contact with contaminated items, even if gloves are worn.

Elements of standard precautions include:

1. Hand washing
2. Personal protective barriers
3. Aseptic technique.
4. Proper handling and disposal of sharp items.
5. Proper instrument handling and processing.
6. Proper infectious-waste disposal
7. Environment cleanliness.

Hand Washing

Hand washing is the first step of infection prevention. All staff should wash their hands thoroughly before and after coming into contact with each patient, as well as immediately following any contact with blood, body fluids, mucous membranes, or contaminated items, even if gloves are worn.

Key points for simple hand washing:

- **Wet** your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
- **Lather** your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails.
- **Scrub** your hands for at least 20 seconds.
- **Rinse** your hands well under clean, running water.
- **Dry** your hands using a clean towel or air-dry them.

Barriers (Personal Protective Barriers)

Put on barriers before an abortion procedure such as cap, mask, eyeglass, gown, gloves, and gum boots. Protective barriers for providers are used when there is danger of infection from hands or contaminated surfaces and materials. Barriers must be worn whenever a particular part of the body is likely to be exposed to blood or body fluids.



Figure: Universal Precaution

Using gloves properly:

- Always change gloves between client contacts; after contact with a potentially contaminated item; before touching sterile instruments; and between rectal and vaginal examinations.
- Wear gloves when drawing blood or starting an intravenous line.
- Remove gloves and wash hands immediately following a procedure.
- Wear gloves (ideally, utility gloves) while cleaning if there is the potential for hand contact with blood or other body fluids.

Aseptic Technique

The three critical components of aseptic technique are antiseptic preparation, no-touch technique, proper processing and handling of instruments.

Antiseptic Preparation:

Antiseptic preparation is needed because resident vaginal flora can very easily be introduced when inserting the cannula into the uterus during uterine aspiration procedures. Ask the woman to clean the vagina using water to remove microorganisms normally present in the vagina. The provider then performs cervical antiseptic prep to remove microorganisms from the cervix prior to inserting an instrument. (For more information on cervical antiseptic prep, See Module 6, Section 3: *Uterine Evacuation with Ipas MVA Plus*™).

No-Touch Technique:

It is possible to introduce pathogens, especially vaginal ones, into the uterus when passing an instrument into the uterine cavity. To avoid introducing pathogens, it is essential to use no-touch technique during uterine evacuation procedures and when handling sterile instruments.

- Always handle instruments by the end that does not come into contact with the woman.
- No instrument that enters a woman's uterus should come into contact with a contaminated surface before insertion through her cervix.
- The tenaculum, cannula, or dilator tips should not touch the providers' gloves, the woman's vaginal walls, or unsterile parts of the instrument area.

Proper Handling and Disposal of Sharp Items:

The greatest hazard of HIV transmission in health care settings is through skin puncture with contaminated needles or sharps. This also applies to transmission of HBV and HCV. Most sharps injuries involving such transmission are through deep injuries with hollow-bore needles. Such injuries frequently occur when needles are recapped, cleaned, or disposed of inappropriately. The proper handling of sharps can significantly reduce this risk: do not carry hypodermic needles, set aside a specific area to keep sharp objects during procedures, and announce the presence and passage of any sharps. Although recapping needles is to be avoided whenever possible sometimes recapping becomes necessary. When this is the case, a single-handed "scoop and pull" method should be used. Puncture resistant disposal containers must be available and readily accessible for the immediate disposal of sharps.

Scoop and pull method instruction:

- Scoop cap onto needle without touching cap or needle.
- Pull cap onto needle by holding cap near base.
- Never put fingers on tip of cap (NEVER PUSH IT ON) while recapping needle.

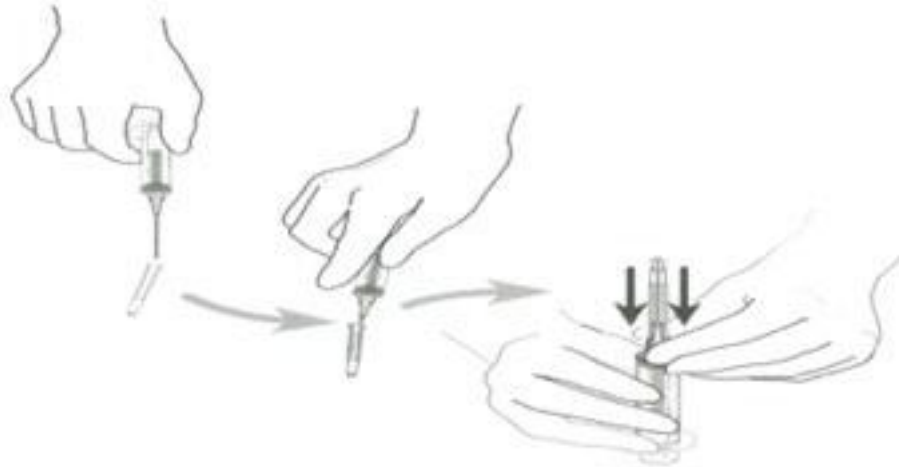


Figure: Scoop and pull method

Management of Accidental Exposure:

- If exposure caused bleeding, allow it to bleed briefly.
- Immediately flush the exposed area with clean water. Wash wounds and skin thoroughly with soap and water. Flush the mucous membranes (nose, eyes, mouth) with water or saline only. If water is not available, use an antiseptic solution.
- Determine the type of fluid and type of exposure.
- Evaluate the exposure source by testing a known source or by evaluating the risk posed by an unknown source.
- Evaluate the exposed person's immune status, including his or her history of HBV vaccination.
- Give post-exposure prophylaxis for exposures posing a risk of infection if available.
- Offer voluntary, confidential HIV, HBV and HCV counseling and testing, if available.
- Consult an infectious-disease specialist.
- Record the exposure and actions taken according to facility protocols. Discuss how another exposure could be prevented in the future and share lessons learned with all staff.
- During follow-up care, advise the exposed person to seek medical evaluation for any acute illness that develops.

Proper Instrument Processing

Immediately after use, all reusable surgical instruments used in the abortion procedure should be cleaned and high-level disinfected or sterilized to prevent them from infecting other women during subsequent procedures. The most important steps of instruments processing are:

1. Decontamination soak
2. Cleaning/drying
3. Sterilization or high-level disinfection (HLD)
4. Safe storage



Figure: Instrument Processing

Appendix E: *Instrument Processing Skills Checklist: Ipas MVA Plus and Ipas EasyGrip Cannulae* provides a full list of all necessary processing steps. This checklist can be used for self-assessment purposes, or in a training situation to evaluate the instrument processing skills of a trainee.

Decontamination

Following the procedure, all instruments should be kept wet until cleaning. Letting the devices dry may make it difficult to completely remove all contaminants. A disinfectant such as a 0.5% chlorine solution for 10 minutes should be used for decontamination soak. Change the chlorine solution whenever it becomes very bloody. For easy accessibility, the container used for the decontamination soak should be kept close to the procedure area – for example, on the bottom shelf of the instrument trolley. Soaking in a disinfectant, however, does not make items safe to handle with bare hands. It is essential to wear gloves and face protection, and forceps to when removing instruments from the solution.

Cleaning and Drying

While decontamination makes items safer to handle, physical cleaning is the second step in processing, which removes organic material, dirt and foreign matter that can interfere with sterilization or HLD. Cleaning also drastically reduces the number of microorganisms. Cleaning refers to scrubbing with a brush, detergent and water and is a crucial step in processing. Without cleaning, further processing might not be effective.

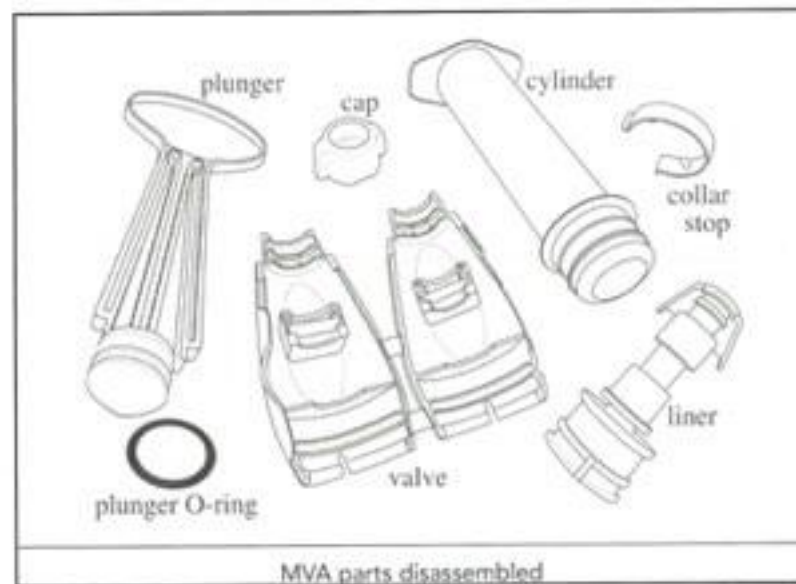
Wearing gloves, submerge the cannula and aspirator completely. Make sure to draw the solution into the aspirator and cannula. Aspirators must then be disassembled before cleaning and further processing.

To disassemble the MVA Plus aspirator:

1. Pull the cylinder out of the valve.
2. Press down the cap-release tabs to remove the cap.
3. Then open the hinged valve by pulling open the clasp and remove the valve liner.
4. Disengage the collar stop by sliding it sideways under the retaining clip or removing it completely from the cylinder.
5. Pull the plunger completely out of the cylinder.
6. Displace the O-ring from the plunger by squeezing the sides of the O-ring and rolling it down into the groove below. It is not necessary to completely remove it.



Steps to **clean the disassembled instruments** are:



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



Figure: Clean thoroughly

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

Sterilization/ High Level Disinfection (HLD)

Sterilization kills all microorganisms, including bacterial endospores such as those that cause tetanus and gas gangrene. High-level disinfection (HLD) destroys all microorganisms including hepatitis and HIV but does not reliably kill bacterial endospores.

Sterilization is best achieved with pressurized steam (autoclave) or soaks in fresh glutaraldehyde solution. HLD can be achieved by shorter soaks in glutaraldehyde or bleach (sodium hypochlorite) solutions or by boiling. Instruments that were cold processed (soaked in solution) must be thoroughly rinsed after processing. Instruments that were subjected to HLD may be rinsed in boiled water. Place the sterile instruments on a sterile container and allow to air dry before storage.

NOTE: All MVA plus syringe and cannulae must be HLD or sterilized prior to reuse. Cannulae must be sterile or high-level disinfected **at the time** of use. Once aspirators are sterilized/HLD then they only need to be kept in a clean place until next use. Since the aspirator does not ever touch the woman, it does not have to be sterile or HLD at the time of the procedure as long as it has gone through the HLD/sterilization process between patients.

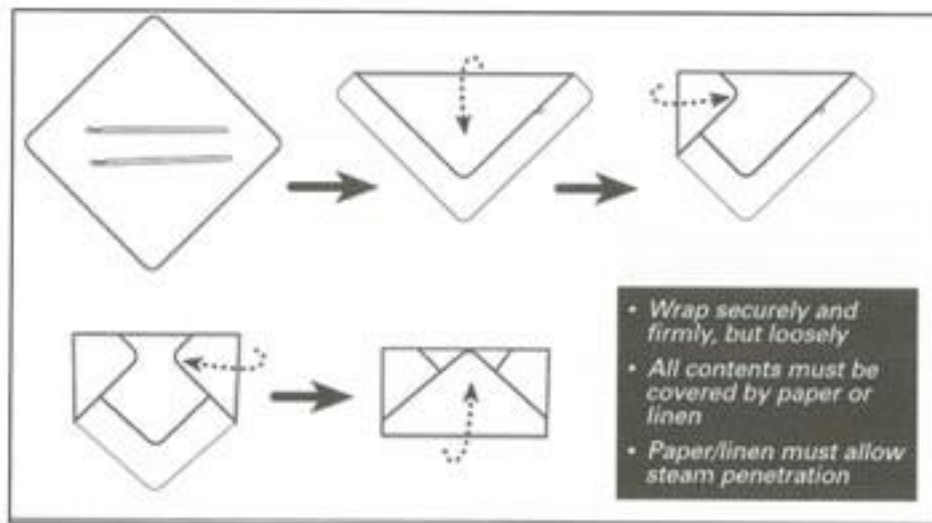


HLD soak and rinse

Steps to Sterilize Using Steam Autoclave:

1. All parts of the Ipas MVA Plus aspirator and Ipas EasyGrip cannulae can be steam sterilized at 121°C (250°F). Parts should not touch each other and the collar stop should be completely removed from the cylinder. Arrange the instruments without obstructing apertures or the opening at the base end of the cannulae to allow drainage.
2. Since the cannulae, particularly the smaller sizes, may curve in a steam autoclave, package them in paper or linen. Place the clean Ipas EasyGrip cannulae and the Ipas MVA Plus aspirator in a single layer in a steam autoclave. Note that steam sterilizing unwrapped Ipas EasyGrip cannulae for 30 minutes may result in slight curvature.
3. Process instruments in the steam autoclave for 30 minutes at 121°C (250°F).
4. Cool all instruments before using.

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



Steps to Sterilize Using Glutaraldehyde:

1. Completely immerse the instruments so that the solution fills them completely.
2. Soak in glutaraldehyde solution for the time recommended by the manufacturer—for example, 10 hours for Cidex.
3. Remove with sterile gloves or forceps.
4. Rinse all parts with sterile water. Do not use tap water to rinse.
5. Dry with a sterile cloth, if desired.
6. Change the solution according to the manufacturer's instructions. Generally, glutaraldehyde has a 14-day shelf life after being activated, but it should be discarded sooner if the solution HLD soak and rinse becomes cloudy. Do not use below 25° C (77° F).

Referrals

- Because of the barriers they face in accessing health-care services, young women may use services less than adult woman. Providers should seize the opportunity to provide or refer young women to any other health-related information and services they may need. These can include services related to age-appropriate physical and psychosocial development, physical and sexual abuse, substance abuse, nutritional status, vision, sexually transmitted infections and tuberculosis. Providers should know where to refer young women for services that cannot be provided at their facility, and make sure that the referrals are made to knowledgeable providers who serve young women with respect.

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INFECTION PREVENTION

Key Topics

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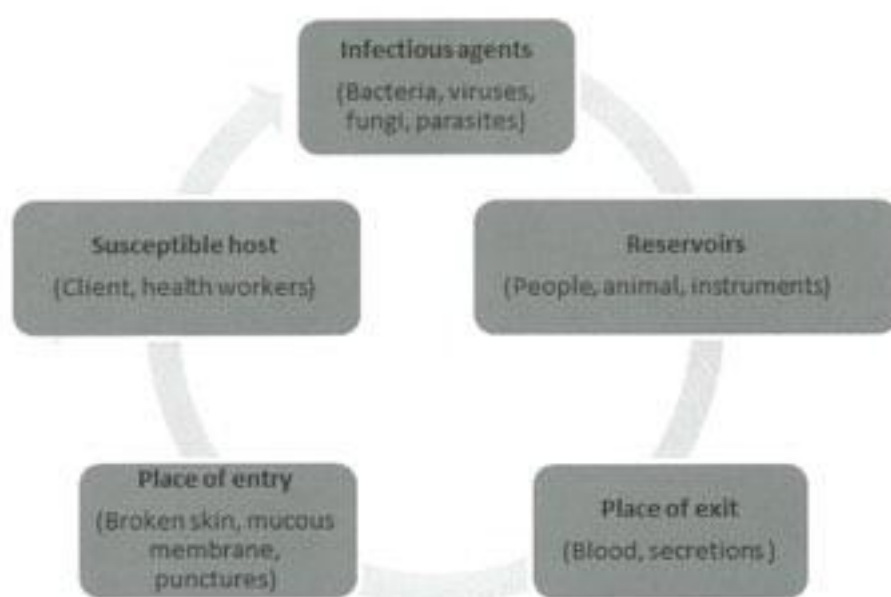


Figure: Mode of Transmission (Direct or Indirect Transmission)

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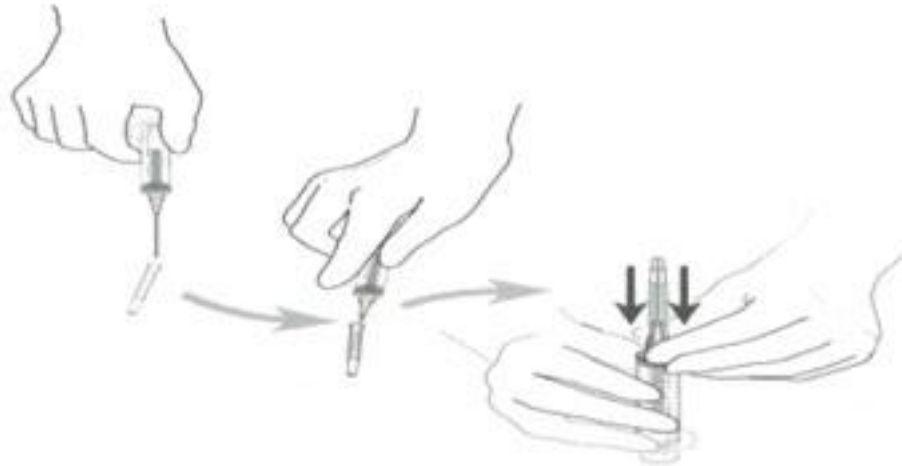


Figure: Scoop and pull method

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- Determine the type of fluid and type of exposure.
- Evaluate the exposure source by testing a known source or by evaluating the risk posed by an unknown source.
- Evaluate the exposed person's immune status, including his or her history of HBV vaccination.
- Give post-exposure prophylaxis for exposures posing a risk of infection if available.
- Offer voluntary, confidential HIV, HBV and HCV counseling and testing, if available.
- Consult an infectious-disease specialist.
- Record the exposure and actions taken according to facility protocols. Discuss how another exposure could be prevented in the future and share lessons learned with all staff.
- During follow-up care, advise the exposed person to seek medical evaluation for any acute illness that develops.

