Ipas works globally to increase women’s ability to exercise their sexual and reproductive rights and to reduce abortion-related deaths and injuries. We seek to expand the availability, quality and sustainability of abortion and related reproductive-health services, as well as to improve the enabling environment. Ipas believes that no woman should have to risk her life or health because she lacks safe reproductive-health choices.

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- Karen Trueman
- Judith Winkler
About Ipas
Ipas is dedicated to the belief that every woman has a basic right to reproductive- and sexual-health care and to make her own reproductive and sexual choices. We work globally to increase access to high-quality reproductive-health care and to improve women’s ability to exercise their reproductive rights, especially their right to safe, legal abortion. We concentrate on preventing unsafe abortion, improving treatment of its complications and reducing its consequences. We strive for women’s empowerment by increasing access to services that enhance their reproductive and sexual health.

The International Conference on Population and Development (ICPD) and its five-year review (ICPD+5) provided a clear mandate to all signatory governments: make abortion care safe and accessible to women in their communities. Ipas is dedicated to scaling up safe abortion services globally and to the full extent of local laws through training, service-delivery improvement, advocacy, research and provision of reproductive-health technologies.

Scaling up is defined as achieving universal access to high-quality, sustainable abortion-care services.

• Achieving universal access ensures that wherever a woman seeks help when she has unprotected sex, unwanted sex or an unwanted pregnancy, she will find the care she needs, whether it be information, referral, or clinical or related services. Universal access to abortion requires that every public and private facility in a country’s health system is trained and equipped and has other measures in place to ensure women’s access to abortion-related care.

• Achieving sustainability in abortion-care services requires political leadership, policy development, financial resources and an adequate health-system infrastructure with trained health-care providers.
About This Manual

The primary purpose of this reference manual is to provide guidance to health-care personnel on improving the quality of care available to women seeking abortion services. This manual introduces the Ipas MVA Plus® and Ipas EasyGrip® cannulae, and explains the manual vacuum aspiration (MVA) abortion procedure in detail. It also explains medication-abortion methods that use the medications misoprostol and mifepristone. All the methods described here offer women safe, effective options for first-trimester uterine evacuation.

Although this reference manual provides extensive information on abortion-care provision, it is not intended to serve as a self-guided learning tool. It is designed to be used as a participant’s manual during trainer-facilitated individualized and group-based courses that include simulated practice and clinical practice with clients under the supervision of an experienced provider; as a learner’s resource to help refresh and strengthen participants’ skills after completion of a course; and as a reference document for those seeking up-to-date information on comprehensive abortion care.

Health-care providers planning to conduct courses on abortion care should obtain the manual’s companion piece, Woman-Centered Abortion Care: Trainer’s Manual, which supplies educational materials, trainer’s notes and competency-based evaluation tools, and is written to encompass multiple adult-learning styles.

The Woman-Centered Abortion Care: Reference Manual is useful to a broad audience, including sexual- and reproductive-health clinicians, trainers, program managers, health educators, social workers, outreach workers and other health-care workers. The 12 modules bring a woman’s-rights perspective to abortion-care training and service delivery. The manual is divided into two parts. Section I: High-Quality Abortion Care is intended for a wide range of health-facility workers, including administrative personnel and other non-clinicians. These five modules address quality-of-care issues, including client-provider communication, women’s rights to high-quality reproductive-health care, and recommendations for monitoring services and ensuring community linkages.

Section II: Clinical Care for Women focuses on technical information and is intended for a clinical audience that deals directly in abortion care, including physicians, nurse midwives, counselors and others. The seven modules in Section II are in the order in which a woman typically receives care; however, facilities may vary the steps of care according to their own settings and needs. For example, some health-care centers provide contraceptive services after counseling and prior to the abortion procedure, whereas others provide contraceptive counseling and supplies only after the procedure. This manual provides information on both MVA and medication abortion. Whenever possible, choices in uterine-evacuation methods should be made available to women. It is recommended that the techniques introduced in this manual be included in clinical protocols for abortion-related services at health-care centers and systems.

Ipas’s training strategies place equal emphasis on improving the technical quality of abortion care and on the overall quality of care that women receive. This comprehensive approach requires learners to reflect on values, attitudes and
myths associated with abortion and to focus services on the needs and desires of each woman receiving care. Ipas also recommends *Effective Training in Reproductive Health: Course Design and Delivery: Reference Manual* and *Trainer’s Manual*, a curriculum designed to develop core training skills for professionals in various areas of reproductive health, including administration, policy and advocacy.

To order these and other Ipas resources, contact Ipas at:

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Woman-Centered Abortion Care: Reference Manual

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1.0 Introduction

Woman-centered abortion care is a comprehensive approach to providing abortion services that takes into account the various factors that influence a woman’s individual health needs—both physical and mental—as well as her ability to access services and her personal circumstances. Within the law of her country or region, a woman has an individual right to abortion; however, the conditions that enable or hinder her access to safe abortion determine her ability to exercise that right. These conditions include a supportive legal system; government and public commitment to promoting and safeguarding women’s health; the freedom of women to exercise their sexual and reproductive rights; adequate infrastructure and economic resources for the health system; and social and cultural support of women’s rights. Moreover, a woman’s right to high-quality abortion care is honored only when she is provided as many choices as possible; when she can gain access to services; and when she is offered respectful, confidential care.

This module, Overview and Guiding Principles, serves as the foundation module for the entire curriculum. It is a recommended prerequisite for health-care providers offering first-trimester abortion-care services, and provides an introduction to the concepts of abortion care, client rights and provider ethics for any facility staff member who has contact with women seeking services. The module also includes information on the components of high-quality abortion care, and discusses ways in which health workers can use established human-rights principles to provide and advocate for woman-centered abortion care.