Proper Instrument Processing

Immediately after use, all reusable surgical instruments used in the abortion procedure should be cleaned and high-level disinfected or sterilized to prevent them from infecting other women during subsequent procedures. The most important steps of instruments processing are:

1. Decontamination soak
2. Cleaning/drying
3. Sterilization or high-level disinfection (HLD)
4. Safe storage



Figure: Instrument Processing

Appendix E: *Instrument Processing Skills Checklist: Ipas MVA Plus and Ipas EasyGrip Cannulae* provides a full list of all necessary processing steps. This checklist can be used for self-assessment purposes, or in a training situation to evaluate the instrument processing skills of a trainee.

Decontamination

Following the procedure, all instruments should be kept wet until cleaning. Letting the devices dry may make it difficult to completely remove all contaminants. A disinfectant such as a 0.5% chlorine solution for 10 minutes should be used for decontamination soak. Change the chlorine solution whenever it becomes very bloody. For easy accessibility, the container used for the decontamination soak should be kept close to the procedure area – for example, on the bottom shelf of the instrument trolley. Soaking in a disinfectant, however, does not make items safe to handle with bare hands. It is essential to wear gloves and face protection, and forceps to when removing instruments from the solution.

Cleaning and Drying

While decontamination makes items safer to handle, physical cleaning is the second step in processing, which removes organic material, dirt and foreign matter that can interfere with sterilization or HLD. Cleaning also drastically reduces the number of microorganisms. Cleaning refers to scrubbing with a brush, detergent and water and is a crucial step in processing. Without cleaning, further processing might not be effective.

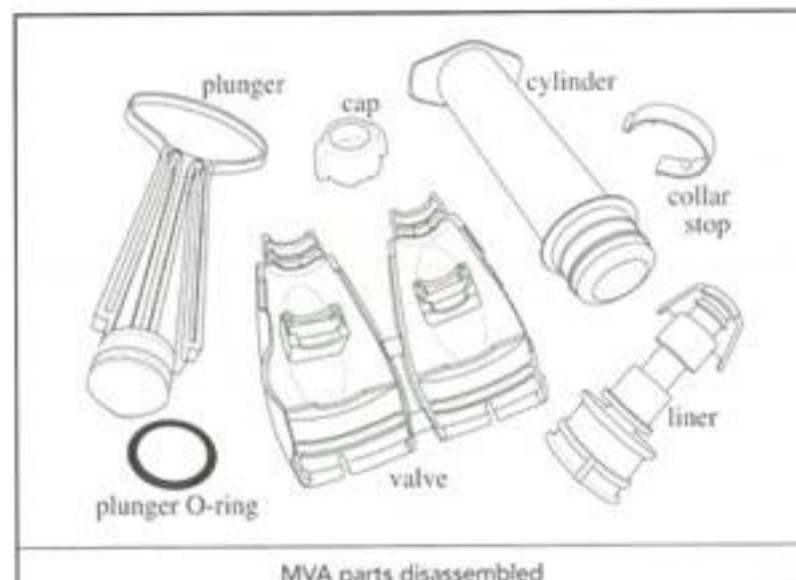
Wearing gloves, submerge the cannula and aspirator completely. Make sure to draw the solution into the aspirator and cannula. Aspirators must then be disassembled before cleaning and further processing.

To disassemble the MVA Plus aspirator:

1. Pull the cylinder out of the valve.
2. Press down the cap-release tabs to remove the cap.
3. Then open the hinged valve by pulling open the clasp and remove the valve liner.
4. Disengage the collar stop by sliding it sideways under the retaining clip or removing it completely from the cylinder.
5. Pull the plunger completely out of the cylinder.
6. Displace the O-ring from the plunger by squeezing the sides of the O-ring and rolling it down into the groove below. It is not necessary to completely remove it.



Steps to **clean the disassembled instruments** are:



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



Figure: Clean thoroughly

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

Sterilization/ High Level Disinfection (HLD)

Sterilization kills all microorganisms, including bacterial endospores such as those that cause tetanus and gas gangrene. High-level disinfection (HLD) destroys all microorganisms including hepatitis and HIV but does not reliably kill bacterial endospores.

Sterilization is best achieved with pressurized steam (autoclave) or soaks in fresh glutaraldehyde solution. HLD can be achieved by shorter soaks in glutaraldehyde or bleach (sodium hypochlorite) solutions or by boiling. Instruments that were cold processed (soaked in solution) must be thoroughly rinsed after processing. Instruments that were subjected to HLD may be rinsed in boiled water. Place the sterile instruments on a sterile container and allow to air dry before storage.

NOTE: All MVA plus syringe and cannulae must be HLD or sterilized prior to reuse. Cannulae must be sterile or high-level disinfected **at the time** of use. Once aspirators are sterilized/HLD then they only need to be kept in a clean place until next use. Since the aspirator does not ever touch the woman, it does not have to be sterile or HLD at the time of the procedure as long as it has gone through the HLD/sterilization process between patients.

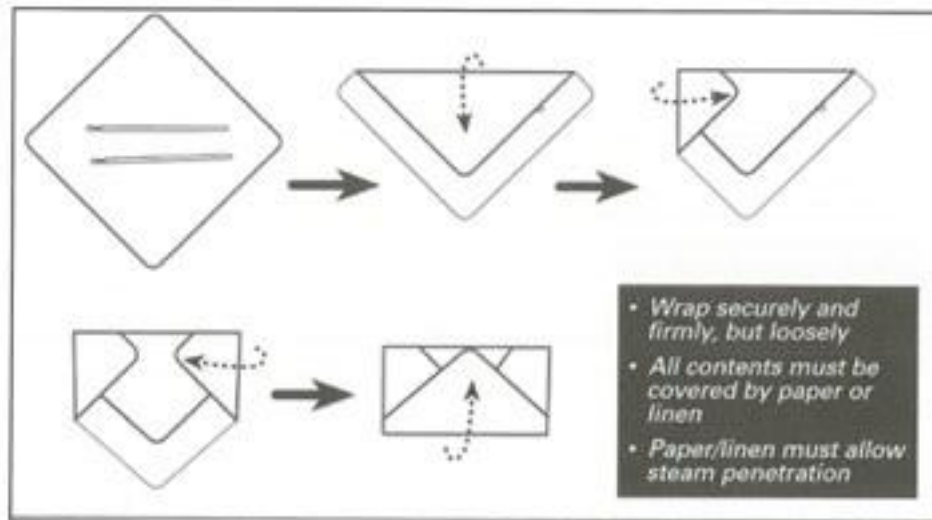


HLD soak and rinse

Steps to Sterilize Using Steam Autoclave:

1. All parts of the Ipas MVA Plus aspirator and Ipas EasyGrip cannulae can be steam sterilized at 121°C (250°F). Parts should not touch each other and the collar stop should be completely removed from the cylinder. Arrange the instruments without obstructing apertures or the opening at the base end of the cannulae to allow drainage.
2. Since the cannulae, particularly the smaller sizes, may curve in a steam autoclave, package them in paper or linen. Place the clean Ipas EasyGrip cannulae and the Ipas MVA Plus aspirator in a single layer in a steam autoclave. Note that steam sterilizing unwrapped Ipas EasyGrip cannulae for 30 minutes may result in slight curvature.
3. Process instruments in the steam autoclave for 30 minutes at 121°C (250°F).
4. Cool all instruments before using.

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

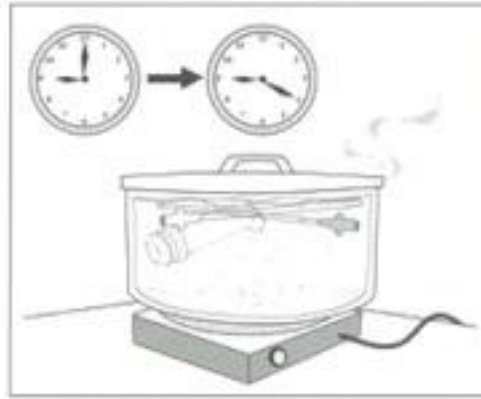
**Steps to Sterilize Using Glutaraldehyde:**

1. Completely immerse the instruments so that the solution fills them completely.
2. Soak in glutaraldehyde solution for the time recommended by the manufacturer—for example, 10 hours for Cidex.
3. Remove with sterile gloves or forceps.
4. Rinse all parts with sterile water. Do not use tap water to rinse.
5. Dry with a sterile cloth, if desired.
6. Change the solution according to the manufacturer's instructions. Generally, glutaraldehyde has a 14-day shelf life after being activated, but it should be discarded sooner if the solution HLD soak and rinse becomes cloudy. Do not use below 25° C (77° F).

Note: Once instruments have been sterilized, anything that subsequently comes in contact with them must also be sterile, for example, gloves or a storage container.

Steps to High-Level Disinfect by Boiling:

1. Place the instruments in water at a rolling boil. Items do not need to be fully immersed.
2. Boil for 20 minutes.
3. Remove using HLD or sterile gloves or forceps.
4. Dry with a sterile cloth, if desired.
5. Cool before use. Handle the cannulae by the base ends when removing. Grasping hot instruments may cause flattening. The boiling process may discolor cannulae without affecting their function.



Steps to High-Level Disinfect Using Glutaraldehyde:

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

Steps to High-Level Disinfect Using a 0.5 Chlorine Soak:

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

Instruments Processing

Method	Agent	Time	Notes
Sterilization	Pressurized steam (autoclave)	30 minutes at 121.c and 106 kPa pressure	Steam must reach all surfaces of item. Instruments should be arranged so that their openings are not obstructed to permit drainage
	2% glutaraldehyde	10 hrs	Discard 14 days after mixing or sooner if solution becomes cloudy.
High-level disinfection (HLD)	0.5 % Chlorine (sodium hypochlorite)	20 minutes	Change solution daily or sooner if it became cloudy.
	2% glutaraldehyde (Cidex)	20 minutes	Discard 14 days after mixing or sooner if solution becomes cloudy.
	Boiling	20 minutes at a "rolling boil"	Items do not need to be fully immersed. The pot should be covered Cool before use.

Some manufacturers produce aspirators and cannulae made of high-grade plastics that are engineered to be sterilized in an autoclave, while other plastic instruments will crack and melt when exposed high heat for sterilization. Always refer to the instructions for use of all items being disinfected or sterilized, to ensure they are using the appropriate form of disinfection.

Assembly and Lubrication of the Aspirator

Aspirators should be reassembled after processing and the plunger O-ring should be lubricated. They must be correctly assembled after processing in order to function properly. To assemble the MVA Plus aspirator:

1. Place the valve liner in position inside the valve by aligning the internal ridges. Close the valve until it snaps in place.
2. Snap the cap into place on the end of the valve.
3. Push the cylinder into the base of the valve.
4. Place the plunger O-ring in the groove at the end of the plunger and lubricate it by spreading one drop of lubricant around the O-ring with a fingertip. Silicone, which is not sterile, is provided with the aspirator; other non-petroleum-based lubricants can also be used (for example, olive oil).



Figure: Steps to Lubrication

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

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

Safe Storage of Instruments

Store instruments in an environment that preserves the level of processing desired. Once instruments have been processed, the challenge is to ensure that they are not re-contaminated during storage or handling. It is very important to maintain sterility or HLD of instruments until the actual time of use. After an instrument has been processed, it remains only as clean as the last item with which it came in contact.

- Instruments should be kept in dry, covered, HLD or sterile containers with tight-fitting lids, protected from dust and other contaminants. Cannulae must be in HLD or sterile containers. Aspirators can be stored in clean, HLD, or sterile containers.
- Cannulae that have been processed by wet methods (HLD) should be used daily, if they are not used in that time period, they should be reprocessed.
- If autoclaved, wrapped cannulae that are safely stored can be used within one week.
- Proper storage is as important as the HLD/sterilization process itself

Safe Disposal of Infectious Wastes

All human tissue, such as POC; bodily fluids; and all disposable materials that have come in contact with body fluids need to be properly disposed to protect the community. If infectious waste from a clinic gets into the community the risks include accidental needle sticks and exposure to infected blood and other body fluids. Hence proper waste disposal protects the clinical staffs, patients, and whole community.

The waste can be burned in a closed incinerator or buried in a deep pit, which should be 2 to 5 meters deep at a minimum and 50 meters away from source of water. As waste is added, cover it with 10-30 cm (4-10 inches) of soil. When the level of waste reaches to within 30-50 cm of the ground surface, fill the pit with dirt, seal it with concrete, and dig another pit. Liquid infectious waste can be poured down a sink or drain connected to an adequately treated sewer or pit latrine, or buried. Added precautions need to be taken to prevent "sharp" injuries include wearing gloves. Never discard sharps in general waste, and keep sharps out of the reach of children.

Note:

- Waste should at least be least be secured and contained (no open pits).
- Incineration is ideal.
- Should be buried away from water sources.
- POC resulting from MA should be disposed of in the same way as other infectious waste. A woman who chooses to complete MA at home should be advised of proper disposal methods.
- Contaminated sharps should be placed in containers made from material that is not easily perforated, such as heavy cardboard or plastic.

Environment Cleanliness

Detergents and hot water (or 0.5% chlorine solution) are adequate for the routine cleaning of floors, beds, toilets, walls, and rubber draw sheets. Following spillage of body fluids, heavy-duty rubber gloves should be worn and as much body fluid as possible removed with an absorbent material. This can then be discarded in a leak proof container and later incinerated or buried in a deep pit.

At the beginning of each clinic session:

- Wipe all horizontal surfaces with a clean cloth.
- Mop floors with a clean mop to remove any dust.

Between clients:

- Clean any potentially contaminated surfaces, such as procedure tables and trolley tables, with a clean cloth dampened with a disinfectant cleaning solution.
- Clean visibly soiled areas of the floor, walls, or ceiling with a disinfectant cleaning solution.
- Check sharps disposal containers and replace them if they are three-quarters full.
- Remove infectious waste.

At the end of each day:

- Check sharps disposal containers and replace them if they are three-quarters full.
- Remove infectious waste.
- Clean all surfaces with a clean cloth dampened with a disinfectant cleaning solution.
- Mop floors with a disinfectant cleaning solution.
- Wash waste containers with a disinfectant cleaning solution.

Summary

- Health-care facilities are prime settings for infection transmission to health-care workers, clients, and community members because of the presence of numerous types of infectious agents.
- Standard precautions should be applied in all situations where health-care workers anticipate contact with blood, secretions, excretions, and other body fluids, non-intact skin, and mucous membranes.
- Hands are the most common vehicles for infection transmission. The essential elements of infection prevention are hand washing, use of personal protective barriers, proper handling and disposal of sharp instruments and items, proper handling and processing of instruments and materials, use of aseptic technique, environmental cleanliness, and proper disposal of infectious waste.
- The three critical components of aseptic technique for MVA are antiseptic preparation, no-touch technique, and proper handling and disposal of sharp items.
- If a health-care worker is exposed to blood or other body fluids, follow appropriate procedures for the management of occupational exposures.
- After decontamination soak and cleaning, aspirators and cannulae must undergo sterilization or high-level disinfection between patients to remove contaminants.
- Sterilization can be accomplished using an autoclave or glutaraldehyde. High-level disinfection can be accomplished using boiling, glutaraldehyde, or 0.5% chlorine solution.
- The plunger O-ring must be lubricated with one drop of lubricant after processing.
- Proper handling and storage are essential to maintaining the sterility or high-level disinfection of instruments.
- After fully processing, aspirators do not need to remain sterile or high-level disinfected for the next use. Cannulae must be sterile or high-level disinfected at the time of use.
- All infectious waste should be incinerated or, at the very least, secured and contained properly.

MODULE 6:

TYPES OF ABORTION PROCEDURES

Key Topics:

1. MA: mechanism and regimen, expected effects and potential side effects, pain management
2. MVA instruments: Information on Ipas MVA Plus and Easy Grip cannulae parts, assembly, and handling
3. Uterine Evacuation Procedure with Ipas MVA Plus
 - Pre and Post Procedure Pain Management
 - Steps of the MVA Procedure
 - Precautions for performing an MVA procedure

1.0 Introduction

According to the World Health Organization (WHO), the preferred methods for uterine evacuation are medical methods using a combination of mifepristone followed by a prostaglandin or MVA.

Appendix F: *Uterine Evacuation with Medical Methods Skills Checklist – Mifepristone and Misoprostol*, Appendix G: *Misoprostol for Treatment of Incomplete Abortion Skills Checklist*, and Appendix H: *Uterine Evacuation Procedure with Ipas MVA Plus Skills Checklist* have been provided as tools in the handbook to evaluate and improve a provider's performance of MA and MVA procedures.

Section 1: Medical Abortion

1.1 Mechanism of Action

The combination of mifepristone plus misoprostol is more effective in achieving complete abortion than either drug used alone.

Mifepristone, developed in France and originally known as RU-486, was first approved for clinical use in 1988. Mifepristone blocks progesterone activity in the uterus, leading to detachment of the pregnancy. Mifepristone increases uterine sensitivity to prostaglandins (like misoprostol) and softens the cervix and causes the uterus to contract.

Misoprostol, a synthetic prostaglandin, stimulates uterine contractions and causes uterine evacuation. Misoprostol is inexpensive and available in many countries for the prevention and treatment of gastric ulcers. It can also be used for cervical preparation before MVA, labor induction, prevention and treatment of postpartum hemorrhage, and treatment for missed or incomplete abortion.

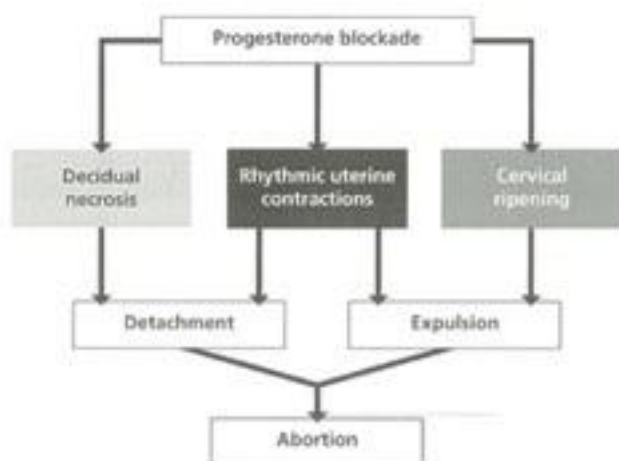
Efficacy and safety of medical abortion with mifepristone and misoprostol or misoprostol only were similar between younger and older women. One study with few adolescent participants showed increased medical abortion efficacy in this group.

Misoprostol Clinic Use and Storage

Even misoprostol manufactured in high-quality conditions and packaged well can become inactive if it is shipped or stored in conditions that expose it to heat or humidity for prolonged periods of time. There have not been large field studies on the stability of misoprostol in tropical climates, but laboratory studies show that misoprostol is less stable when exposed to moisture or heat. Even in normal room temperature conditions (25°C and 60 percent humidity), when providers cut blister packs to distribute tablets, if the packaging on the remaining stored tablets is inadvertently opened, the tablets' potency degrades within 48 hours and continues to degrade over time.

Recommendation:

Because different misoprostol products have varying quality and can degrade over time, providers should track MA success rates to ensure that they are using an effective product. Providers should store misoprostol in a cool dry place.



National Abortion Federation, 2025



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1.2 Eligibility

Indication

Termination of first-trimester intrauterine pregnancy (up to 9 weeks)

Contraindications

- Known allergy to mifepristone, misoprostol, or to other prostaglandins
- Confirmed or suspected ectopic pregnancy
- Inherited porphyria
- Chronic adrenal failure

Precautions

- IUCD in place (remove before beginning regimen)
- Severe uncontrolled asthma or long-term corticosteroid therapy (applies only to mifepristone with misoprostol regimen). No evidence exists regarding use of mifepristone in steroid-dependent women. Providers must use clinical judgment if no other alternatives to safe abortion exist. Increase steroid dose for 3-4 days and monitor the woman very closely. Conditions such as poorly controlled asthma may still be worsened.
- Severe/unstable health problems. No evidence exists on the use of medical methods for uterine evacuation in women with hemorrhagic disorder, heart disease, and severe anemia or severe/unstable health problems. Whether to provide uterine evacuation with medical methods to women with these conditions will depend on the available options for safe abortion care, referrals, and clinical judgment. If mifepristone or misoprostol are given, they should be given under close observation.

1.3 Regimen

The recommended regimen for pregnancies up to 9 weeks is:

- Mifepristone 200 mg orally (swallowed), followed by:
- Misoprostol 800 mcg sublingually (under the tongue) or intra-vaginal 24 hours after mifepristone.

Misoprostol may be taken at home or in the clinic. The provider should administer MA only after the woman has received the following information:

- When and how to take the medications
- What she should expect to feel and see in the abortion process
- Warning signs and what to monitor as potential problems
- Who to contact in case of questions or an emergency
- When to follow up
- Which pain-management drugs to take

1.4 Routes of Administration

Mifepristone

Mifepristone is taken orally (swallowing the pill) on day one of the abortion.



Figure: Oral use of mifepristone

Misoprostol

Misoprostol can be taken either sublingually (under the tongue) or vaginally (inserted by the provider or the woman herself).

- Place four pills under tongue.
- After 30 minutes, swallow remaining pill fragments.

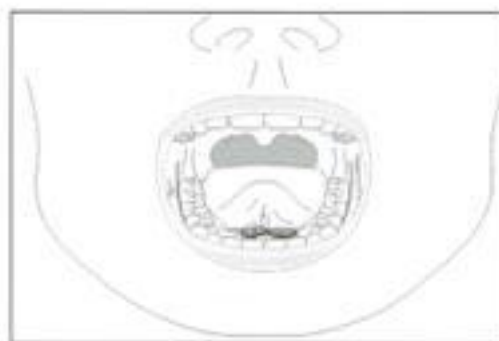


Figure: Sublingual use of misoprostol

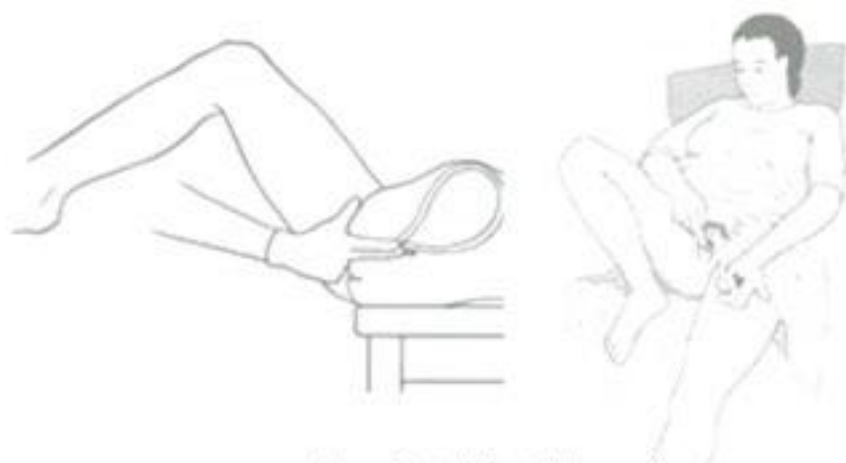


Figure: Vaginal Use of Misoprostol

- Empty bladder and lie down.
- If clinician is inserting tablets: wash hands and put on clean exam gloves.
- Insert all the misoprostol tablets.
- Push the tablets as far into the vagina as possible; they do not need to be in any special place in the vagina. Do not push the pills through the cervix.
- Often tablets will not dissolve but medication is still absorbed.
- Fragments of the tablets may remain visible for many hours.
- After lying down for 30 minutes, if tablets fall out when a woman stands up or goes to the bathroom, the tablets do not need to be reinserted; the active medicine has absorbed by that time

1.5 Expected Effects

When taking mifepristone (for abortion with mifepristone and misoprostol), most women feel no change after taking the pills. Approximately 8-25 percent of women will have some spotting or bleeding after mifepristone, prior to taking misoprostol.

When taking misoprostol, the expected effects (cramping and bleeding) and the potential side effects detailed below occur after the woman takes misoprostol.

The MA process may feel like an intense, crampy menstrual period or similar to a spontaneous miscarriage. This may not mean much to young women who have had very few periods or never been pregnant. The expected effects — vaginal bleeding and cramping — are normal and should be distinguished from side effects of the medications or warning signs of true complications.

Vaginal Bleeding

Vaginal bleeding, often accompanied by passage of clots, is usually heavier than a menstrual period but sometimes may be lighter. Bleeding most often starts within three hours after misoprostol administration and tends to decrease after the pregnancy tissue has been expelled.

The number of days of bleeding or spotting following the abortion varies widely. Most women having MA bleed between one and two weeks, but some will have more and others less. Women tend to bleed or spot longer after MA than after abortion using MVA. Approximately 20 percent of women undergoing MA continued to bleed or spot for 35 to 42 days, which may include start of the first post abortion menses.

Concerns about Bleeding and Cramping

Clinicians new to MA, as well as women themselves, often have questions about how to tell between expected and abnormal bleeding. All women should be given information about the bleeding and pain they might experience, keeping in mind factors that might put her at higher or lower risk of experiencing these symptoms. Older age, having given birth before, and a higher number of previous births are associated with reduced pain. Young women and women who

have never been pregnant tend to experience increased pain. Women with painful periods may also experience increased pain with MA independent of other factors such as age or reproductive history.

Accurately describing the sensations a woman might feel can alleviate fear and anxiety that may make pain worse. It may be helpful to explain to women the “bell curve” illustrated below. Most women will fall into the middle range of experience, but it is impossible to tell ahead of time where on the range an individual woman will fall. Women who bleed more than they are comfortable with can be offered MVA. However, this is usually not necessary when women are well informed and know what to expect about bleeding.



Most women's experience will fall somewhere in the middle and few women's experience will fall on either end.

A woman may have concerns about where she may begin bleeding and how to maintain privacy and obtain support during the process. Her provider should be prepared to support her in thinking through and deciding on the most private and comfortable location to undergo the process and who in her family or social network might be the most supportive and trustworthy person to support her.

Cramping

There is wide variation in the level of pain and cramping that women experience when having MA, though the majority of women report some cramping. Some women do not notice cramping; others say the pain is intense. Most women fall somewhere in the middle. Cramping usually begins one to three hours after taking misoprostol. As the uterus contracts and its contents are expelled through the cervix, women generally feel some degree of cramping, which diminishes soon after expelling passing the pregnancy tissue.

1.6 Potential Side Effects

MA medicines may produce a range of relatively minor side effects that usually do not require treatment. The following side effects are associated with misoprostol and apply to women undergoing mifepristone and misoprostol abortion:

- Nausea
- Vomiting
- Diarrhea
- Fever, warmth, or chills
- Headache
- Weakness
- Dizziness

Some of these symptoms may be caused by the pregnancy itself rather than MA. These pregnancy symptoms can actually decrease after MA begins. Those symptoms that increase after taking misoprostol include transient fever and diarrhea as well as nausea and vomiting.

Gastrointestinal Effects

Nausea, vomiting and diarrhea are regularly reported following misoprostol. MA gastrointestinal side effects are usually mild and last less than 24 hours. If severe gastrointestinal side effects such as persistent vomiting continue to occur 24 hours after the last dose of medications, a woman should be clinically evaluated.

Headache, Weakness, and Dizziness

Some women undergoing MA report headache, weakness, or dizziness. One study found approximately 20 percent of women reported headache after taking MA medications. Headache is treatable with analgesics. Mild dizziness of short duration is managed by hydration, rest and by using caution when moving around. Women experiencing persistent dizziness and weakness in combination with heavy or prolonged bleeding should be promptly evaluated for hypovolemia.

Fever, Warmth, and Chills

Many women experience short-lived fever, a feeling of warmth, chills, or shivering during MA as a side effect of the medications. Treatment is generally not required, but women should know that they might experience these symptoms.

1.7 Expulsion of Pregnancy

Timing

With the mifepristone and misoprostol regimen before 9 weeks gestation, the median time from misoprostol use to expulsion has been found to be three hours for women who used sublingual misoprostol and four hours who used vaginal misoprostol.

What the Woman Might See

Most women will see only blood and clots, some of which may be large. Occasionally women with pregnancies between 8-9 weeks may see a recognizable fetus though it is usually less than two centimeters in length (less than 2.3 cm) and often not visible.

Disposal

At home women can flush everything that is expelled in the toilet or can dispose of it by burying it.

1.8 Pain Management for MA

Most women find MA-related pain to be manageable, especially if they are prepared for the range of pain that might be experienced and take pain medicines as advised. Women should be provided with pain medication or a prescription at the time of their first visit.

The best regimen for pain control for MA has not been established. Nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen are more effective than acetaminophen. Ibuprofen can be given with misoprostol or once cramping starts. Nonsteroidal anti-inflammatory drugs (NSAIDs) do not interfere with MA efficacy.

In addition to medical management, other methods that may help women manage pain during the process are counseling, a supportive environment, and applying mild heat to the abdomen or lower back with a hot water bottle, warm cloths, or a hot bath or shower. Music may help to manage pain. These methods are complementary but not adequate substitutes for pain management with medications.

1.9 Considerations for Postabortion Care

- Eligibility criteria are: open cervical os, vaginal bleeding or a history of vaginal bleeding during the pregnancy and uterine size less than 13 weeks.
- Contraindications for misoprostol for incomplete abortion include:
 - Previous allergic reaction to misoprostol or other prostaglandin
 - Known or suspected ectopic pregnancy
 - Signs of pelvic infection and/or sepsis
 - Hemodynamic instability or shock
- Following misoprostol for incomplete abortion, fertility returns quickly. Therefore if a woman wants to avoid pregnancy, contraception should be provided when she initially presents for PAC.
- Women receiving misoprostol for incomplete abortion are likely to experience pain, cramping and bleeding. They may experience side effects from misoprostol such as nausea or fever and chills. Providers should offer pain management to women using misoprostol incomplete abortion. After misoprostol for incomplete abortion, bleeding will be similar to a woman's period and may continue for days.
- The dose of misoprostol for incomplete abortion is a single dose of 400 mcg sublingually or 600 mcg orally.
- If the initial dose fails and the woman is clinically stable, options include expectant management or provision of MVA.

1.10 Summary

- Studies indicate that the combination of mifepristone and misoprostol has a somewhat higher success rate than misoprostol only.
- Misoprostol may be administered at home for gestations up to 9 weeks LMP. Appropriate facilities and staff support should be available to women who remain in the clinic during the MA process.
- Before taking any medications, the woman should receive instructions about what she may experience, what pills to take, when and how to take them, when to follow up, and when and where to seek medical help in case of a problem.
- Vaginal bleeding and cramping are expected and normal components of MA. Other side effects include nausea, diarrhea, vomiting, fever, warmth or chills, headache and dizziness.
- All women should be offered pain medications. Non- narcotic and narcotic analgesics can be used to treat pain associated with MA. NSAIDs have been shown to be significantly more effective than acetaminophen.
- Abortion completion, preferably with MVA, is recommended for continuing pregnancies.

Section 2: MVA Instruments

Ipas MVA Plus and Ipas EasyGrip cannulae are safe, effective instruments designed to meet women's uterine evacuation needs. Information in this section is based on the product labeling for the Ipas MVA Plus aspirator and Ipas EasyGrip cannulae.

2.1 Description of MVA Instruments

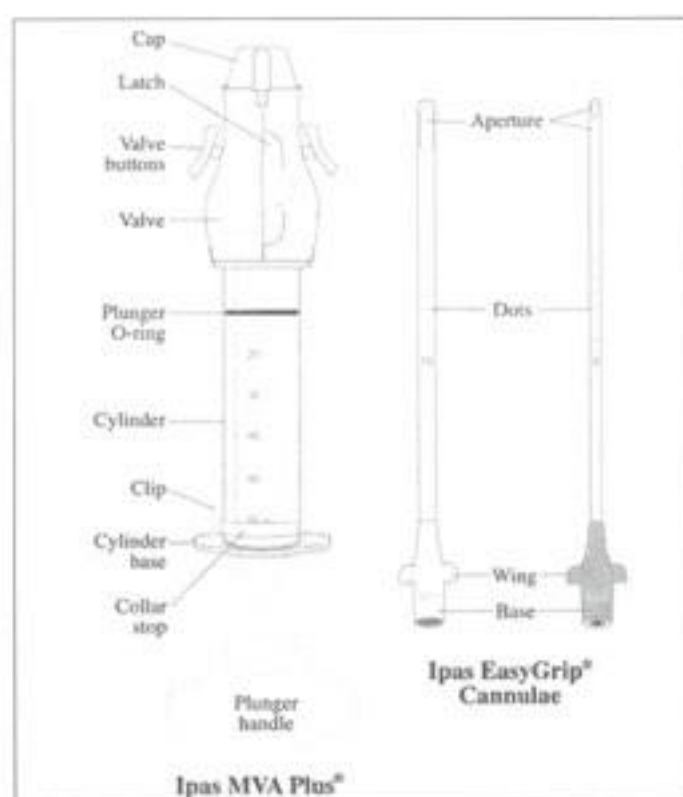
MVA instruments consist of a manual vacuum source (aspirator), which produces suction and holds tissue and blood removed in uterine evacuation procedures. Cannulae are attached to the aspirator and used to apply suction to aspirate tissue from the uterus.

Aspirators

The Ipas MVA Plus aspirator provides a vacuum of 24 to 26 inches (609.6 to 660.4 mm) of mercury. It is composed of a hinged valve with a cap, a removable liner, a pair of buttons that control the vacuum, a plunger with a handle, a collar stop with a retaining clip, an O-ring and a 60 cc cylinder for holding evacuated uterine contents. The MVA Plus is compatible with EasyGrip cannulae.

MVA aspirators are designed for multiple uses. Although aspirators are clean when shipped, they must be high-level disinfected or sterilized prior to first use and after each procedure to remove

contaminants. The MVA Plus aspirator is made of steam-autoclavable materials and was designed specifically to allow steam contact with all surfaces when disassembled.



Cannulae

Ipas Easy Grip cannulae are compatible with the Ipas MVA Plus aspirator. EasyGrip cannulae, depending on size, have either one aperture (9, 10 and 12 mm sizes) or two apertures (4, 5, 6, 7 and 8 mm sizes). The winged shape of the base of the cannulae provides leverage, making it easy to attach a cannula to the aspirator and remove it quickly. No separate adapters are needed with EasyGrip cannulae. There are six dots on each cannula, with the first located 6 cm from the end and the other dots at 1 cm intervals. The dots indicate the location of the main aperture.

Easy Grip cannulae are considered “semi-rigid” cannulae. This means that the cannulae are less pliable than the flexible Karman cannulae. Some providers have reported that the smallest Easy Grip cannulae feel a bit firmer than the flexible Karman cannulae and are easier to insert through the cervix, while other providers have reported no notable difference in the feel and flexibility of the cannulae.