Health-care workers working in environments where abortion is prohibited or highly restrictive or where access to safe, legal abortion is not widely available should refer to the companion Ipas curriculum, Woman-Centered Postabortion Care: Reference Manual. That curriculum provides information on caring for women experiencing complications resulting from unsafe abortion.

2.0 Key Elements of Woman-Centered Abortion Care

Woman-centered comprehensive abortion care includes a range of medical and related health services that support women in exercising their sexual and reproductive rights. A woman-centered model for abortion care comprises three key elements:

- Choice
- Access
- Quality

2.1 Choice

In its broadest definition, choice means the right and opportunity to select
between options. With regard to sexual and reproductive rights, it means that others should not interfere with a woman’s choices and 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. A woman’s choices must be informed by complete and accurate information and the opportunity to ask questions of, and express concerns to, knowledgeable health-care personnel. To be woman-centered in their care, health workers must recognize and respond to a woman’s right to choices within the circumstances of her environment.

Many women needing abortion care are in vulnerable situations that make it difficult for them to exercise autonomous decisionmaking. They 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.

2.2 Access

It is the medical and ethical responsibility of appropriate professionals to provide abortion care for legal indications. A woman’s access to services is determined in part by the availability of trained, technically competent providers who use
appropriate clinical technologies and who are easily reached—preferably in local communities and at 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 counter this, health systems can focus resources on training both public and private providers at the most local level. Links between the public and private sectors can also offer a supportive network for providers in areas where abortion laws are restrictive.

A woman has better access when services are affordable and delivered in a timely manner without undue logistical and administrative obstacles. Emergency services should always be available regardless of the woman’s ability to pay. Moreover, a woman should not be 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 who display disrespectful, abusive or coercive attitudes can discourage women and limit access.

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.

More subtle factors that can limit women’s access to services include preferences for male children, the excessive influence of in-laws, and the prominent role of procreation in society. Gender roles and expectations also influence the way women and health-care workers interact. Some women may feel embarrassed to seek reproductive health-care services, particularly from a male provider. Some may be afraid to ask or answer questions or to make decisions in the presence of health-care workers. These types of situations can result in poor health outcomes and can be important factors in maternal morbidity and mortality. Health-facility personnel should strive to understand these factors, take them into account when providing abortion care and act to help expand access to services.

The long-term sustainability of services is also critical to access to high-quality care. Abortion services should be instituted in a way that can be maintained by the health system. To sustain abortion services at local levels, health systems must have training programs in place for health-care staff members that also educate them about local referral services. There must be obtainable, reliable and adequate supplies of equipment and medications, as well as the effective management, monitoring and evaluation of services.

Community and service-provider linkages are key factors in preventing unwanted pregnancies and unsafe abortion. 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.

2.3 Quality
A quality-of-care (QoC) framework for abortion gives a structure for the intersection between a woman having choices about abortion and having access to services, and those services being of high quality.
High-quality abortion care includes many factors that will vary somewhat given local contexts and available resources. Some fundamental aspects of high-quality care are:

• Tailoring each woman’s care to her social circumstances and individual needs.
• Providing accurate, appropriate information and counseling that supports women in making fully informed choices.
• Using internationally recommended medical technologies, particularly manual vacuum aspiration (MVA) and medication abortion (WHO, 2003), as well as appropriate clinical standards and protocols for infection prevention, pain management, management of complications and other clinical components of care.
• Offering postabortion contraceptive services, including emergency contraception, to help women prevent unwanted pregnancies, practice birth spacing and avoid repeat abortions.
• Referring women to or providing 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.
• Ensuring confidentiality, privacy, respect and positive interactions between women and staff of the health facility.

3.0 Upholding Women’s Rights in an Abortion-Care Setting

The International Planned Parenthood Federation (IPPF) has produced a formal statement declaring women and men’s sexual and reproductive rights to be essential components of human rights. The IPPF Charter includes 12 rights based on international human-rights agreements. The charter asserts that sexual and reproductive rights are human rights by applying language from human-rights treaties that have been internationally agreed upon and have the status of international law. Following are the 12 principles:

• The Right to Life, which means among other things that no woman’s life should be put at risk by reason of pregnancy
• The Right to Liberty and Security of the Person, which recognizes that no woman should be subjected to female genital mutilation, or forced into pregnancy, sterilization or abortion against her will
• The Right to Equality and to Be Free from All Forms of Discrimination, including in one’s sexual and reproductive life
• The Right to Privacy, which means that all sexual and reproductive health-care services should be confidential and that all women have the right to make independent reproductive choices
• The Right to Freedom of Thought, which includes freedom from the restrictive interpretation of religious texts, beliefs, philosophies and customs as tools to curtail freedom of thought on sexual- and reproductive-health care and other issues
• The Right to Information and Education, as it relates to sexual and reproductive health for all, including access to full information and free and informed consent
• The Right to Choose Whether or Not to Marry and to Found and Plan a Family
• The Right to Decide Whether or When to Have Children
• The Right to Health Care and Health Protection, which includes the right to the highest possible quality of care and freedom from traditional practices that are harmful to health

• The Right to the Benefits of Scientific Progress, which includes the right to new reproductive-health technologies that are safe, effective and acceptable

• The Right to Freedom of Assembly and Political Participation, which includes the right of all persons to seek to influence communities and governments to prioritize sexual and reproductive health and rights

• The Right to Be Free From Torture and Ill-Treatment, which includes the rights of all women, men and young people to protection from violence, sexual exploitation and abuse

(Adapted from International Planned Parenthood Federation, 1996)

Even health-care workers who do not perform clinical services have a role in ensuring that women receive high-quality abortion-care services. Therefore it is essential that all staff members deliver services that are based on an understanding and respect for women's rights. Following are some of the principles and skills that support women's rights in an abortion-care setting.

3.1 Values, Attitudes, Empathy and Respect

As professionals, health-care workers must learn to separate their personal beliefs and values from their professional practices and treat all women equally, regardless of their reproductive behaviors and decisions. All health-care workers need to treat their clients with empathy, which refers to the ability to understand another person's feelings and point of view and to communicate this understanding. (See the Counseling module for more information on these concepts.)

It is crucial that health-care workers realize their attitudes toward women carry considerable 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 inclined to trust health-care workers and seek appropriate medical care in the future (Hall et al., 1988).

Abortion-care service providers should strive to:

• Identify their values and attitudes regarding sexuality and reproductive-health care
• Separate their values from those of their clients
• Recognize how their attitudes can negatively 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. (See the Monitoring to Improve Services module for more information.)

3.2 Interaction and Communication

Positive relationships and rapport between health-care workers and their clients
are essential to high-quality medical care. Providers can initiate this by speaking respectfully, listening attentively, asking thoughtful questions and giving courteous and accurate information and answers, and showing empathy and kindness to each woman in their care. Simple considerations—such as apologizing for a long wait or offering a woman the option to remain clothed until the physical assessment is about to begin—can reduce frustration or anxiety and improve the overall quality of a woman’s visit. If helpful interactions are established with each woman from the beginning, the remainder of her clinical visit—including assessment, the abortion procedure and follow-up care—will likely be more effective.

Health-care workers’ interaction and communication skills are particularly important in the abortion-care setting, as women’s physical and emotional states may influence their ability to accurately describe their physical conditions, respond to questions, and understand information and directions. It is important not to make assumptions about women seeking abortion-care services. Health-care workers need to think, speak and act as neutrally as possible at the beginning of clinical interactions, adapting their behavior and language according to cues given by each particular woman.

Soliciting and answering questions from a client is an important skill that results in the woman’s increased understanding of her medical condition, recommended care and follow-up care. By engaging women in this manner, health-care workers encourage them to become active participants in their medical care. All information should be presented in a straightforward, non-technical manner. (See the Counseling module for more information on communication skills and principles.)

3.3 Privacy and Confidentiality
It is essential that abortion counseling and care are private and confidential, two qualities that contribute greatly to a woman’s sense of dignity. Once a client’s trust is broken, it may be difficult to regain. Therefore, health-care workers should strive to maintain that trust. Managers can post confidentiality policies in client-care areas and staff can verbally discuss them with each woman. Administrators can also preserve trust by establishing and enforcing strict confidentiality policies and procedures that apply to all health-care workers, and by securing access to client information. (See the Counseling module for more information on privacy and confidentiality.)

3.4 Voluntary, Informed Consent
In abortion-care settings, voluntary, informed consent refers to the process by which women make their own health-care decisions after they understand complete and accurate information about the benefits, risks and alternatives to medical procedures, medications, contraceptive methods or other health services. Health-care workers should not proceed with medical services until the woman has given her informed consent and signed a written consent form. In some settings, it is appropriate and common to provide witnessed verbal consent in lieu of written consent. However, under some circumstances, medical treatment becomes a priority and obtaining informed consent should not delay emergency procedures needed to save a woman’s life. (See the Clinical Assessment module for more information.)
4.0 Summary

- The **Overview and Guiding Principles** module serves as the recommended prerequisite module for this entire curriculum.
- Women who seek abortion care have the right to high-quality health care.
- Choice, access and quality are three key elements of woman-centered abortion care.
- Health-care workers must understand the concept of women’s rights in order to conduct professional interactions and to provide compassionate, high-quality care.
- Health-care workers should exhibit empathy and respect for the women in their care and ensure privacy and confidentiality.
- 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.

**Additional Resources**


**Bibliography**


Reproductive Rights

1.0 Introduction
Governments and individuals worldwide are increasingly recognizing that a woman must be able to exercise control over her sexual and reproductive health if she is to achieve her fullest potential as a human being. In recent years, international human-rights documents have increasingly addressed matters of sexual and reproductive health, advocating the rights of individuals to decide when and with whom to have sexual relations, as well as whether and when to bear children.

To best serve their communities, health-care providers need to understand the crucial role they can play in helping women exercise their reproductive rights. The first section of this module presents information on international documents related to human rights and health care that lend support to reproductive health-care professionals’ efforts to meet the pressing needs of women and their families.

In the 1990s, governments and United Nations (UN) agencies agreed that facilitating access to existing legal abortion services is an essential component of women’s rights. All too often, the reality is that numerous barriers stand in the way of women’s ability to exercise those rights. As members of the healing profession and authorities on matters of health and well-being, health-care providers are in a position to be powerful advocates for increasing women’s access to safe abortion as permitted by law.

The second part of this module addresses various obstacles that prevent women from accessing safe, legal abortion, along with potential solutions for overcoming those obstacles. The solutions that are presented focus on approaches that health-care providers can take in their daily work and in their communities. Providers who wish to take additional steps can find more information on activism and advocacy in the Additional Resources section.

2.0 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. … Bearing in mind the above definition, 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 is expressed in the Programme of Action agreed upon at the UN International Conference on Population and Development (ICPD), held in September 1994. That international document, along with many others, provides a framework for legitimizing and protecting women’s reproductive rights. The degree to which governments uphold the commitments they have made to advancing and protecting women’s reproductive rights is partially evidenced through the laws and policies that they create. Governments also must demonstrate a commitment to enforcing such laws and policies and ensuring environments in which women can exercise their rights.