Each cannula is sterilized with ethylene oxide (ETO) after packaging and remains sterile until the stated expiration date, as long as the packaging is intact. The shelf life for packaged cannulae is three years. Where regulations allow, these cannulae are reusable after undergoing sterilization or high-level disinfection. Cannulae must be sterile or high-level disinfected (HLD) at the time that it is inserted into the uterus. Always follow proper protocols on the processing of medical instruments and on the disposal of infectious waste when processing and discarding MVA instruments.

2.2 Uses of MVA Plus Aspirator and EasyGrip Cannulae

All aspirators and cannulae up to 12 mm are intended for uterine evacuation/uterine aspiration in obstetrics and gynecology clients. Clinical indications for uterine aspiration with this product are: treatment of incomplete abortion for uterine sizes up to 12 weeks since the LMP; first-trimester abortion (menstrual regulation) and endometrial biopsy.

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

- Uterine size 4–6 weeks since the LMP: 4–7 mm cannula
- Uterine size 7–9 weeks since the LMP: 5–10 mm cannula
- Uterine size 9–12 weeks since the LMP: 8–12 mm cannula

Indication for MVA

- Non-viable intrauterine pregnancy, other spontaneous abortion in progress
- Undesired pregnancy of 12 weeks gestation or less
- No clinical evidence of active uterine or cervical infection
- Endometrial biopsy.

Warnings and Precautions

As with any uterine evacuation procedure, one or more of the following may occur during or after an MVA procedure: vagal reaction, incomplete evacuation, uterine or cervical injury or perforation, pelvic infection or acute hematometra. Rarely, some of these conditions can lead to secondary infertility, serious injury, or death.

Before performing uterine evacuation or endometrial biopsy, any serious medical conditions that are present should be addressed immediately. These include: shock, hemorrhage, cervical or pelvic infection, sepsis, perforation or abdominal injury as may occur with incomplete abortion or with clandestine abortion. Uterine aspiration/uterine evacuation is often an important component of definitive management in these cases and once the patient is stabilized, the procedure should not be delayed. History of blood dyscrasia may be a factor in the woman's care. In cases where the woman has a history of a blood-clotting disorder, Ipas cannulae and aspirators should be used only with extreme caution and only in facilities where full emergency backup care is available.

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

Contraindications

Endometrial biopsy should not be performed in cases of suspected pregnancy. There are no known contraindications for other clinical indications.

2.3 Functioning of the Ipas MVA Plus Aspirator

Appropriate client preparation and counseling should be performed and informed consent should be obtained before any uterine evacuation procedure. To perform the procedure, a cannula is inserted through the cervical os and then attached to an aspirator in which a vacuum has been prepared. The vacuum is then started by releasing the valve buttons and the cannula is used to aspirate the uterus as required. Suction can be started and stopped as needed during the procedure.

Preparing a Vacuum and Checking Vacuum Retention

With the Ipas MVA Plus, a vacuum should be prepared in the aspirator and the vacuum checked before beginning the procedure. To prepare a vacuum in the aspirator, follow the steps below:

1. Begin with the valve buttons open (not depressed), the plunger positioned all the way into the cylinder and the collar stop locked in place, with the tabs pushed down into the holes in the cylinder.
2. Push the buttons down and forward until they lock into place.
3. Create a vacuum by pulling the plunger back until the arms of the plunger snap outward and catch on the wide sides of the cylinder base. Both plunger arms must be fully extended

to the sides and secured over the edges of the cylinder. Incorrect positioning of the arms can allow them to slip back inside the cylinder, possibly injecting the contents of the aspirator back into the uterus.

4. The vacuum-charged aspirator should **never** be grasped by the plunger arms. If the charged aspirator is grasped by both arms, it may inadvertently release the plunger back into the cylinder. Releasing the plunger into the cylinder during a procedure could push the aspirator contents back into the uterus. Check the aspirator for vacuum retention before each use. To do this, follow steps 1, 2, and 3 and then let the aspirator sit for a few moments after establishing the vacuum. Then push the buttons to release the vacuum. A rush of air into the aspirator should be heard, indicating that a vacuum was retained.
5. If the rush of air is not heard, displace the collar stop, withdraw the plunger and check the following:
 - a. Is the plunger O-ring intact, rather than nicked or damaged, free of foreign bodies and positioned in the groove?
 - b. Is the cylinder firmly placed in the valve?
 - c. Has the plunger O-ring been properly lubricated, over-lubricated, or not lubricated at all?
 - d. Create a vacuum and test it again. If the vacuum is still not retained, discard and use another aspirator.

Stopping and Starting Suction

To start suction, release the valve buttons on the vacuum-charged aspirator. To stop suction, push the buttons to close the valve. During use, suction is started after the cannula is in place in the uterus. It may be stopped and started during the procedure, if needed.

Disposal and Replacement

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

Aspirators:

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

Cannulae:

- Cannula has become brittle
- Cannula has become cracked, twisted or bent, particularly around the aperture

- Tissue cannot be removed during the cleaning process

2.4 Solving Instrument Technical Problems

The most common technical problem seen with MVA instruments is loss of vacuum. In most MVA procedures, the aspirator vacuum remains constant until the aspirator is approximately 80%, or 50 mL, full. However, a decrease in vacuum may occur before the aspiration is complete for the following reasons: the aspirator is full, the cannula is withdrawn past the external os prematurely, the cannula is clogged, or there is a loss of vacuum due to incorrect assembly.

Aspirator is full

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

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

Cannula is Withdrawn Prematurely

If the aperture of the cannula is accidentally withdrawn from the uterus beyond the external os into the vaginal canal, remove the cannula, being careful not to contaminate it through contact with the vaginal walls or other non-sterile surfaces. Detach the aspirator from the cannula, empty it and then reestablish a vacuum in the aspirator.

If the cannula has not been contaminated, it can be reinserted. If contamination has occurred, another sterile or HLD cannula should be inserted using no-touch technique. Reconnect the aspirator, release the valve and continue aspiration.

Cannula is Clogged

If the cannula becomes clogged, a lack of tissue or bubbles flowing into the aspirator will be noted. Ease the cannula back toward, but not through, the external os of the cervix. This movement will often unclog the cannula. Alternately, depress the buttons, close the valve on the aspirator and withdraw the cannula from the uterus, taking care to prevent contamination. Remove the tissue from the opening in the cannula with sterile or HLD forceps. Reinsert the cannula using no-touch technique, reattach the aspirator and continue the procedure. Never try to unclog the cannula by pushing the plunger back into the cylinder while the cannula is in the uterus.

Incorrect Assembly

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

preparing a Vacuum and Checking Vacuum Retention and the section Assembly and Lubrication of the Aspirator for more information.)

2.5 Summary

- The MVA Plus aspirator is composed of a valve body, plunger, a 60 cc cylinder, and a collar stop.
- Ipas easy Grip cannulae are available in 4, 5, 6, 7, 8, 9, 10, and 12 mm sizes, have either one aperture (9, 10, and 12 mm sizes) or two apertures (4, 5, 6, 7, and 8 mm sizes), and do not require separate adapters. Size 11 is not available.
- Cannulae must be sterile or HLD at the time of use; Aspirators must HLD or sterilized between uses, but do not need to remain sterile or HLD at the time of use.
- Clinical indications for uterine aspiration with Ipas MVA Plus and Ipas Easy Grip cannulae are: first-trimester abortion, treatment of incomplete abortion for uterine sizes up to 12 weeks since LMP, and endometrial biopsy.
- Endometrial biopsy should not be performed in cases of suspected pregnancy. There are no known contraindications for other clinical indications.
- Providers should be able to prepare a vacuum, check vacuum retention, and start and stop suction.
- Instrument that are worn out or damaged should be discarded and replaced.
- The aspirator vacuum remains constant until the aspirator is approx. 80% or 50 ml full. Instrument technical problems that can occur during an MVA procedure include a full aspirator, a cannula that is clogged or withdrawn prematurely, or a loss of vacuum due to incorrect assembly.

Section 3: Uterine Evacuation Procedure with Ipas MVA Plus

3.1 Pain Management

The purpose of pain management during uterine evacuation is to help the woman remain as comfortable as possible, while minimizing medication-induced risks and side effects. Most women undergoing first trimester MVA will experience pain during the procedure. Many providers underestimate the amount of pain a woman experiences during MVA. Women who present for uterine evacuation should be offered all pain management options and provided these services without delay. It is her choice if to refuse it if desired. Providers should always offer gentle, respectful care and provide appropriate information, which can help women stay calm and reduce anxiety and pain.

The amount of pain that women experience with uterine evacuation, as well as their response to that pain, varies with each individual. Some women may experience minimal discomfort while others may feel very uncomfortable. After an MVA, most women describe moderate though tolerable levels of discomfort. Physical aspects that have been associated with increased pain during MVA include nulliparity, young age, higher gestational age, and dysmenorrhea. Psychosocial elements such as anxiety and depression have also been associated with increased pain.

Anxiety: The choice to terminate a pregnancy is likely to be a major decision, and women undergoing abortion care often experience some emotional stress. Additionally, women will commonly experience anxiety about the procedure itself. This nervousness heightens their sensitivity to pain. If the woman's anxiety reaches very high levels, she may not be able to lie still on the table and her muscles will tighten, making the procedure more painful and difficult.

Aspects of the procedure that can affect pain levels include cervical dilation, uterine manipulation, the skill and clinical technique of the provider, and the physical environment.

Cervical dilatation: Cervical dilatation, a process that is often required in MVA procedures, can cause additional pain. Most women experience at least some discomfort related to cervical dilatation and stimulation of the os. The network of nerve fibers around the cervix transmits this pain.

Uterine manipulation: Lower abdominal pain with cramping is associated with movement of the uterus, movement of the cannula against the uterine walls, and the spasm of muscles related to emptying of the uterine cavity that marks completion of the procedure. This uterine pain is transmitted from the fundus of the uterus along major uterine nerves that follow the uterine ligaments. For this pain analgesics such as ibuprofen or other non-steroidal anti-inflammatory drugs (NSAIDs) or narcotics can be administered for pain relief.

Pain Management Plan

The provider should create a pain-management plan in conjunction with the woman through discussion and clinical assessment prior to the procedure. The purpose of a pain management

plan is to reduce any physical pain and anxiety the woman experiences, while minimizing medication-induced risks and side effects. Pain during a uterine evacuation with MVA can be reduced with a combination of verbal support, oral medications, paracervical block and skilled and gentle clinical technique and calming environment.

The provider should explain to the woman that the MVA procedure is usually a brief procedure, lasting fewer than 10 minutes; however, during that time she probably will experience at least some discomfort. The provider should discuss with the woman the various options that are available to reduce pain, along with their potential side effects. Together, the provider and the woman should decide on a pain-management plan that meets her individual needs. One of the most important considerations of the pain-management approach is that women have a sense of control over which options are chosen. Providers can increase client satisfaction by offering the woman all her options for pain management and allowing her to select the method that best fits her individual circumstances.

An example of a pain-management plan that meets the needs of many women receiving abortion care would include oral analgesics administered 30 minutes prior to the MVA procedure, a paracervical block, and effective non-pharmacological approaches, such as verbal reassurance and gentle clinical technique.

The following factors should be taken into account:

- The woman's physical status and medical history: providers should determine if the woman has any medical problems, which medications she uses on a regular basis, and whether she has any allergies
- The degree of cervical dilatation necessary
- Any psychological concerns, such as anxiety
- The skill of staff members and the nature of the procedures they will be performing
- The availability of pain medications, instruments and supplies

Each health-care facility should develop a feasible protocol for pain management based on supplies that are available.

Health-care workers should never withhold pain medication or treat women roughly, particularly as punitive measures. They should strive to provide the woman with respectful care and appropriate information, both of which can help her stay relaxed and reduce her perception of pain.

Non-Pharmacological Methods for Pain Management

Non-pharmacological methods can decrease a woman's anxiety and perception of pain considerably. They should be used in every MVA procedure as part of high-quality abortion care.

Verbal and physical reassurance:

Verbal reassurance before, during and after the procedure may help the woman relax. The woman's perception of pain is strongly affected by her level of anxiety and the amount of information



Figure: Verbal and physical reassurance

she receives about the procedure. Respectful, supportive care by staff throughout the procedure helps to reduce anxiety and decrease pain, and should be a standard part of care. It must be stressed, however, that verbal reassurance is not a substitute for pharmacological methods of pain control, but rather a useful supplement to them. The health-care team should ask the woman which supportive

A woman may feel more relaxed and comfortable if a nurse, assistant or companion talks with her during the procedure. It may be appropriate to hold her hand or rub her arm. Some women may prefer that the health-care worker distract her by talking with her about work or family.

During an MVA procedure, the woman is usually awake. The provider can show attentiveness to her comfort throughout the procedure by taking a few simple measures. Most women prefer to know what they will feel during the procedure. The provider should let her know that the cramping she feels toward the end of the procedure indicates that the procedure is almost complete.

Gentle clinical technique:

The provider should always be gentle during physical contact with the woman, including by ensuring that all instruments are at a comfortable temperature before they come in contact with her. As instruments are inserted and moved, providers should use smooth motions and gentle technique to minimize discomfort. It is also important for providers to always inform the woman that they are going to touch her and explain what she is going to feel, before actually performing the action. Movements that are jerky or sudden can cause the woman additional discomfort.

Pharmacological Methods for Pain Management

If the provider administers too little medication, the woman may be subjected to unnecessary pain. On the other hand, overmedication will lengthen recovery time and possibly increase both risk and cost. The overall goal should be to administer enough medication to last through the procedure, but not so much that the effects last long after the procedure is complete.

It is important that any medication administered to the woman be in full effect by the time the procedure commences. The provider should continually monitor and manage medication-induced side effects and complications.

The three categories of medications used for pain control:

Analgesics alleviate the sensation of pain in the receptors of the spinal cord and brain. Premedication with non-steroidal analgesics such as ibuprofen has been shown in clinical trials to decrease pre and post-procedure pain including uterine cramping. Paracetamol is found to be ineffective in management of pain due to abortion.

Anesthetics numb all physical sensation locally, regionally or generally. Local anesthesia interrupts the awareness of pain from a small area in the body. The term paracervical block refers to the injection of local anesthesia into the cervix. It is recommended for most women undergoing an MVA procedure. For instructions for administering a paracervical block, see Step 4: Perform paracervical block of this module.

Regional anesthesia is delivered through the spinal or epidural route and blocks all sensation below a particular point on the spinal column. Conscious sedation is an option in centers where it is offered. General anesthesia increases the risk of complications and is not recommended for routine discomfort.

Anxiolytics depress the functions of the central nervous system and are used to decrease anxiety and to induce relaxation and sometimes amnesia. Premedication with anxiolytics such as lorazepam may be of benefit to some women but clinical trial evidence does not support its routine use.

Post-Procedure Pain Management

Some pain is normal following even uncomplicated abortion procedures because the uterus is contracting. Pain that increases over time requires clinical evaluation. Mild analgesics such as ibuprofen help relieve cramping pain.

Narcotics are usually not necessary. If narcotics or other strong pain medications were given before, during or after the uterine evacuation procedure, close monitoring may be necessary depending on the route, dose and type of drug given.

Providers should inform women about all their choices for pain management in the post-procedure period and provide them with instructions about how to take any pain medications that they receive.

3.2 Steps of the MVA Procedure

Precautions Prior to Performing an MVA Procedure

Before beginning, it is important that the provider confirm the uterine size and position to ensure that MVA is the most appropriate method for uterine evacuation. Large fibroids or uterine anomalies may make it difficult to determine the size of the uterus and to perform intrauterine procedures, including MVA. Therefore, providers should be well trained in determining length of pregnancy prior to using MVA. (See Module 2: Client Assessment for more information.)

Steps for Performing MVA:

1. Prepare instruments
2. Prepare the woman
3. Perform cervical antiseptic prep
4. Administer paracervical block
5. Dilate cervix
6. Insert cannula
7. Suction uterine contents
8. Inspect tissue
9. Perform any concurrent procedures
10. Process instruments and dispose of waste

Step 1: Prepare Instruments

The provider should check the aspirator for vacuum retention before beginning the MVA procedure, and then create a vacuum for evacuation during the procedure.

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

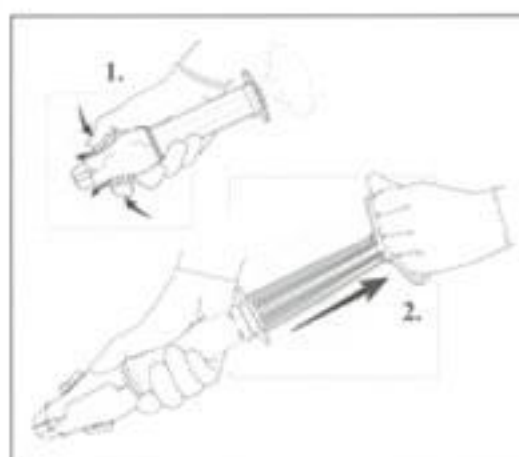


Figure: Create a Vacuum

Step 2: Prepare the Woman

Administer pain medication to have maximum effect when the procedure begins. Give prophylactic antibiotics to all women, and therapeutic antibiotics if indicated. Ask the woman to empty her bladder. Carefully help the woman onto the procedure table and ensure that she is securely positioned and that she has given permission to start the procedure.

Wash hands and put on appropriate barriers, including gloves. Perform a bimanual examination to confirm or update findings of the earlier clinical assessment. It is crucial to have an accurate



Figure: Perform Bimanual Exam

assessment of uterine size and position before performing a uterine evacuation. If there is doubt about the uterine size but the provider must continue with the procedure, the pregnancy should be treated as if it is further advanced than was initially suspected. Next, insert the speculum. If a range of sizes is available, use the size appropriate to the woman and conducive to the exam or procedure.