2.1 Treaties and Agreements

The principles of universal human rights are codified in international conventions, which are also referred to as treaties, charters, covenants and pacts. Initially, nation States indicate their agreement to uphold an international convention by signing it. The next step is for a State to ratify the convention, which legally binds it to enforce the convention’s purposes and objectives. Ratification takes place through mechanisms that vary from country to country, for example, through a decision by the executive branch of government or through legislative approval. The following widely ratified conventions provide the basis for women’s sexual and reproductive rights within a human-rights framework:

- The International Covenant on Civil and Political Rights (CCPR)
- The International Covenant on Economic, Social and Cultural Rights (CESCR)
- The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
- The Convention on the Rights of the Child (CRC)
- The African Charter on Human and Peoples’ Rights (ACHPR)
- The Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (Belém do Pará)

Advocates and policymakers can use these conventions to promote, create and implement laws, regulations and policies that protect women’s reproductive and sexual health. For example, Article 15.1(b) of the International Covenant on Economic, Social and Cultural Rights affirms the human right to “...enjoy the benefits of scientific progress and its application.” In the context of abortion care, this protection would encompass a woman’s right to receive care that uses the newest, safest abortion technologies available.

Treaty Monitoring Committees have been established to monitor State compliance with particular international conventions. States are required to submit reports to the committees on a regular basis summarizing the actions they have taken toward compliance. Individuals and organizations can submit their
own “shadow reports,” providing committees with their findings on State compliance. After considering the State’s report and any shadow reports, Treaty Monitoring Committees make Concluding Observations with recommendations on the ways that a State can improve its compliance with a convention. States are not legally obliged to carry out these recommendations but are expected to do so as a result of ratifying a convention. Advocates can use those recommendations to hold governments accountable for making changes in laws and practices that uphold women’s sexual and reproductive rights. For more information, see Appendix A: Treaty Monitoring Committees.

2.2 Consensus Statements and Declarations

While the above-mentioned treaties and conventions provide a broad foundation for human rights, consensus statements and declarations from international conferences convened by the UN and affiliated agencies are valuable resources for elaborating on specific aspects of women’s sexual and reproductive health and rights. Although consensus statements and declarations have political value rather than legal standing, some Treaty Monitoring Committees do use them as part of a framework for evaluating State compliance with human-rights agreements.

Several landmark international conferences in the 1990s addressed women’s reproductive health and safe abortion care. The 1994 ICPD, held in Cairo, marked the first time that policymakers jointly addressed the topic of unsafe abortion as a public-health concern. Paragraph 8.25 of the ICPD Programme of Action clearly recognizes unsafe abortion as a public-health problem, calls for safe abortion in instances in which abortion is permitted by law, and outlines steps that governments and nongovernmental organizations (NGOs) can take to improve the safety of abortion services and enhance women’s access to care. Elaborating on the ICPD meeting, policymakers made further progress at the UN Fourth World Conference on Women, held in Beijing in 1995, by calling on governments to “consider reviewing laws containing punitive measures against women who have undergone illegal abortions” (Paragraph 106k).

At the 1999 five-year review of the ICPD, commonly called ICPD+5, governments reaffirmed their commitment to addressing unsafe abortion and agreed that adequate access to services must accompany laws and policies that permit safe, legal abortion. Paragraph 63(iii) of the conference report states: “In circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women’s health.” This statement is the most powerful evidence to date of international support for safe abortion care.

2.3 Statements From Policymaking Bodies

By stating a position and challenging professionals to meet its provisions, major policymaking bodies—ranging from UN agencies to professional health associations—can set standards that help advance women’s reproductive rights. Although such statements are not legally binding, they convey the authority and consensus of respected health-care experts.

UN agencies

In its role of setting technical health-care standards and providing advice to Member States on strengthening their health systems, the World Health
Organization (WHO) has issued a number of guidance documents on abortion. These include the *Making Pregnancy Safer Initiative*, which stated in 2000 that “access to safe abortion (where it is legal) and counseling to ensure informed decision making and consent by the woman, should be part of the services.” In 2002, the Executive Board of WHO adopted a resolution on reproductive health entitled *WHO’s Contribution to Achievement of the Development Goals of the UN Millennium Declaration*. The resolution affirms WHO’s commitment to implementing recommendations from the Cairo and Beijing conferences and recognizes “the importance of access to good-quality reproductive-health care.”

Guidelines released in 1998 by the Joint and Co-Sponsored UN Programme on HIV/AIDS (UNAIDS) and the Office of the High Commissioner for Human Rights represent another significant public-policy statement. These guidelines define human rights for people with HIV/AIDS and acknowledge that women with HIV/AIDS are entitled to exercise their sexual and reproductive rights, including their right to access abortion services: “Laws should also be enacted to ensure women’s reproductive and sexual rights, including the right of independent access to reproductive and STD [sexually transmitted diseases] health information and services and means of contraception, including safe and legal abortion and the freedom to choose among these, the right to determine number and spacing of children, the right to demand safer sex practices and the right to legal protection from sexual violence, outside and inside marriage, including legal provisions for marital rape.”

Professional associations

The International Federation of Gynecology and Obstetrics (FIGO) has produced a number of key statements and recommendations supporting women’s reproductive rights. In September 2000, the FIGO General Assembly adopted *Ethical Guidelines Regarding Induced Abortion for Non-Medical Reasons* as part of the pre-Congress Workshop Report at the XVI FIGO World Congress in Washington, DC. The guidelines state that “…after appropriate counseling, a woman [has] the right to have access to medical or surgical induced abortion, and that the health-care services [have] an obligation to provide such services as safely as possible” (*FIGO Committee for the Ethical Aspects of Human Reproduction and Women’s Health, 1999*).

In October 2002, the Latin American Federation of Obstetric and Gynecological Societies (FLASOG) adopted landmark recommendations calling on regional obstetrics and gynecology societies and their members to work actively to ensure that women’s rights are upheld. These recommendations include working with governments to establish guidelines that assure sufficient public-sector health services for women; collaborating with medical schools to establish pre-service training related to women’s sexual and reproductive rights; and joining with public and private institutions and NGOs to strengthen these recommendations. Specifically, the statement called for broadening the indications under which abortion is legally permitted to include fetal malformation and life-threatening conditions.

Also in 2002, the Council of the International Confederation of Midwives strengthened a 1996 resolution, stating that “the care of women post abortion is an integral part of the role of the midwife as defined in the International Definition of the Midwife.” This statement endorses the involvement of midwives in the treatment of abortion complications and postabortion contraceptive counseling.
For these and other health professional association statements, see Appendix B: Statements from Health Professional Associations.

### 3.0 Barriers to Legal Abortion

Almost all countries permit abortion in some circumstances. Most countries permit legal abortion to save a woman’s life and to preserve a woman’s physical and/or mental health. Other legal indications for abortion include economic or social grounds, fetal impairment, and pregnancy resulting from rape or incest. However, even in contexts where it is legal, abortion is often subject to regulatory restrictions that may impede women’s access to services. Following are some of the barriers that women may face and possible actions that providers can take to address those barriers. (See Appendix C: Common Regulatory and Administrative Barriers to Obtaining Safe Abortion for more information.)

### 3.1 Narrow Interpretations of the Law

Access to legal abortion depends largely on the ways in which abortion laws are interpreted by courts, policymakers and health-care providers. It is not uncommon for courts and health systems to interpret laws very narrowly, sometimes placing tighter restrictions on abortion than are legally required or medically necessary. For example, in some settings, although spousal consent for an abortion is not stipulated in the law, it may be carried out as official policy. Fortunately, examples of laws that endow women with empowering rights also exist, as is the case in Vietnam (see box).

Laws that are not codified by medical protocols can also contribute to difficulty in interpretation and the creation of unnecessary restrictions. For example, laws that allow abortion to preserve a woman’s health usually do not provide any guidance as to which type of health-threatening conditions or diseases would jeopardize a pregnant woman's health. If medical protocols do not provide guidance, midwives,

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The Vietnam Law on Protection of People’s Health, adopted in 1989, states:

“All people are free to select and use their contraceptive measures, all acts of obstruction or compulsion in the implementation of family planning shall be prohibited; women have the right, out of their own free will, to have abortion(s) and to receive gynecological diagnosis and treatment and physical examinations during pregnancy and medical service when they are delivered at health facilities.”

(Vietnam Ministry of Health, 2002)
physician assistants, doctors, lawyers, judges and other relevant professionals may refuse services to women to avoid possibly breaking the law.

At the national level, Ministries of Health should work with medical professionals to develop and disseminate standards and guidelines guaranteeing abortion to the full extent of the law. If no national guidelines exist for legal abortion, health-care providers can help women exercise their rights to the full extent of the law by ensuring that their health facilities have clear guidelines on how to interpret existing abortion laws. Professional associations and hospital ethics committees are two examples of channels through which this can be accomplished.

3.2 Restrictions That Affect Access

In some cases, abortion-related laws restrict women’s decisionmaking authority; examples include parental consent requirements for adolescents or spousal consent requirements for married women. Laws may also impose a mandatory waiting period, requiring the passage of a certain number of days between the woman’s request for an abortion and the actual procedure. In some countries, delays may result when laws require two or more physicians to certify the indication for abortion, especially in cases where women do not have access to even one physician. Even when laws do not carry such restrictions, the restrictions might be included in regulations issued by a Ministry or health facility. Additionally, some providers will act overly cautious and informally impose such restrictions to protect themselves in the absence of clear laws or guidelines from an administrative health body.

Requiring a woman to obtain consent from a partner or parent clearly violates her right to make decisions about her reproductive health. Consent laws can be detrimental in other ways as well: for example, a young woman may not want to tell her parents about an unwanted pregnancy because she fears provoking verbal or physical abuse, confronting a parent who abused her or bringing shame on her family. Data from the United States show that parental-consent requirements have increased the number of girls who delay abortion procedures because they must travel to a neighboring state that does not have such consent laws (Lichter et al., 1998). This type of delay, which can result in the need for a second-trimester procedure, increases the risk to women’s health (Cates et al., 1977; Lichtenberg et al., 1999).

Health-care providers can work with professional associations and government or health-facility authorities to eliminate these types of restrictions. If no national policy exists regarding parental consent, health-care providers should follow the principle of the evolving capacity of the child, which states that there is no single, defined age at which a minor has the maturity and comprehension necessary to make her own decisions. Each young woman should be evaluated individually as to her ability to make decisions about health care and reproduction. Through this approach, endorsed in the Convention on the Rights of the Child, health professionals can use their own judgment to expand safe abortion services to young women who otherwise might resort to an unsafe abortion.

3.3 Provider Shortages

Policymakers and health-care professionals need to ensure that women have access to safe services from trained providers. Many countries either formally or informally restrict the provision of abortion to medical doctors, in particular obstetrician-gynecologists. For example, although India has a liberal abortion
law, only obstetrician-gynecologists or physicians who have undergone cumbersome certification programs are allowed to perform abortions, and most of the country's training facilities function far below capacity.

Evidence demonstrates that abortion procedures are extremely safe when performed by trained providers and can be accomplished competently by midlevel health professionals (Ipas and IHCAR, 2002; WHO, 2003). Training and authorizing midwives, nurses, physician assistants and other midlevel health workers to offer abortion care can increase women’s access to services. Care by competent midlevel providers can reduce the cost of services and make it easier for women to obtain care closer to their homes because these providers are generally more numerous, geographically dispersed and located at the community level (Ipas and IHCAR, 2002).

Health-care providers can have a huge impact on the availability of services by advocating that authorized, trained midlevel providers be allowed to perform abortion-related care, such as manual vacuum aspiration (MVA), medication abortion and postabortion contraceptive counseling. Providers can also participate in writing training curricula for medical and nursing faculties and provide in-service training practica to help expand the number of available providers.