Step 3: Perform Cervical Antiseptic Prep

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



Figure: Perform Antiseptic Prep

Step 4: Perform Paracervical Block

When mechanical dilatation is required in an MVA procedure, it is recommended that providers administer a paracervical block. Any time a cannula is passed through the os, it causes friction and irritation of the nerves in the cervical canal, which may produce pain. Pain is also produced when the uterus contracts after the uterine evacuation.

1. Fully load a 10 mL syringe with 1% plain xylocaine (10 ml).
2. Attach the 20-gauge hypodermic needle to the syringe. (Other needles may be used, such as a spinal needle or the needle from an IV insertion set.)
3. Inject 2 mL superficially into the cervix at the site where the vulsellum/ tenaculum will be placed (12 o'clock).
4. Grasp the cervix with the vulsellum /tenaculum.
5. Use slight traction to push the cervix inward and to the side firmly to expose the tissue where the cervix meets the vagina, first on one side and then the other. This transition marks the site of further injections around the cervix. Compared to cervical tissue, vaginal mucosa is more elastic and appears folded.

- Inject the remaining 8 mL in equal amounts at the cervicovaginal junction at 2, 4, 8 and 10 o'clock. The injection is continuous from superficial to deep to superficial to a depth of 3cm. These superficial tissues can bleed briefly, but it is not serious, and the uterine vessels are several centimeters away. Always aspirate before injecting to prevent injecting into a vein.

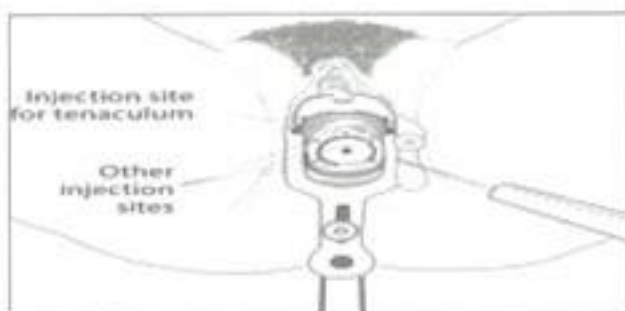


Figure: Paracervical Block

- Dilatation begins 3 minutes after the paracervical block is complete.

Step 5: Dilate cervix

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

It is essential to carefully examine the position of the uterus and cervix and to gently use instruments that accommodate the woman's anatomy. Dilate the cervix as necessary to allow a cannula approximate to the uterine size to fit snugly through the os.

The provider should dilate gently, never using force. Use mechanical dilators or progressively larger MVA cannulae, being careful not to tear the cervix or create a false opening. The tenaculum or volsellum can be used to straighten the cervical os to allow for easier passage of the dilators. Uterine perforation can occur, particularly if the provider miscalculates the position, size and depth of the cervix and uterus or uses force to insert instruments.

Dilatation or cervical preparation may also be accomplished by administering pharmacological agents such as misoprostol, where available.

Misoprostol as Cervical Preparation for First-Trimester MVA

Cervical preparation is recommended before MVA for all women over 12-14 weeks. Providers may offer cervical preparation before 12 weeks but do not need to use it routinely. In the first-trimester, women with cervical preparation have decreased procedure time and a decreased risk of incomplete abortion compared to women without cervical preparation. However, because first trimester MVA is so safe, it is not known whether cervical preparation decreases the risk of serious complications like injuries to the cervix and uterus.

Women experience side-effects from the medicine or dilators including increased pain, bleeding and nausea. Cervical preparation increases the complexity, cost and time needed to perform an abortion. These disadvantages must be weighed against the benefits of cervical preparation. For women at higher risk of complications (young women, nulliparous women, women with cervical abnormalities, or women at later gestational ages) or inexperienced providers, there may be a benefit from cervical preparation even before 12 weeks gestation.

The following table shows choices for cervical preparation. The choice depends on availability, expense, convenience and preference. If misoprostol is used, vaginal misoprostol has fewer systemic side-effects than sublingual misoprostol. Misoprostol should not be given more than three hours before an abortion as it increases the risk that a woman will expel her pregnancy before the procedure can occur.

Table: Examples of Dose/Route/Timing of Misoprostol

Dose	Route	Timing
400 µg (two 200 µg tablets)	Vaginally	3 hours before procedure
400 µg (two 200 µg tablets)	Sublingually	2-3 hours before procedure

Notes:

- Side effects may include chills, fever, nausea, vomiting and diarrhea.
- Side effects may also include bleeding, cramping and risk of expelling the pregnancy prior to vacuum aspiration.
- Increasing the vaginal dose to 600 µg or 800 µg gives similar dilation rates to the 400 µg dose, with more side effects.
- Misoprostol has been shown to be as effective as mechanical (for example, laminaria) dilators.

Step 6: Insert Cannula

While gently applying traction to the cervix, insert the cannula through the cervix, just past the cervical os and into the uterine cavity. Alternately, move the cannula slowly into the uterine cavity until it touches the fundus, and then withdraw it slightly. Rotating the cannula while gently applying pressure often helps insertion.

Do not insert the cannula forcefully through the cervical os into the uterus. Forceful movements may cause damage to the cervix or uterine perforation and damage to pelvic organs and blood vessels. Remain alert to signs that may indicate perforation throughout the procedure, and stop suction immediately if they appear. It is important to use a cannula size appropriate to the size of the uterus and amount of cervical dilation present. Using a cannula that is too small may result in retained tissue or loss of suction.

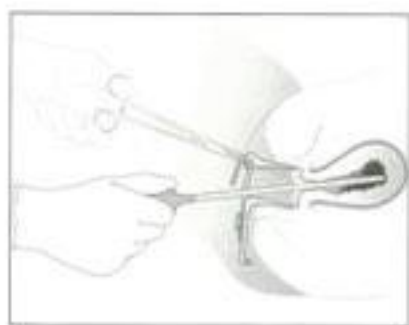


Figure : Insert cannula



Figure : Attach Aspirator

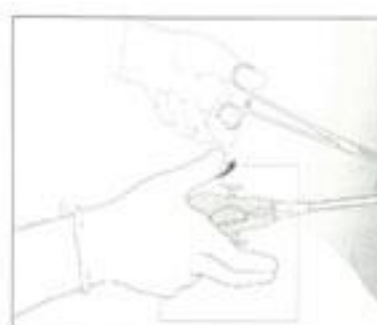


Figure : Release Buttons

Step 7: Suction Uterine Contents

Attach the prepared MVA aspirator to the cannula, holding the tenaculum and the end of the cannula in one hand and the aspirator in the other hand. Suction is started by pressing the buttons in; suction will start immediately.

Evacuate the contents of the uterus by gently and slowly rotating the cannula 180 degrees in each direction, using an in-and-out motion. Blood and tissue will be visible entering the cylinder of the aspiration device through the cannula. It is important not to withdraw the opening of the cannula beyond the cervical os, as this will cause the vacuum to be lost. If this happens, or if the aspirator is full, detach cannula from aspirator and re-establish the vacuum. Be aware that Ipas EasyGrip® cannulae fit firmly into the valve body and care should be used when disconnecting a cannula from the aspirator.

The following signs indicate that the uterus is empty:

1. Red or pink foam appears and no more tissue is seen passing through the cannula.
2. A gritty sensation is felt as the cannula passes over the surface of the evacuated uterus.
3. The uterus contracts around (grips) the cannula.
4. The woman complains of cramping or pain, indicating that the uterus is contracting.

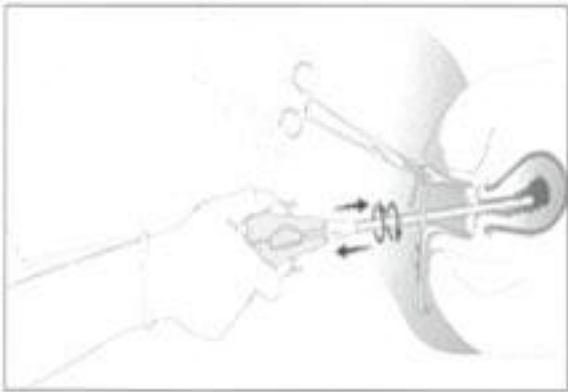


Figure : Evacuate Uterine Contents

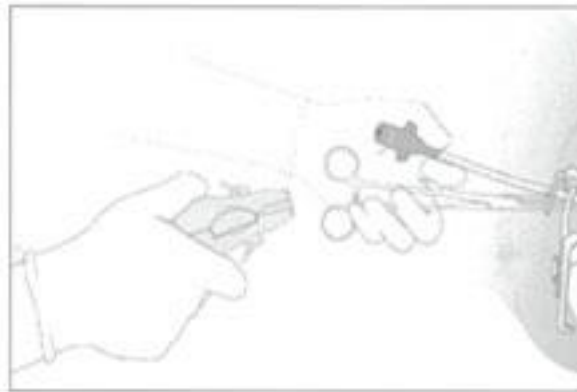


Figure : Detach Cannula from Aspirator

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

Step 8: Inspect Tissue

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

Inspect the tissue for these signs:

- The quantity and presence of POC
- Complete evacuation
- Molar pregnancy

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

Villi and decidua should be visible in the tissue and the amount of tissue should correspond to the uterine size. In cases of molar pregnancy, grape-like chorionic villi are usually seen.

If no POC are visible, less tissue than expected was removed from the uterus or the tissue sample is inconclusive, this may indicate:

- **Incomplete abortion:** The uterine cavity still contains POC, even though it appeared to be empty at the end of the procedure. This may result from using a cannula that is too small or stopping the procedure prematurely.
- **A spontaneous abortion** that has already completed itself
- **A failed abortion**
- **Suspected ectopic pregnancy:** When no villi or decidua are seen, ectopic pregnancy is a possibility and should be followed up on immediately
- **Anatomical anomaly:** For example, in a bicornuate or septate uterus, the cannula may have been inserted into the side of the uterus that did not contain the pregnancy.

If it appears after tissue inspection that tissue may still be present in the uterus, re-evacuate the uterus.

Wipe the cervix clear with a clean swab to assess the amount of blood still coming from the uterus or any other source before removing the speculum. If significant bleeding continues or other issues are identified, the provider should intervene as needed. (See Module 7: **Complications module** for more information.)

Use clinical judgment to determine if a bimanual exam will be necessary to check the size and firmness of the uterus.



Figure: Inspect the Tissue

Step 9: Perform any Concurrent Procedures

When the MVA procedure is complete, proceed with any contraceptive or other concurrent procedures to be conducted, such as inserting an IUCD, performing female sterilization, or repairing a cervical tear.

Step 10: Post-Procedure Steps and Instrument Processing

When the uterine evacuation and any additional procedures are complete, providers should take the following steps:

- Immediately process or discard all instruments, including the aspirator and cannula, according to instrument processing procedures. (See the **section *Processing Ipas Instruments of module 5*** for more information.)
- Remove barriers, such as gloves, and wash hands.
- Reassure the woman that the procedure is finished.
- Help her into a comfortable resting position on the table.
- Assist with moving her to the recovery area.
- Record information about the procedure, according to local protocol.

3.3 Considerations for Postabortion Care

- Post abortion care treatment can be an emergency situation, and the woman's condition can change quickly at any point during her care. The provider should remain alert for changes in the patient's emotions and physiology throughout the procedure, as these changes may indicate complications.
- Women who are unstable due to hemorrhage or sepsis need to be stabilized and treatment started immediately. Treatment may require immediate uterine evacuation.
- Cervical dilatation is required in some cases.
- Pain management should be provided, including paracervical block, to address pain due to cervical manipulation.

3.4 Summary

- Pain management should address both the physical aspects of pain (nulliparity, young age, higher gestational age, dysmenorrhea), psychosocial contributors (anxiety, depression), and procedural aspects (cervical dilation, uterine manipulation)
- All women who present for abortion should be offered pain management and provided these services without delay. Providers should always offer gentle, respectful care and provide verbal reassurance and appropriate information, which can help women stay calm and reduce anxiety and pain.

- Pain and discomfort during an MVA procedure can be reduced using a combination of verbal support, oral medications, paracervical block and gentle clinical technique and a calming environment.
- The three categories of medication used for pain control are analgesics, anesthetics and anxiolytics.
- Some amount of post-procedure pain is normal, and women should be offered choices for managing that pain.
- An accurate assessment of uterine size and position must be completed before performing a uterine-evacuation procedure. Providers should not attempt to evacuate a uterus until the size has been determined.
- Prophylactic antibiotics should be administered prior to the procedure.
- It is recommended that providers administer a paracervical block to all women undergoing MVA procedure for uterine evacuation.
- Cervical dilatation can be performed by using mechanical dilators progressively larger MVA cannulae, by pharmacological agents such as misoprostol. Cervical dilation is required in most, but not all cases.
- Dilation is not needed when the cervix allows a cannula of appropriate size to fit snugly through the os.
- Signs that indicate the uterus is empty include: red or pink foam appears and no more tissue is seen passing through the cannula; a gritty sensation is felt as the cannula passes over the surface of the evacuated uterus; the uterus contracts around (grips) the cannula; the woman complains of or notes pain, indicating that the uterus is contracting.
- Evacuated tissue should be inspected for quantity and the presence of POC and fetal parts and signs of complete evacuation or molar pregnancy.
- No visible POC, a lower quantity of tissue than expected or an inconclusive tissue sample may indicate incomplete abortion, completed spontaneous abortion, failed abortion, suspected ectopic pregnancy or anatomical anomaly.

MODULE 7:

POST-PROCEDURE CARE AND FOLLOW-UP

Key Topics:

1. Steps and purposes of post-procedure monitoring
2. Assessing bleeding, cramping and other symptoms during recovery
3. Assessing a woman's emotional state
4. Contraceptive need
5. Follow-up appointment and referrals
6. Discharge instructions, including how to monitor for danger signs that may indicate complications

1. Introduction

Post-procedure care comprises all services provided to the woman after her medical procedures (uterine evacuation) are complete but before she is released from the facility. See Appendix I: *Post-Procedure Care Skills Checklist* for a concise list of all services that should be provided as part of post-procedure care. It is necessary to ensure that any complications that occur during or immediately after medical care are identified and addressed. In addition, post-procedure care provides an opportunity for the woman to obtain information about how to identify and seek treatment for complications that could arise after she has left the facility. Thus the post-procedure period as well as any subsequent follow-up represents important opportunities to ensure the health of woman who has just undergone abortion service.

2. Immediate Care after Abortion Service

- The woman should be given the options of lying down or reclining in a position that is comfortable for her, ensuring privacy.
- The vital signs woman should be observed (e.g. BP, pulse, respiration) until she is stable, pain and discomfort have subsided, she can walk comfortably on her own and drink fluids. This usually occurs within half an hour to one hour after the procedure. However, the length of the recovery period will vary depending on the woman's condition, the ease of the procedure, the types of pain medication administered, and any other procedures performed.

- Monitor for vaginal bleeding. Passage of clots, soakage of more than two pads in an hour for two hours indicates ongoing heavy bleeding and should be addressed. Women who are experiencing excessive blood loss may appear pale and increasingly weak, possibly with diminished consciousness, and abdominal pain. There may be a drop in blood pressure or increase in heart rate.
- During monitoring take special note of woman's reports of severe pain, since pain maybe due to uterine perforation or acute haematometra.
- In the absence of complications, most women can leave the health care facility as soon as they feel able and their vital signs are normal.
- During this time additional post abortion contraceptive counseling and service can be provided if needed. Also address any other reproductive and sexual health issues like reproductive tract infections, sexually transmitted infections, psychological counseling, counseling for domestic and sexual violence, etc.



Figure: Monitoring Vital Signs



Figure: Emotional Support

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

Significant physical decline as reflected in deteriorating vital signs or physiological status.

Dizziness, shortness of breath or fainting. These symptoms may be caused by internal or external blood loss. Fainting may also be due to anxiety or to a transient vagal reaction.

Severe vaginal bleeding. While some post-procedure bleeding is expected, the amount of bleeding should decrease over time. Excessive bleeding may be a sign of retained POC, the lack of normal uterine tone, cervical laceration, or other complications.

Severe abdominal pain or cramps. Although some post-procedure cramping is normal, the severity of cramping should decrease over time. Severe, prolonged cramping may be a sign of uterine perforation or postabortal hematometra, which is a pooling of blood in the uterus that can occur following uterine evacuation. Postabortal hematometra can present either immediately following the procedure or several days later. Signs of a hematometra include an enlarged, tender uterus.

3. Emotional Monitoring and Support

Staff who work with women during the post-procedure period should be trained to assess and respond sensitively to each woman's emotional state, and to monitor and provide care accordingly. A woman's emotional state affects the amount of pain she experiences and her rate of recovery.

Studies have shown that when health-care staff demonstrate empathy and employ effective communication skills, clients are more satisfied with their health care. These clients are more likely to experience a better overall recovery and to seek follow-up care, if needed. The more information a woman is given before, during and after her abortion procedure, the better equipped she is to care for herself.

Before discharge, the woman should be offered counseling support. The counselor can then refer her for other services, when appropriate, such as support services for women who have experienced violence. (See Module 3: *Counseling, Information, and Informed Consent* for more information.)

4. Post Procedure Information and Follow-Up

The recovery period presents an important opportunity to provide woman with relevant information and education, contraceptive services including counseling and follow-up instructions.

Woman undergoing abortion should receive clear, simple, verbal and written instructions about how to care for themselves after leaving the health-care facility, and how to recognize complications that require medical attention.

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

If anemia is suspected or has been diagnosed, the provider should discuss dietary recommendations and nutritional supplements with the woman. Treatments for anemia include iron tablets and iron-rich foods such as green, leafy vegetables and red meat.