3.4 Technological Limitations

Another common barrier to safe abortion services is the continued use of medical technology and methods, such as sharp curettage, that are not in keeping with the most up-to-date technology. WHO recommends that health systems shift from using sharp curettage to vacuum aspiration or medication abortion (WHO, 2003). When women’s options are limited to inferior technology and methods, they are denied the benefits of new methods that cost less money, produce less pain and are safer and more effective. The failure to implement new technology and methods also places an unnecessary burden on health-care facilities and personnel. Outmoded methods frequently demand more time, resources and trained staff members. For example, sharp curettage differs from MVA and medication abortion in that it usually involves the use of general anesthesia and is usually not performed on an outpatient basis, limiting services to urban hospitals while increasing costs and resource use.

Health-care providers can help ensure that they are able to offer modern technologies by requesting that vacuum-aspiration equipment and medication-abortion supplies are added to their facility’s standard equipment lists and that the procurement of new supplies is handled in a timely manner. They can also make a personal commitment to frequently update their own skills and familiarity with current technology and to encourage their colleagues to do the same. Furthermore, they can gain the skills necessary to train others to use newer technologies.

3.5 Conscientious Objection

The refusal of health-care professionals to provide abortions based on personal objections presents another barrier for women. Although all health-care providers have the right not to perform abortions as long as a woman’s life is not in danger, they are ethically and often legally required to ensure that women can access safe services at a nearby facility. It should be noted that only health-care workers directly performing the abortion service can invoke conscientious
Objection. Health-care workers who are indirectly involved—for example, individuals who provide post-procedure or follow-up care—cannot refuse to perform their tasks on the grounds of conscientious objection.

According to WHO’s guidance for reproductive-health laws, administrators of public-health facilities, who are charged with implementing the policies of the government and offering health services to the community, cannot invoke conscientious objection (WHO, 2000). They are obligated either to have skilled staff available to provide abortion services to the fullest extent of the law or to have procedures in place to refer women to alternate facilities. These referral facilities must meet certain standards, such as accessibility, affordability, adequately trained staff and safe, sanitary conditions.

Health-care providers can advocate that their facilities offer abortion services. They also can ensure that their health facility addresses conscientious objection in its abortion protocols. For example, a list of providers who invoke conscientious objection should be created so that women seeking abortion care are not referred to them. Providers who abstain on these grounds should also be furnished with lists of referral physicians and facilities that they can provide to women seeking abortion care. The protocol might also stipulate sanctions to be taken against providers who refuse to provide referrals or who refuse to treat women whose lives are in danger.

4.0 Providers As Advocates

Some health-care providers may want to participate in broader advocacy efforts to change laws and policies that restrict women’s reproductive rights. The first step in advocating for legal and policy change is to know what current laws permit, how the laws are being implemented and whether there are barriers that inhibit women from exercising their legal rights. Health-care providers can request their professional associations to organize seminars that review abortion laws and discuss how they are interpreted and implemented. They can also join with lawyers’ associations to plan advocacy strategies.

In countries where legal reform is possible, health-care professionals can work to liberalize laws by encouraging colleague organizations to publish statements recognizing reproductive rights as human rights or stating their support for safe, legal abortion. They can also use their authority as health professionals to take an active role in defining current laws and policies, and can educate policymakers and others by disseminating statistics on abortion-related maternal mortality and morbidity.

For more information about actions to ensure women’s access to safe, legal abortion, please refer to Making Safe Abortion Accessible: A Practical Guide for Advocates and the other publications listed in the Bibliography.

5.0 Summary

- International documents that can help legitimize and protect women’s reproductive rights include treaties, conventions, consensus statements and declarations.
- The principles of universal human rights are codified in international conventions, also referred to as treaties, charters, covenants and pacts.
- Treaty Monitoring Committees exist to monitor State compliance with...
particular international conventions.

- Although they have no binding legal status, consensus statements and declarations from international conferences convened by the UN and affiliated agencies provide valuable resources for elaborating on specific aspects of women’s sexual and reproductive health and rights.

- Landmark conferences for women’s reproductive rights include the 1994 International Conference on Population and Development, held in Cairo; the 1995 UN Fourth World Conference on Women, held in Beijing; and their respective five-year review conferences (ICPD+5 and Beijing+5).

- Statements by UN agencies and associations of health-care providers and policymakers can help set standards that can advance women’s reproductive rights.

- Induced abortion, when permitted by law, is often subject to legal and regulatory restrictions that impede many women’s access to services.

- Providers who wish to engage in advocacy efforts to expand women’s reproductive rights should know what current laws permit, how they are being carried out, and whether there are obstacles that regularly inhibit women from exercising their legal rights.

**Additional Resources**


International Women’s Tribune Center (IWTC) website: http://www.iwtc.org (last accessed March 2005).


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Reproductive Rights Appendix A: Treaty Monitoring Committees

Seven international human-rights conventions have Treaty Monitoring Committees that monitor implementation of the conventions by the States that have ratified them. They are:

2. Committee on the Rights of the Child – Convention on the Rights of the Child
3. Committee Against Torture – Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
4. Human Rights Committee – International Covenant on Civil and Political Rights
7. Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families – International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families

Excerpts

General Comments and General Recommendations

Committee on the Elimination of Discrimination Against Women (monitors the Convention on the Elimination of All Forms of Discrimination Against Women—CEDAW)

General Recommendation 19 (Violence against women)

Paragraph 22: “Compulsory sterilization or abortion adversely affects women’s physical and mental health, and infringes the right of women to decide on the number and spacing of their children.”

Paragraph 24(m): “The Committee on the Elimination of Discrimination Against Women recommends…States parties should ensure that measures are taken to prevent coercion in regard to fertility and reproduction, and to ensure that women are not forced to seek unsafe medical procedures such as illegal abortion because of lack of appropriate services in regard to fertility control.”