Women may wish to obtain more information and referral resources for various aspects of their sexual and reproductive health, such as testing for STIs and HIV/AIDS, screening for cervical cancer or counseling for violence. The follow-up appointment is an opportunity to provide health education and referral on the above-mentioned topics, if women are interested, it can be provided.

After an uncomplicated abortion, the woman may have vaginal intercourse and as soon as she desires to do so. If she wants to prevent future unwanted pregnancy, she should use an effective form of birth control when having intercourse. Conception can occur again within 8 days after a first-trimester abortion.

5. Contraceptive Counseling

Contraceptive counseling should be provided during the recovery period or prior to discharge, if it has not yet been offered. The health-care worker should sensitively initiate a discussion with the woman about her desire for future childbearing in the short and long term. If the woman wishes to prevent pregnancy, the provider should ensure that she receives the contraceptive method, including emergency contraceptive, of her choice before leaving the facility or that she knows where to get her desired method. If the woman desires a method that is not clinically appropriate at this time, she should be offered a choice of temporary methods to use in the interim. (See Module 3: *Counseling, Information, and Informed Consent* for more information.) Abortion service delivery sites should be able to provide most methods in the facility if the woman chooses a method. If the contraceptive chosen by the woman cannot be provided (e.g. sterilization is rarely offered at primary care level), the woman should be given information about where and how she can get it and offered an interim method.

All women should be informed about emergency contraception and consideration should be given to providing it to women who choose not to start using a routine contraceptive method immediately.



Figure: Post-abortion Contraceptive Counseling

Providers should discuss prevention of STIs including HIV and the importance of condom use with all women regardless of the contraceptive method chosen. Information about infection prevention should be particularly emphasized for people who may be at increased risk, and in areas of known high prevalence of HIV. Voluntary testing and counseling may be offered, or referral to HIV counseling and testing in other facilities. Dual protection, or the use of methods to protect against both pregnancy and STIs, should be promoted.

6. Recovery and Discharge

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

If the woman aborts in the clinic:

- Observe the expelled tissue, if possible, to confirm a complete abortion.
- Review postabortion instructions and provide information on warning signs.
- Encourage the woman to contact or return to the clinic with any problems, questions or concerns.
- Provide a contraceptive method, if desired by the woman.

If the woman leaves the clinic before she aborts:

- Ensure that she has instructions and supplies relevant to aborting in non-clinical setting.
- Provide her with pain medication to take away from clinic.

For all women undergoing MA:

- Follow-up visit can be scheduled within two weeks if a woman desires to be followed up. If the women cannot visit the facility she should know where to contact if in case of emergency.
- Review instructions and provide information on warning signs indicating the woman should contact the clinic.
- Provide a contraceptive method if desired.

Signs of a normal recovery:

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

Discharge of Women with Complications

Women who experienced complications during or after abortion care may need additional discharge instructions. Providers should place particular emphasis on the importance of follow-up care when discharging these women. In addition, it is essential for providers and facilities to develop adequate protocols for following up with women who are at high risk for delayed complications or adverse sequelae. (See Module 8: *Complications* for more information).

7. Follow-Up Care for MA

A routine follow-up visit after MA or VA is not recommended by WHO but if the woman feels she is uncomfortable and wants to follow up then this can be done at 2 weeks. If the woman taking MA at home then the provider can follow up with the woman by telephone also. A woman who takes medication at home should be given an explanation of how to recognize the signs of expulsion (bleeding and cramping) that occur with a successful MA. In general, women who feel they have had a successful MA do not need further care.

When to follow up:

- If a woman takes the medication and has minimal or no bleeding or still feels pregnant, she should return to the provider to check whether she has had a successful abortion or if she needs a procedure to complete her abortion.
- If a woman is concerned about ongoing bleeding or other problems, she may return at any time.
- If a woman desires reassurance after the abortion, she may return in approximately two weeks to confirm that she has had a successful abortion, or to receive additional desired services.

If the woman returns for follow-up care, the provider should:

- Inquire about the woman's experience with the abortion process.
- Confirm success of the abortion: Steps to assess completion of abortion process in women treated with MA
 - Assess the amount and timing of vaginal bleeding and cramping.
 - Ask the woman if she ever felt pregnant, and if she still feels pregnant now. Review what pregnancy symptoms she experienced prior to and after the abortion. For example, if the woman had morning sickness and breast tenderness beforehand, has that resolved?
 - For women who used MA at home, review adherence to the protocol. For example, ask "Tell me how you took the pills?"
 - Perform a pelvic exam. Compare it to the exam documented prior to the MA.
- If the woman was up to 7 weeks at the clinical assessment, the uterus should feel non-pregnant at a 2 week follow-up.

- If the woman was 8 weeks or more, the uterus should be smaller than the period of gestation at the 2-week follow-up.
 - The abortion is most likely completed if her pregnancy symptoms have stopped, her bleeding pattern is normal, and her uterine size is non-pregnant or smaller than before.
 - If still in doubt, conduct an ultrasound to look for a viable pregnancy.
 - Perform MVA to complete the process in the case of a continuing pregnancy.
 - Inform the woman of what to expect following completion or continued treatment.
 - Stabilize, treat, or refer for any acute problems.
 - Review any laboratory test results.
 - Provide a contraceptive method, if desired and not already provided.
 - Refer for other medical, gynecologic or counseling services where indicated.

What to Expect at the Follow-Up Visit

At follow up, clinicians commonly encounter the following scenarios:

Normal

This is the most common outcome if the woman took the medicines as instructed. Generally, the day after the woman takes misoprostol, she will start to feel better and by the follow-up visit will no longer feel pregnant. Her bleeding and cramping will be significant for about a day following misoprostol, but then diminish over the following week so that by the time of the follow up visit, cramping is usually gone. If 2 week follow up is conducted, approximately 60 percent of women who had MA are still having light bleeding or spotting.

Problematic bleeding

Some women report tiresome or problematic bleeding at the follow up visit despite the fact that the pregnancy is not continuing, pregnancy symptoms have resolved and the uterus is smaller in size. **Various patterns of problematic bleeding are:**

- **Persistently heavy bleeding:** The woman bleeds like a heavy menstrual period continuously since taking misoprostol. If the woman has clinical symptoms of low blood volume due to bleeding (fatigue, weakness especially upon standing, racing pulse, feeling faint), and/or if hemoglobin or hematocrit (if testing is available) has dropped significantly from the initial value, MVA should be performed.
- If her bleeding is currently not heavy but is somewhat prolonged or erratic and she is clinically stable and feels well, a repeat dose of misoprostol may be offered as long as the woman is willing to return in 1 to 3 days for assessment. Providing a second dose of misoprostol to enhance uterine contractility is a common practice, although it is not clear from evidence whether the repeat misoprostol actually decreases bleeding. Fluid intake (oral hydration) and iron-rich foods or iron supplements should be strongly encouraged.

- **Erratic bleeding:** Some women have days of very little or no bleeding followed irregularly by heavy, gushing bleeding. If she is symptomatic of anemia, consider performing MVA. Fluid intake (oral hydration) and iron-rich foods or iron supplements should be strongly encouraged.
- **Hemorrhage:** See Complications module.
- **Delayed bleeding:** Very rarely, after a normal follow-up exam and several weeks of little or no bleeding, a woman will experience sudden, heavy bleeding. Treat the woman according to the severity of clinical presentation.
- **Ongoing Pregnancy:** See Complications Module-8

Problematic bleeding, along with continuing pregnancy, is a signal that MA may not be successful. If the woman is experiencing problems, but not severe bleeding, discuss treatment options with her including:

- 1) Waiting and watching for several weeks;
- 2) MVA.

Sometimes a woman is tired of persistent bleeding and requests MVA even though it may not be clinically necessary; this option should be available to her if possible.

8. Referrals

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

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

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

9. Summary

- The purpose of post-procedure monitoring is to ensure that the woman is recovering well, to offer counseling and referrals, and to provide the woman with discharge instructions and information.
- Post-procedure care ensures that any serious complications or medical concerns that arise during or after care are identified and treated prior to a woman's discharge from the facility.
- Every woman should be offered contraceptive counseling and, if desired, a contraceptive method or referral before being discharged from the facility.
- It is essential to provide information that can help the woman identify and seek attention for any danger signs that may appear after she has left the facility.
- If needed providers should assist each woman and arrange for follow-up care before she leaves the facility.
- A follow up visit is not mandatory but this can be done if the provider or the woman feels it is necessary.
- Clinical elements of the follow-up visit include reviewing medical records, assessing the woman's physical status, conducting a pelvic exam, following up diagnostic test results and identifying and managing any physical conditions.
- MVA is recommended for continuing pregnancies.
- Referral protocols and resource lists that provide simple, accurate and up-to-date information are essential components of an effective referral system.

MODULE 8:

COMPLICATIONS

Key Topics

1. Signs and symptoms of presenting, procedural and pregnancy-related complications
2. Steps to diagnose, manage or refer complications

1. Introduction

Complications are rare during or after uterine evacuation but they do occur. Women who access services for post abortion care may have presenting complications that need treatment. Safe abortion does not cause future infertility, breast cancer or severe psychological reactions. This module gives information on the most common complications that women may experience during the course of abortion or post abortion care, their signs and symptoms and basic management.

When abortion is performed by appropriately trained personnel, complications are rare. Nevertheless, every service delivery site at every level of the health system should be equipped and have personnel trained to recognize abortion complications and to provide or refer women for prompt care, 24 hours a day.

Major complications can sometimes be avoided by intervening at the right time with the proper treatment. Problems can be reduced if women know what to expect and when to seek care and if appropriate care is provided in a timely manner. This module addresses complications that may occur during or after CAC procedures.

2. Presenting Complications

Typically, women presenting for post abortion care are ambulatory and complaining of vaginal bleeding and pain and fever or chills and need treatment for incomplete abortion. Women who have suffered more severe complications may present with shock, hemorrhage, sepsis and intra-abdominal injury. Severe complications are more likely in settings where unsafe abortion is common.

3. Procedural Complications

When uterine evacuation is performed by a trained provider, procedural complications are infrequent. However, even in the most skilled hands complications will occur. It is important to be prepared to diagnose complications and provide treatment quickly and safely. Complications can occur during uterine evacuation, during the recovery period or later, and facilities must have an established protocol to address this possibility. Complications may occur with MVA and MA. In most cases, complications can be managed successfully if treatment is initiated promptly. Serious complications are rare, and can usually be treated by a trained clinician providing general emergency medical and surgical care. If emergency facilities are not available on site, complications should be managed through the timely transfer of the woman to an acute-care facility.

4. Pregnancy-Related Complications

Some women may have pregnancy-related or gynecologic complications such as molar pregnancy, ectopic pregnancy or uterine abnormalities that require specific clinical consideration and management. These conditions are often discovered during the clinical assessment and can be addressed before the procedure is performed. Some may not become evident until during or after the uterine evacuation.

Ectopic Pregnancy

All women should be evaluated for the possibility of ectopic pregnancy prior to receiving MA or MVA. (Please see Module 2: *Clinical Assessment*). Neither MVA nor MA will end an ectopic pregnancy.

After a MVA procedure, ectopic pregnancy should be suspected and the woman treated immediately if no villi or decidua are seen when POC are examined.

If a woman has used MA and presents with the following symptoms, ectopic pregnancy should be suspected and the woman should be treated immediately:

- Minimal vaginal bleeding after taking medications for abortion
- Uterine size that is smaller than expected
- Sudden, intense and persistent lower abdominal pain or cramping, initially one-sided then generalized, that may be accompanied by irregular vaginal bleeding or spotting and/or a palpable adnexal mass
- Fainting, shoulder pain, rapid heartbeat or lightheadedness (from internal bleeding). Internal bleeding is not necessarily accompanied by vaginal bleeding

A ruptured ectopic pregnancy is a gynecologic emergency that can be life threatening and requires immediate surgical intervention. A woman with suspected ectopic pregnancy should be treated or transferred as soon as possible to a facility that can confirm diagnosis and begin treatment. Early diagnosis and treatment of ectopic pregnancy save women's lives and help preserve their fertility.

5. Complications of MVA or MA

Several types of complications may infrequently occur with either MVA or MA. These include: incomplete abortion, infection, continuing pregnancy, hemorrhage, and uterine atony.

Incomplete Abortion

After uterine evacuation, some tissue may remain in the uterus. Large amounts of retained tissue can result in heavy bleeding and infection if untreated. If a woman has heavy bleeding or signs and symptoms of infection, the recommended treatment is immediate repeat MVA.

Small amounts of retained tissue may pass spontaneously without requiring further intervention. Close monitoring until the retained products are expelled may be sufficient or a woman may be offered misoprostol for incomplete abortion. Otherwise, treatment involves evacuation of the uterus, preferably using MVA.

Infection

The rate of infection after a safe first-trimester abortion is low, occurring in less than one in 100 women. Routine use of prophylactic antibiotics with MVA can decrease the rate even further. Infection is more likely to occur if a woman has had an incomplete abortion. If the woman has retained tissue in the uterus, it should be evacuated immediately. All women with infection should be started on broad-spectrum antibiotics with the route of administration dependent on the severity of the infection.

Signs and symptoms of uterine infection after vacuum aspiration or medical abortion

- Lower pelvic or abdominal pain
- Bleeding
- Fever and chills
- Uterine or lower abdominal tenderness on exam
- Cervical motion tenderness

Continuing Pregnancy

Continuing pregnancy after MVA is rare, occurring in approximately two per thousand procedures. Risk factors include:

- Early gestational age (<six weeks)
- Operator inexperience
- Uterine anomalies such as bicornuate uterus
- Extrauterine pregnancy

Examining the aspirate immediately after abortion can decrease the risk of failed MVA. If a woman presents a week or more after the abortion and still has pregnancy symptoms, she should be evaluated for continuing pregnancy and offered repeat uterine evacuation.

After MA, a continuing pregnancy occurs in less than one percent of women who take mifepristone and misoprostol and approximately 4-6 percent of women who use misoprostol alone for gestations up to nine weeks. A continuing pregnancy is suggested by a lack of vaginal

bleeding, persistent pregnancy symptoms and/or increasing uterine size. When pregnancy continues after taking misoprostol only for abortion, MVA is recommended.

Hemorrhage

Hemorrhage requiring transfusion is rare after safe abortion, occurring in less than 1 in 1,000 women after MA with mifepristone and misoprostol and MVA. Hemorrhage may occur because of incomplete abortion, infection or uterine atony.

Indications that bleeding requires immediate attention are:

- Abundant gushing bleeding
- Bleeding like a heavy period that persists for weeks leading to significant anemia and hypovolemia
- Pale appearance accompanied by weakness, agitation or disorientation
- Blood pressure drop or woman feels faint when she stands up
- Rapid pulse especially when associated with low blood pressure
- Paleness around the inner eyelids, mouth, palms or fingertips
- Dizziness and fainting
- Decreased urine output.

Severe hemorrhage and prolonged heavy bleeding require immediate attention. Supportive therapy including intravenous fluid and blood replacement and oxygen administration should be started. MVA is the first option treatment for hemorrhage; this enables the uterus to contract and decrease bleeding. Uterotonics may also be used (see text box).

Uterine Atony

Uterine atony is a condition in which the uterus loses muscle tone and does not stop bleeding. It is a potentially serious complication due to the risk of hemorrhage. This complication is most common in women who have had several children and those with later pregnancies. Uterine atony can usually be treated with uterine massage and uterotonics. Signs and symptoms of uterine atony include:

- Copious vaginal bleeding
- Large, soft, boggy uterus

Uterotonics:

Therapies that may be given for bleeding or to stabilize a patient for transfer that have been used after vacuum aspiration or postpartum hemorrhage include:

- Methylergonovine 0.2 mg, intramuscularly or intracervically, repeat after 15 minutes for a maximum of 5 doses
- Oxytocin 20 units in 1L IV at a rate of 60 drops per minute, maximum of 3L of fluid
- Misoprostol 200-800 mcg orally, rectally or sublingually
- Intrauterine tamponade with sterile gauze packing, 30-75 ml Foley balloon or inflated condom

These therapies may also be effective after a medical abortion.

Management should be done step by step to control bleeding. Providers should move quickly to the next step if bleeding is not controlled. Hysterectomy should be done only as a last resort.

- Conduct bimanual massage
- Give uterotonic therapies (see text box)
- Proceed with uterine aspiration
- Perform intrauterine tamponade
- Perform hysterectomy if bleeding cannot be stopped by other measures

Though rare, other complications may occur that are specific to MVA and MA. These are reviewed below.

6. Complications of MVA

MVA is an extremely safe procedure with only rare complications. Those complications that do occasionally occur which are specific to MVA are: cervical, uterine, and abdominal injuries; medication-related complications; hematometra; vasovagal reaction; and Asherman syndrome.

Cervical, Uterine, and Abdominal Injuries

Minor cervical lacerations can occur from movement of the tenaculum or dilatation. If applying pressure does not stop then applying pressure by clamping a ring forceps over the tear will usually stop the bleeding. It can also be repaired by suturing. Uterine perforations that occur during MVA are usually very small and undetected, and may resolve without the need for surgical intervention. However, some perforations may result in injury to other organs or intra-abdominal bleeding. Depending on experience, availability and the extent of the injuries, laparoscopy or laparotomy can be used to investigate the perforation, diagnose any abdominal injuries and perform repairs. Vaginal packing may be used for emergent treatment of bleeding.