General Recommendation 21 (Equality in marriage and family relations)

Paragraph 22: “Some reports disclose coercive practices which have serious consequences for women, such as forced pregnancies, abortions or sterilization. Decisions to have children or not, while preferably made in consultation with spouse or partner, must not nevertheless be limited by spouse, parent, partner or Government. In order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services, as provided in article 10(h) of the Convention.”

General Recommendation 24 (Women and health)

Paragraph 12(d): “While lack of respect for the confidentiality of patients
will affect both men and women, it may deter women from seeking advice and treatment and thereby adversely affect their health and well-being. Women will be less willing, for that reason, to seek medical care for diseases of the genital tract, for contraception or for incomplete abortion and in cases where they have suffered sexual or physical violence.”

**Paragraph 31(c):** “States parties should also, in particular...Prioritize the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance. When possible, legislation criminalizing abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion.”

**Human Rights Committee** (monitors the International Covenant on Civil and Political Rights—CCPR)

**General Comment 28 (Equality of rights between men and women)**

**Paragraph 10:** “When reporting on the right to life protected by article 6, States parties should provide data on birth rates and on pregnancy- and childbirth-related deaths of women. Gender-disaggregated data should be provided on infant mortality rates. States parties should give information on any measures taken by the State to help women prevent unwanted pregnancies, and to ensure that they do not have to undergo life-threatening clandestine abortions. States parties should also report on measures to protect women from practices that violate their right to life, such as female infanticide, the burning of widows and dowry killings. The Committee also wishes to have information on the particular impact on women of poverty and deprivation that may pose a threat to their lives.”

**Paragraph 11:** “To assess compliance with article 7 of the Covenant, as well as with article 24, which mandates special protection for children, the Committee needs to be provided information on national laws and practice with regard to domestic and other types of violence against women, including rape. It also needs to know whether the State party gives access to safe abortion to women who have become pregnant as a result of rape. The States parties should also provide the Committee with information on measures to prevent forced abortion or forced sterilization. In States parties where the practice of genital mutilation exists, information on its extent and on measures to eliminate it should be provided. The information provided by States parties on all these issues should include measures of protection, including legal remedies, for women whose rights under article 7 have been violated.”

**Paragraph 20:** “States parties must provide information to enable the Committee to assess the effect of any laws and practices that may interfere with women’s right to enjoy privacy and other rights protected by article 17 on the basis of equality with men. An example of such interference arises where the sexual life of a woman is taken into consideration in deciding the extent of her legal rights and protections, including protection against rape. Another area where States may fail to respect women’s privacy relates to their reproductive functions, for example, where there is a requirement for the husband’s authorization to make a decision in regard to sterilization; where general requirements are imposed for the sterilization of women, such as having a certain number of children or being of a certain age, or where States impose a legal duty upon doctors and other health personnel to report cases of women who have undergone abortion.”
Committee on the Rights of the Child (monitors the Convention on the Rights of the Child—CRC)

**General Comment 4 (Adolescent health and development)**

**Paragraph 31:** “Adolescent girls should have access to information on the harm that early marriage and early pregnancy can cause, and those who become pregnant should have access to health services that are sensitive to their rights and particular needs. States parties should take measures to reduce maternal morbidity and mortality in adolescent girls, particularly caused by early pregnancy and unsafe abortion practices, and to support adolescent parents. Young mothers, especially where support is lacking, may be prone to depression and anxiety, compromising their ability to care for their child. The Committee urges States parties (a) to develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling; (b) to foster positive and supportive attitudes towards adolescent parenthood for their mothers and fathers; and (c) to develop policies that will allow adolescent mothers to continue their education.”

**Paragraph 37:** “Adolescents who are sexually exploited, including in prostitution and pornography, are exposed to significant health risks, including STDs, HIV/AIDS, unwanted pregnancies, unsafe abortions, violence and psychological distress. They have the right to physical and psychological recovery and social reintegration in an environment that fosters health, self-respect and dignity (art. 39). It is the obligation of States parties to enact and enforce laws to prohibit all forms of sexual exploitation and related trafficking; to collaborate with other States parties to eliminate intercountry trafficking; and to provide appropriate health and counselling services to adolescents who have been sexually exploited, making sure that they are treated as victims and not as offenders.”

Committee on Economic, Social and Cultural Rights (monitors the International Covenant on Economic, Social and Cultural Rights—CESCR)

**General Comment 14 (Standards of health)**

**Paragraph 8:** “The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.”

**Paragraph 12(b)(iii):** “Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.”

**Paragraph 12(d):** “Quality. As well as being culturally acceptable, health
facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.”

**Paragraph 34:** “In particular, States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women’s health status and needs. … In addition, States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people’s participation in health-related matters.”

**Paragraph 36:** “The obligation to fulfil requires States parties, inter alia, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health. States must ensure provision of health care…. Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas. States have to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country. Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all, the promotion of medical research and health education, as well as information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health, traditional practices, domestic violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances.”

**Concluding Observations**

**CESCR Concluding Observations to Brazil, 2003, Paragraph 51:** “The Committee requests the State party to undertake legislative and other measures, including a review of its present legislation, to protect women from the effects of clandestine and unsafe abortion and to ensure that women do not resort to such harmful procedures. The Committee requests the State party to provide in its next periodic report detailed information, based on comparative data, about maternal mortality and abortion in Brazil.”

**CEDAW Committee Concluding Observations to India, 2000, Paragraph 79:** “The Committee recommends the adoption of a holistic approach to women’s health throughout the life cycle in the country’s health programme. It urges the Government to allocate resources from a “women’s right to health” perspective, following the guidelines of the Committee’s general recommendation 24. The Committee calls upon the Government to elicit the support of medical associations in enforcing professional ethics and preventing sex-selective abortions. The Committee also recommends that the Government obtain the support of the medical profession in creating awareness of the urgent need to
eliminate practices associated with son preference.”