Signs and symptoms

During the procedure

- Excessive vaginal bleeding
- Sudden, excessive pain
- Instruments pass further than expected
- Aspirator vacuum decreases
- Fat or bowel in aspirate

Post-Procedure

- Persistent abdominal pain
- Rapid heart rate
- Falling blood pressure
- Pelvic tenderness
- Fever and/or elevated white blood cell count

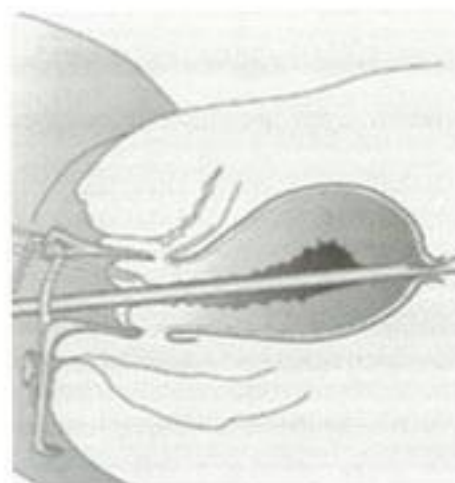


Figure: Uterine Perforation

Medication-Related Complications

Medications are widely used in a safe and effective manner for abortion care, but there are some potential complications associated with their use. Complications can be caused by:

- Overdose
- Intravascular injection of local anesthesia
- Hypersensitivity reaction

General anesthesia increases the rate of abortion complications and is not recommended for routine MVA. Treatment for anesthesia- and other medicine-related complications may include using reversal agents, treating respiratory and cardiac depression and stabilizing convulsions.

Signs and symptoms

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

Reversible agents

Drug Type	Generic Drug Name	Dose and Timing	Comments
Reversal agent for narcotic	Naloxone	IV: 0.4 mg vial mixed in 10 mL saline. Give 1 mL (40 mcg/mL) every two minutes until reversal is seen	Naloxone's duration of action is one hour and may wear off before the narcotic. Therefore, patients treated with naloxone must be monitored closely for several hours. Maintain airway and respirations while giving naloxone.
Reversal agent for benzo-diazepine	Flumazenil	IV: 0.2 mg every minute until respirations return. Do not exceed 1 mg	Flumazenil's duration of action is one hour and may wear off before the benzo-diazepine. Therefore, patients treated with flumazenil must be monitored closely for several hours. In the event of overdose with narcotic and benzodiazepine, reverse the narcotic first with naloxone and use flumazenil subsequently if needed. Maintain airway and respirations while giving Flumazenil.

Hematometra

Hematometra refers to the accumulation of blood clots in the uterine cavity. In such cases, the uterus cannot properly contract. Re-evacuation with MVA will usually resolve the condition.

Signs and symptoms

- Enlarged, firm, tender uterus
- Pelvic pressure
- Intense cramps and pain
- Lightheadedness
- Mild fever
- Scanty vaginal bleeding

Vasovagal Reaction

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

Signs and Symptoms

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

Asherman Syndrome

Asherman syndrome is a rare complication that can occur after MVA in which the inside of the uterus can become scarred. Asherman syndrome is rare after an uncomplicated VA and is more commonly associated with postpartum curettage. Signs and symptoms include amenorrhea, cyclical cramping and infertility.

Providers may also encounter Asherman syndrome when it appears as a pre-existing condition from a woman's previous procedure. However, Asherman syndrome is linked to decreased fertility, thus reducing the chance that women with this condition would experience unwanted pregnancy and seek abortion care.

7. Complications of MA

The majority of women undergoing MA do not have any problems or complications. Problems following MA, if they occur, can range from minor to true emergencies. Major complications are

rare, but can sometimes be avoided by intervening at the right time with the proper treatment. Problems can be reduced if women know what to expect, when to seek care and appropriate care is provided in a timely manner.

Those that do occasionally occur and are specific to medical methods are failure of MA, persistent pain and allergic reactions. Women who experience complications of MA need clear, evidence-based explanations of the situation and should be included in decision making about their treatment options. Fears about complications, perhaps compounded by pain, can add to the emotional stress that may accompany the abortion process. Most women cope better with their situation when they receive accurate, thorough information and have the opportunity to ask questions and express their feelings.

Although persistent side effects and serious complications are rare, clinic staff must be able to provide timely treatment or make appropriate referrals. If ultrasound is not routinely used in clinical that offer medical abortion, a referral system for ultrasound services should be established to evaluate any questionable or troublesome cases that may occur. An alternative method, preferably MVA, should be available on-site or through referral as back up for failed medical abortions.

Failure of MA

Failure of MA is defined as situations requiring an intervention to empty the uterus due to a continuing pregnancy or unacceptable symptoms such as hemorrhage. Unsuccessful MA may present as a medical emergency with significant hemorrhage. Alternatively, a woman may desire treatment to end persistent bleeding. Both situations should be evaluated and treated quickly. A woman's request is sufficient to offer repeat uterine evacuation.

A continuing pregnancy occurs in less than one percent of women who take mifepristone and misoprostol and approximately 4-6 percent of women who use misoprostol alone for gestations up to nine weeks. A continuing pregnancy is suggested by a lack of vaginal bleeding, persistent pregnancy symptoms and/or increasing uterine size.

Persistent Pain

If a woman has intense pain that persists for longer than 4-6 hours after taking misoprostol, or if she reports intense pain unrelieved with ibuprofen and mild narcotics, consider the possibilities of:

- Pregnancy tissue trapped in the os: If this is the case, it can sometimes be grasped with an instrument such as ring forceps and gently removed
- Ectopic pregnancy
- Upper reproductive tract infection
- Low pain tolerance

A woman who has intense or ongoing pain warrants further examination to ensure that she does not have one of these conditions. She should have a careful history taken along with a complete physical and bimanual exam, and management or referral as necessary.

Allergic Reactions

Allergic reactions to mifepristone and misoprostol are rare, but have been reported occasionally. These reactions have been accompanied by swelling of the hands or feet, rashes or wheezing.

Allergic reactions can be managed conventionally, for example with an antihistamine.

A severe allergic reaction is very rare but can occur with any medicine, food or substance. Women who experience sudden shortness of breath or swelling of the airway or any other severe or unusual reaction should receive emergency treatment.

8. Complications in Women who present for Post abortion Care

Women may present for post abortion care after spontaneous, safe, unsafe or self-induced abortion. When a woman presents with light to moderate bleeding and no complications, treatment may be limited to uterine evacuation. However, complications are more frequent and severe when women have unsafe abortions compared to safe abortions. Complications may be due to injury from the abortion procedure, incomplete uterine evacuation or infection. Often, because of healthcare barriers or stigma, women will delay seeking care after an unsafe abortion, which makes their condition worse.

When a woman presents with a life-threatening emergency, complete clinical assessment and voluntary informed consent may be deferred until actions have been taken to save the woman's life. Once the woman is stabilized, the provider should make a complete clinical assessment and obtain her consent for continuing treatment.

- Before treating complications, perform a rapid initial assessment and obtain voluntary informed consent if possible. Conduct a clinical assessment while beginning to treat complications. In cases of shock or other life-threatening emergency conditions, a complete clinical assessment and voluntary informed consent may be deferred until after the woman is stabilized.
- Severe complications may include shock, hemorrhage, sepsis and intra-abdominal injury.
- Shock can develop in any patient at any time during treatment, especially if significant injuries were not initially detected. Shock is a life-threatening complication and rapid action is needed.
- Facility staff should be well-trained on the treatment of complications, including shock, and all necessary supplies and medications should be available, as well as a referral system and transport in case referral to a higher-level facility is necessary.
- For women presenting with signs and symptoms of pelvic infection or sepsis or hemorrhage due to incomplete abortion, prompt uterine evacuation is a part of the emergency management and stabilization.

9. Emergency Response

In rare situations, using existing emergency response systems may be necessary. In an emergency, sometimes women need to be transferred to a higher-resource center for care. Having plans for such a situation in advance saves time, prevents confusion and facilitates appropriate care in extremely urgent scenarios.

Emergency response plans may include:

On Call Provider: Ensure that a clinically knowledgeable person is available to answer women's questions and provide or refer for care 24 hours a day. This provider can triage those women who need reassurance or instructions versus those who need clinical assessment or emergency care. In the case of MA, most women will take misoprostol at home and they may need reassurance that the process is normal and should be over in a few hours, or they may have a problem that requires immediate medical attention.

Referral:

It is important to put in place referral agreements (such as a memorandum of understanding) about transferring a woman to the referral center if necessary; it is preferable to refer women to the most accessible site.

If possible, providers can establish a relationship with emergency room staff and gynecologists at their referral hospital. It can be helpful to provide an information session for the staff that serve as emergency referrals for women. The session could include an overview of both MA and MVA, the continuum of expected effects and side effects, the types of complications that may be seen, and how to triage a woman having a postabortion emergency. Invite hospital staff to the clinic providing abortion.

Information Sharing:

If a woman will be transferred to a referral hospital, providers will need to call the hospital to notify them that the woman is being transported, why she is being referred for care, her history, what measures have been taken in the clinic and her current condition.

Develop a mechanism to receive records or verbal reports of a woman who received emergency care at the hospital so that the clinic can stay informed of such cases and their outcome and provide appropriate follow-up care.

Practicing for emergencies:

On a routine basis, facility staff should review and practice how they will handle emergencies so that everyone knows their roles and protocols. Staff need to practice how to treat hemorrhage, shock, starting intravenous fluids, giving oxygen (if available), and cardiopulmonary resuscitation.

Supplies:

Have an emergency cart or container with all the medicines and supplies that may be useful in an emergency. Have a regular monthly checklist of the contents of the cart to be sure it is stocked and that supplies and medications are not expired.

Links to communities:

Providers can work with community leaders and organizations, particularly women's and youth groups, to educate them about signs and symptoms of abortion complications that require prompt medical attention, as well as how and where women can receive emergency care. Communities can prevent delays in getting women with emergencies to health services such as through community-based emergency transportation systems. Health facility staff can train community health workers or local health volunteers to refer women in emergency situations to health-care services, to follow up with women after care and to link women to contraceptive and other reproductive health services.

10. Post-Procedure Care

During post-procedure care following abortion complications, the woman must be:

- Physically monitored and emotionally supported
- Advised about her condition, use of medications, contraceptive methods, and follow-up care
- Counseled about any long-term changes resulting from the complications—for example, post-hysterectomy or bowel perforation repair
- Told what to expect and what to do in emergency situations
- Given written or illustrated materials about her condition

11. Summary

- Uterine evacuation rarely results in immediate or long-term complications when performed by well-trained providers.
- Women presenting for Post abortion care may have existing complications that need treatment.
- Health-care staff must recognize and be able to treat—or make the appropriate referral for—complications that might occur during Post abortion care, during an abortion, in the recovery period or later. Complications may be presenting, procedural, or pregnancy-related.
- The possibility of ectopic pregnancy should be evaluated, for women receiving both MA and MVA, and should also be suspected after the abortion if no POC are found (after MVA) or the symptom profile is met (after MA).
- Possible complications related to both MVA and medical methods include: incomplete abortion, infection, continuing pregnancy, and hemorrhage.
- Possible complications related to MVA include: cervical, uterine and abdominal injuries, medication-related complications, hematometra, vasovagal reaction, and Asherman syndrome.

- Possible complications related to medical methods include: failure of MA, persistent pain, and allergic reactions to the medications.
- Women presenting for Post abortion care need a rapid initial assessment and immediate treatment for life-threatening conditions
- It may be necessary to refer women to another facility if life-threatening complications or pre-existing conditions require additional resources.
- Health systems should partner closely with communities to help ensure that women, including young women, with abortion-related emergencies can recognize signs and symptoms and access care in a timely manner.
- Women with abortion complications must be closely monitored, informed about necessary follow-up care and counseled on any medical and emotional consequences.

MODULE 9:

MONITORING, RECORDING AND REPORTING

Key topics:

1. Definition of monitoring
2. Key steps of monitoring
3. Recording and reporting in national log book
4. Definition of severe adverse event and its overview

1. What is Monitoring and why is it Important?

Monitoring is a way of using information to identify strengths and weaknesses, provide feedback and make adjustments to improve quality of care. Monitoring examines all aspects of care, including client satisfaction that may not be addressed through other means. Regular monitoring and adjustment help ensure that clients receive high-quality services and health-care workers have the resources and support they need for service delivery. Monitoring is an ongoing process that should be continued whenever and wherever services are provided.

Monitoring can range from inexpensive and simple to more complete, formalized approaches. A simple approach may be to only monitor a few indicators while more formalized approaches usually encourage assessment and monitoring across a wide range of service delivery components.

Information for monitoring can be gathered using existing or slightly modified routine information-collection systems, such as service delivery logbooks, service statistics and client records. Monitoring tools measure the same services at several points over time. The resulting "time series" information provides a long-range overview of how services change over time. Monitoring information enables providers and managers to recognize trends and identify problem areas, make necessary adjustments to services and check that these adjustments have had the desired effect.

Monitoring should be conducted at both public sector and private sector health facilities. The number and complexity of activities will vary according to the availability of staff and resources. In larger health facilities, administrators and managers usually conduct monitoring activities. In smaller facilities, providers may need to do the monitoring themselves.

2. Keys to Effective Monitoring Systems

Monitoring is most effective when it:

...is integrated into routine work

When monitoring adds too many extra steps, the process becomes time-consuming and burdensome for health-care workers. Information gathered for monitoring purposes can be gathered from existing sources such as logbooks and service statistics.

...uses simple indicators

A small number of simple, thoughtfully chosen indicators can provide invaluable information about service provision.

...is participatory and open

When the monitoring process is genuinely inclusive of all health-care staff members, they are more likely to feel a sense of ownership of the results. Staff should be trained to use monitoring tools so they can incorporate monitoring into their responsibilities.

...is conducted in an ethical manner

Women's privacy and confidentiality must be respected at all times. Informed consent must be obtained before women are interviewed or any provider-client interactions are observed.

...is not punitive

Monitoring is most effective when staff monitor themselves and the information gathered is used as a basis for reward and recognition.

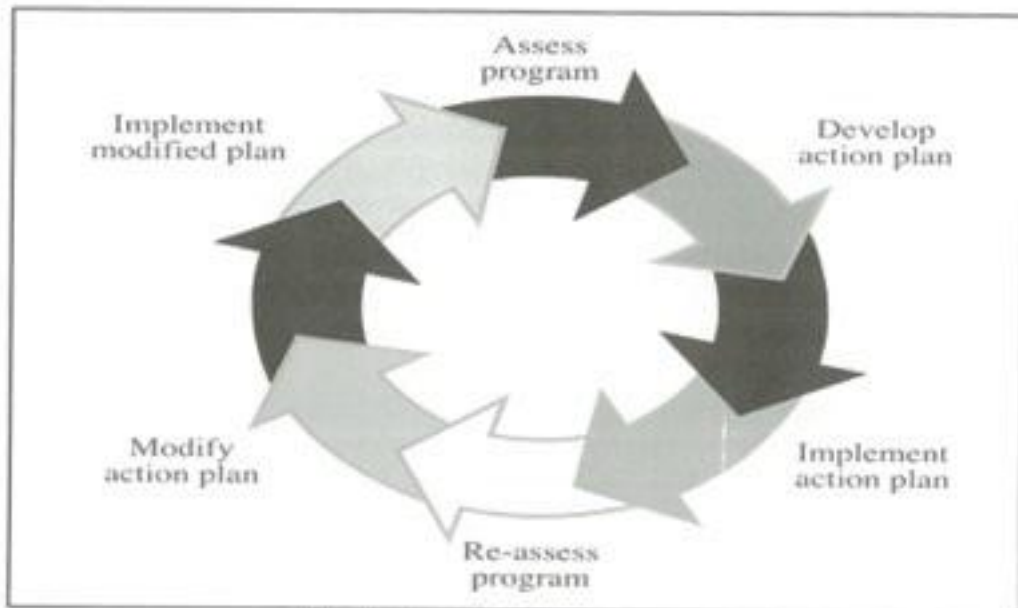
...includes recipients of the services, including young women in the design and implementation of the monitoring process

Conducting exit interviews, focus groups, or client satisfaction checklists is a good way to get information directly from the users of services to make improvements in quality of care.

Using indicators

Indicators are measurements that help quantify activities and results. It is important to pick indicators that are actually under staff control; otherwise the process can be very demotivating. The sample indicators below can help describe the overall quality of abortion care:

- Number and type of procedures performed by age of the client
- Number and type of procedures using appropriate uterine evacuation methods
- Number and percentage of women who receive pain medication
- Number and type of complications
- Number and percentage of women desiring contraception who receive a contraceptive method, by age
- Number of referrals made
- Number and percentage of women screened for sexually transmitted infections, including HIV
- Number and percentage of women screened for exposure to violence
- Number and percentage of women satisfied with services, by age
- Number and percentage receiving safe induced abortion services out of all women presenting for abortion-related care (PAC and induced)



Monitoring is a continuous process

3. Four Steps of Effective Monitoring

Monitoring involves four basic steps:

1. Planning

Develop a monitoring plan that specifies how information will be collected, shared and analyzed. Involve a range of stakeholders in the planning process. The plan should include:

- Members of the monitoring team, comprising a range of staff and recipients of services, including young women, and how team members will be trained
- Aspects of services to be monitored
- Quality standards and indicators to measure them
- Sources of information, such as logbooks with service statistics and client records
- Methods for gathering information, such as interviews, focus groups, observation and records review
- Checklists and other tools to guide observations, interviews and records review. Checklists should include the essential features of delivery of high-quality care, such as the availability of supplies, use of preferred medical techniques and quality of counseling
- A plan for sharing results with staff and the community, and improving services, if needed
- A timeline for the monitoring process, with information about activities and persons responsible for their completion

The following table illustrates aspects of abortion services that could be monitored and provides some sample questions.

Table: Examples of Abortion Services Monitoring

Types of Services <i>Which services should be monitored?</i>	Indicators <i>What will we use to measure our activities?</i>	Information Sources <i>Where can we get this information?</i>	Checklists, Questionnaires and Exit Interviews <i>What type of questions should we ask?</i>
Infection prevention	Percentage of cases in which infection-prevention practices were fully adhered to	Observe services using performance checklists	Was no-touch technique performed? Were MVA instruments properly processed?
Management and organization of services	Average amount of time clients spend in the facility Average amount of time from arrival to procedure Hours during which services are available	Review records of clinic finances, personnel and inventory Observe and evaluate clinic flow Review client records and conduct interviews with staff	During what times of the day does client waiting time increase?
Counseling	Number and percentage of women receiving high-quality counseling services	Observe contraceptive counseling services using performance checklists Review recent cases in logbooks	Were women with special needs given appropriate referrals when necessary?
Contraceptive counseling and services	Number and types of contraceptives dispensed on site Number and percentage of women who received contraceptive counseling Number and percentage of women desiring contraception who received a method	Observe counseling services using checklists Conduct exit interviews with women Review recent cases in logbooks	How well was the woman counseled about which contraceptive methods are available? Did the woman leave with the desired method or information? Did the woman have to go to another facility to receive a contraceptive method?
Client satisfaction	Percentage of women who indicate that they received respectful care Percentage of women who agree that clinic costs are reasonable	Conduct exit interviews with women Review financial records	Did you feel that you were treated respectfully? Do you think the amount you had to pay for services was reasonable?

2. Information gathering

Once the monitoring team has developed checklists and other tools, they can begin collecting information. There are several ways to gather data:

- Use information that is routinely collected by the health facility in logbooks, clinical records and supply ledgers. Local analysis of these data also prevents redundant monitoring and promotes collaboration between the administration and providers.
- To measure a change in a specific area of service delivery, use the same indicator over time.
- Conduct periodic observation and client interviews to examine aspects of service delivery such as quality of client-provider interaction and client satisfaction. The monitoring team should make sure to seek young women's perspectives.

The monitoring team should identify themselves, explain to the woman why she is being observed or interviewed and ask her permission to continue. The interview or observation must not proceed if the woman does not give her consent. Monitors must also ensure that privacy and confidentiality is respected. Clients' names and unique identifying information should not be included on monitoring forms.

3. Analysis

The information that is collected during monitoring should be compiled for review by the monitoring team. The review of monitoring data presents an opportunity for health-care staff to openly discuss the facility's strengths and weaknesses. Compile the findings, and review the data to:

- Reveal problem areas
- Develop improvement plans
- Assess progress in improving care

Quantitative data reveals numbers and straightforward facts. For example, clinic visits have dramatically decreased in the past two months.

Qualitative data, such as interviews, can be used to complement quantitative information. For example, exit interviews in one facility revealed that women were dissatisfied with the quality of counseling.

Once the staff has a better understanding of the issues, they can look deeper into the underlying causes of the identified problems. Health-care staff must ask, "What factors contributed to these problems?" In the example above, poor-quality counseling services might stem from inadequate training of newly hired staff and a client-intake process that leaves insufficient time for counseling.

Low-literacy client satisfaction assessment

One low-literacy approach to assess client satisfaction is for staff to give each client a small bean which they place in a box upon exiting the facility. The bean indicates how they feel about their care that day. The box is divided into 3 sections and each has a face on it expressing feelings - a happy face, a blank or flat expression face, and a sad face. The staff use this as a qualitative sample of what clients think about services as part of their performance quality monitoring.

The staff review may also identify causes that are more pervasive—for instance, an underlying belief that counseling is not an important part of services. Staff should also seek input from clients and community members to determine the root cause of a problem or issue.

4. Action Planning

The team should first assess which problems can be addressed with relative ease, given the available resources. They can then formulate a plan of action. Include young people from the community in discussing how to address problems in services for young people. A range of approaches to each problem should be discussed before making a decision on the best possible solution.

Alternate solutions should be listed as potential future options, in case the initial solution does not meet expectations.

To create an action plan:

- Draft a written plan that includes a timeline for implementation and assessment.
- Specify who will be responsible for implementing each step of the proposed solution.
- Discuss the plan with staff members who may help implement the steps.
- Present the findings and proposed solutions to the entire staff. This is an opportunity to obtain valuable staff feedback. Share positive findings with staff and community members, when appropriate, including areas of strength and competency and any improvements that have been made. Staff contributions that have led to improved services should be recognized so that staff members can celebrate their successes.

Solutions to problems in abortion services might include...

- Providing on-the-job training
- Reorganizing clinic services
- Changing clinic hours of operation
- Revising systems for procuring and storing supplies
- Strengthening referral systems

4. Considerations for Postabortion Care

- It may be useful to collect information on the method of unsafe abortion women present with (for example, if they seem to have already taken misoprostol as compared to having had an unsafe surgical procedure), and use this information to focus community education activities.
- A distinction should be made in the logbook between any complications the woman may present with and complications arising from PAC services.
- Monitoring the proportion of services for women with obstetric complications that are abortion related helps to assess the demand placed upon health care systems by abortion complications.

5. Routine Reporting Activities

Service providers have responsibilities in the provision of abortion services. Providers ensure that clients receive high quality and safe abortion services. Recording and reporting of relevant information is one of the important responsibilities regarding abortion services. Both MVA and MA that are provided must be recorded, and this data should be reported monthly to medical recorder or statisticians.

All listed sites must document the first trimester abortion services in the following:

- Client personal profile
- HMIS-3.7 registers
- HMIS-9.3/9.4/9.5

Client Personal Profile

All client information (personal history, gynecological information, general and physical examination, pelvic examination and the eligibility for the type of abortion) will be recorded on this form and kept confidential. It should not be made public unless required by the court (*Rajapatna, Procedural Order, 2003*). Consent of all clients before undergoing abortion service needs to be taken.

The provider will use this form to document the presence and management of any abortion related complications. For all young women below 16 or mentally challenged women, consent from a guardian (above 16 years) is needed.

HMIS 3.7 (Health Management Information System 3.7)

The provider should record accurate documentation in HMIS 3.7. In this register, abortion cases need to be documented for the type of procedure performed, post abortion contraception, if any complications occurred during and after the procedure and outcomes of complications treatment. This register is to record data for the purpose of monthly reporting of all CAC data.

HMIS 9.3 (Health Management Information System 9.3)/ HMIS 9.4 / HMIS 9.5

PHC/HP should record documentation in HMIS 9.3 and hospitals should record documentation in HMIS 9.4, and private facilities should document in 9.5. All three HMIS has the same four indicators as mentioned below.

1. The total number of abortion clients (MA or MVA),
2. Complications from a) this site and b) outside the service site.
3. Postabortion short-term contraception (Condom/ OCP/ Injectable),
4. Postabortion long-term contraception (IUCD/ Implant/ sterilization)

This need to be sent to concerned DPHO/DHO and the sample of HMIS 9.3/9.4/9.5 is given in the participants Handbook.

6. Severe Complication/Severe Adverse Event Reporting

Adverse events are complications that a patient suffers during treatment that are not a result of her presenting condition. Adverse events are rare in routine abortion and contraceptive care, but they do occur. Some adverse events cannot be anticipated (such as an allergic reaction to a medication) while others may be preventable (such as an error in deciding dose of a medication). Some complications are minor and self-limiting; for example, a cervical laceration that resolves after applying pressure. Others may be severe, resulting in life-threatening injury, such as bleeding that requires transfusion or surgical intervention or death.

An adverse event/complication (AE) is a condition requiring intervention and management beyond what is normally necessary that is related to:

- A procedure
- Anesthesia, or
- Postabortion contraceptive method
- *A severe adverse event (SAE)/severe complication* results in:
 - Life threatening injury
 - Permanent impairment of body function or permanent damage to body structure
 - Or necessitates medical or surgical intervention to prevent permanent impairment
 - Death

A near miss is an event that has potential to harm a patient but does not because chance, prevention or mitigation.

Some examples of adverse events and serious adverse events are listed below.

Table: Examples of complications/serious adverse events (SAEs)

Vacuum Aspiration	Medical Methods
Perforation treated conservatively or requiring surgery*	Unplanned aspiration (for example, for heavy bleeding or pain)
Anesthesia related complication requiring hospitalization or causing seizures	Reactions to medications requiring emergency treatment
Bleeding requiring a blood transfusion*	Bleeding requiring a blood transfusion*
Infection requiring intravenous antibiotics and/or hospital admission*	Infection requiring intravenous antibiotics and/or hospital admission*
Unintended intra-abdominal surgery	Unintended intra-abdominal surgery
Ongoing pregnancy	Ongoing pregnancy
Ectopic pregnancy unrecognized at time of procedure	Ectopic pregnancy unrecognized when MA given
Death*	Death*

*SAEs requiring reporting according to National Safe Motherhood Guidelines.

Frequency of Adverse Events

It is estimated that one in every 10 patients in the hospital for any reason suffers some adverse event. Although abortion is extremely safe, even in the safest settings, adverse events can and will occur. The risk of death from safe abortion is extremely rare.

Why Adverse Events Occur

Adverse events occur for many reasons. Adverse events are rarely the result of a single person or event, but usually result from a combination of multiple factors coming together during a single event. The factors leading to an adverse event include the following:

1. **Client factors:** The client may not be able to communicate information or disclose other relevant medical problems or have high-risk medical conditions. In abortion care, we know that increasing gestational age increases the risk of adverse events. Therefore, a woman at 18 weeks is at higher risk than a woman at 10 weeks. Other factors that may make adverse events more likely are complex medical problems, obesity or altered uterine anatomy.
2. **Human error:** Human error comes in two forms: slips and lapses and mistakes.
 - a. Slips and lapses are when a plan of care is adequate but does not go as intended because of improper actions. This may be related to inattention, fatigue, or failure of memory.
 - b. Mistakes are when the plan of care is improper for a certain situation. Most mistakes are due to problems with training, experience or knowledge.
3. **Institutional errors:** These errors occur when institutions do not adequately protect patient safety. For example, to save money an institution may not order the appropriate medications and supplies needed for treatment. A clinical setting that is not supportive may turn a minor complication into a serious life-threatening event.

How to Approach Adverse Events

After an adverse event has occurred and the patient has been cared for, there are two ways that events can be evaluated. The first way is in a culture of blame.

1. In a blame culture, a hospital or clinic might look to see which person caused the error so that they can be made to take responsibility or be punished. The goal is not necessarily to improve care, but to focus on individual responsibility.
2. In a safety culture, open dialogue is encouraged by all the people involved in the adverse event including the providers, assistants, administrators, the patients and their family (if appropriate). When adverse events occur, facility staff can hold discussions with family and community members to prevent misunderstandings and even potential threats, while respecting the woman's privacy. In a safety culture, the goal is to see where the system failed and to improve the system so that in future, the same adverse event does not happen again.

Adverse Event Reporting

As per the national policy (*Aama Surukshya* Guideline) severe adverse events need to be reported

if the women are hospitalized in the following condition:

- Bleeding requiring blood transfusion
- Infection requiring intravenous antibiotics
- Unintended intra-abdominal surgery
- Death (this is also covered in National maternal mortality review system)

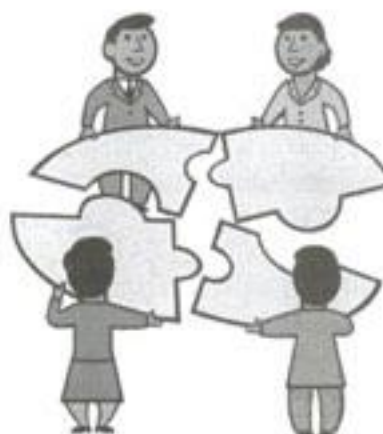
Any time an adverse event occurs during the course of patient care, the event itself gives us an opportunity to learn about how to provide better, safer care for patients. However, learning can only occur if we approach the adverse event from a culture of justice rather than a culture of blame.

The purpose of adverse event reporting is to improve site performance and outcome and prevent avoidable complications.

All severe adverse events need to be reported by a “safety culture approach” by phone, email or fax to the Family Health Division within 24 – 48 hours of the event. The components of a “safety culture” are a just culture, reporting culture, and learning culture. A just culture is one in which human actions are judged fairly and viewed within the complexity of the system factors. A reporting culture is one in which staff feel safe from retribution and report information about safety concerns even when it involves human error. A learning culture is achieved when active improvement efforts are directed at system redesign.



Blame Culture



Learning culture

Learning from Adverse Events

Once an adverse event is identified, recorded, and reported, the final step is to learn from the event. This is best accomplished through a team discussion with all relevant staff members. Conduct the meeting in “the spirit of learning,” that is, non-punitive and everyone is allowed and encouraged to speak.

As a team, discuss and answer these questions:

1. What happened?
2. Why did it happen?
3. What can be changed to prevent similar events in the future?

Determine what could be changed to help prevent the adverse event from happening again and implement that change.

“Each maternal death or case of life-threatening complication has a story to tell and can provide indications on practical ways of addressing the problem” (WHO 2004)

7. Summary

- Monitoring is essential to ensure that women receive high-quality abortion services and that health-care workers have the resources they need to provide high-quality care.
- Monitoring is an ongoing process that works best when it is consistent and continuous and when the same tools are used to periodically measure results.
- Monitoring should fit into the routine work of the facility, use simple indicators, be open and participatory, and be performed ethically.
- When possible, monitoring should include input and participation of community members or clients who have received services.
- Monitoring should not be an overly complex or punitive process.
- The four stages of monitoring are planning, information gathering, analysis and action planning.
- Although abortion is extremely safe, like with any medical procedure, adverse events can and will occur.
- Adverse events should be documented, reported as per national policy, and analyzed so that information learned can be used to improve care and client safety.
- Proper and complete recording at the site and periodic reporting to DPHO is mandatory.

MODULE 10:

SERVICE PROVISION

Key topics:

1. Physical facilities and health services
2. Medication and supply management
3. Staff knowledge and skill
4. Recording and monitoring need
5. Service site equipment guideline

1. Introduction

Several factors need to be in place to provide abortion service. Facilities, supplies, personnel, referral systems and quality assurance mechanisms all contribute to the provision of high-quality services.

2. Physical Facilities and Health Services

A clinical site is most capable of providing high-quality, women-centered CAC services when it has:

- Accessible hours and days of available CAC services
- A space for registration and record-keeping
- Private areas for information and counseling
- A separate area for adolescent and young women for waiting and recovery
- Infection prevention practices and supplies
- A procedure room with an adequate light source and equipment for MVA procedures
- Procedure tables, recovery beds, and a table and chairs
- An effective referral system for complications
- Integrated family planning services
- A laboratory

3. Medication and Supply Management

Supplies and medications are essential to the provision of CAC services. In order to better guarantee the provision of high-quality, accessible MA, there should be an adequate supply of recommended drug regimens available in the clinic at all times. Sanitary pads or cotton wool can be made available for women to use for an MA procedure. If a clinic offers MVA, there should be a sufficient number of aspirators and canulae on-hand that are properly cleaned, maintained, and stored.

There should also be adequate supplies of pain management drugs available for use as desired by the woman; medications such as antibiotics for prophylaxis and/or treatment of infection; and other emergency drugs, in the event they are needed. Contraceptive supplies are an important part of CAC, and should be available at all times in the clinic. Systems for procurement of medications should be in place so as to avoid stock-outs. This should include the use of supply forms and log books.

Clinics should have a secure, clean, and dry storage space to keep these medications and supplies on hand. Clinics must have clean water in order to maintain the cleanliness of the equipment and facility. It is also important to have a clean drinking water supply for staff and patients.

4. Staff Knowledge, Attitude and Skills

All staff involved in the provision of CAC services should know and understand the current Nepal safe abortion law and policy for Comprehensive second trimester abortion. This includes an understanding of any current policies related to the care of specific populations, such as young women less than 16 years of age, or disabled women. Regardless of personal beliefs, staff that provides abortion-related care should be positive, helpful, empathetic, and non-discriminatory toward women seeking abortion. Woman should be treated with dignity and respect, regardless of age or marital status.

CAC providers must have a full understanding of the two recommended abortion procedures, including the MA regimen, mechanism of action, and process. A provider should be able to provide to woman clear and simple information about each abortion procedure, including the expected effects, as well as possible side effects, risks, and complications.

CAC providers must also possess certain requisite skills, including the ability to:

- Perform a clinical assessment, including gestational dating
- Provide abortion counseling (pre, during and post) and obtain informed consent
- Provide contraceptive counseling
- Perform high-quality abortion procedures, whether it be MVA or MA
- Conduct follow-up and assessment of abortion complications
- Refer women for emergency care, if needed.

5. Staff Training

Staff providing CAC services should have the appropriate educational background and related experience. Providers should attend refresher trainings as needed to maintain confidence and competence in their provision of CAC services. Staff should be trained on new technology or methods of care and service provision as they arise, so as to provide the highest quality of CAC services possible.

6. Record Keeping

A patient's medical records contain valuable and sensitive information. Policies should exist regarding which information to collect and record in each client's records, so as to ensure that providers can meet the needs of each woman and give appropriate ongoing care as needed. Referral forms should also be used correctly and consistently to improve communication around care of the patient. Policies should also be in place to ensure that all individual client records are kept private. Complete clinic-level records, such as logbooks or monthly registers, also aid the facility in its monitoring and evaluation of the services provided.

7. Monitoring and Evaluation

When a facility engages in monitoring and evaluation activities, providers and facilities can learn from their experiences and modify their practices to provide the highest quality of care possible. A monitoring and evaluation plan should include:

- Clear definitions of services to be evaluated
- Sources of information
- Indicators for measurement
- Mechanisms for obtaining feedback from women for improving services.

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