CEDAW Committee Concluding Observations to Mexico, 1998, Paragraph 408: “The Committee Recommends that the Government consider the advisability of revising the legislation criminalizing abortion and suggests that it weigh the possibility of authorizing the use of the RU486 contraceptive, which is cheap and easy to use, as soon as it becomes available.” (RU486 is an abortifacient rather than a contraceptive.)

CEDAW Committee Concluding Observations to Romania, 2000, Paragraph 315: “The Committee, while commending the Government for maintaining a system of universal free health care, recommends that increased efforts be placed on improving women’s reproductive health. In particular, it calls on the Government to improve the availability, acceptability and use of modern means of birth control to avoid the use of abortion as a method of family planning. It encourages the Government to include sex education systematically in schools, including vocational training schools. It also urges the Government to target high risk groups for HIV/AIDS prevention strategies and strategies to prevent the spread of sexually transmitted diseases. It encourages the Government to increase its cooperation with non-governmental organizations and international organizations in order to improve the general health situation of Romanian women and girls. …”

CESCR Committee Concluding Observations to the Russian Federation, 2003, Paragraph 63: “The Committee urges the State party to reinforce its efforts to reduce infant and maternal mortality. The State party should promote awareness of safe contraceptive methods and ensure that abortions are carried out under adequate medical and sanitary conditions.”

Human Rights Committee Concluding Observations to the United Republic of Tanzania, 1999, Paragraph 15: “The Committee deplores the law in force in Zanzibar which allows for the imprisonment of both mother and father in the event of an unmarried woman becoming pregnant. In the Committee’s view, this carries risks to the right to life (art. 6) (through resort to illegal abortion) and to the rights of the child (arts. 23 and 24) if born in such circumstances. It recommends the abolition of this law in Zanzibar and, noting in this connection that illegal abortion is a major cause of maternal mortality, that a national review be carried out on the restrictions on abortions (arts. 3, 6 and 26).”

CEDAW Committee Concluding Observations to Zimbabwe, 1998, Paragraph 159: “Noting that illegal abortion is cited by the Government as a major cause of death for women in Zimbabwe, the Committee recommends that the Government reappraise the law on abortion with a view to its liberalization and decriminalization.”

Reproductive Rights Appendix B: Statements From Health Professional Associations

International Federation of Obstetrics and Gynecology (FIGO). Ethical Guidelines Regarding Induced Abortion for Non-Medical Reasons.
Adopted by the FIGO General Assembly as part of the pre-Congress Workshop Report at the XVI FIGO World Congress, Washington, DC, September 2000.

Governments and other concerned organizations should make every effort to improve women’s rights, status, and health, and should try to prevent unintended pregnancies by education (including on sexual matters), by counseling, by making available reliable information and services on family planning, and by developing more effective contraceptive methods. Abortion should never be promoted as a method of family planning.

Women have the right to make a choice on whether or not to reproduce and should therefore have access to legal, safe, effective, acceptable and affordable methods of contraception.

Providing the process of properly informed consent has been carried out, a woman’s right to autonomy, combined with the need to prevent unsafe abortion, justifies the provision of safe abortion.

Most people, including physicians, prefer to avoid termination of pregnancy and it is with regret that they may judge it to be the best course, given a woman’s circumstances. Some doctors feel that abortion is not permissible whatever the circumstances. Respect for their autonomy means that no doctor (or other member of the medical team) should be expected to advise or perform an abortion against his or her personal conviction. Their careers should not be prejudiced as a result. Such a doctor, however, has an obligation to refer the woman to a colleague who is not in principle opposed to termination.

Neither society, nor members of the health care team responsible for counseling women, have the right to impose their religious or cultural convictions regarding abortion on those whose attitudes are different. Counseling should include objective information.

Very careful counseling is required for minors. When competent to give informed consent, their wishes should be respected. When they are not considered competent, the advice of the parents or guardians and when appropriate the courts, should be considered before determining management.

The termination of pregnancy for non-medical reasons is best provided by the health care service on a non-profit-making basis. Post-abortion counseling on fertility control should always be provided.

In summary, the Committee recommended that after appropriate counseling, a woman has the right to have access to medical or surgical induced abortion, and that the health care service have an obligation to provide such services as safely as possible.

International Confederation of Midwives (ICM). Care of Women Post Abortion.
Rationale
The care of women post abortion is an integral part of the role of the midwife as defined in the International Definition of the Midwife.

Statement of Belief
The International Confederation of Midwives believes that a woman, who has had an abortion, whether spontaneous or induced, is entitled to receive midwifery care. In keeping with this belief the midwife should:

- Consider such care to be within the role of the midwife
- Provide any immediate care and counselling following abortion
- Appropriately refer the woman for any further treatment that may be required and which is beyond the scope of midwifery practice
- Provide the woman (and where appropriate her family) with education concerning the woman’s future health, including family planning
- Recognise the emotional, psychological and social support which may be needed by the woman and respond appropriately

Policy
Education of midwives should include the care of women following abortion.

Guiding Statement for Member Associations
Member associations are urged to seek to influence the training/education of midwives to ensure that they have the knowledge and skills to care for women post abortion.


Adopted by the FLASOG General Assembly at the XVII Congress, Santa Cruz, Bolivía, October 2002.

The Obstetrics and Gynecology Societies in Latin America and their members should work proactively to accomplish the following objectives:

The right to interruption of pregnancy according to the law of each country.

Ensure easy access to legal interruption of pregnancy for those women who meet the legal requirements of each country.

Introduce guidelines that define the criteria and procedures to facilitate the rapid authorization of an abortion (pregnancy interruption), when legal conditions are met. The guidelines currently in effect in Brazil, prepared by the Brazilian Ministry of Health in close collaboration with FEBRASGO, on the care of high risk pregnancy and care of women and adolescents who suffer sexual violence, and which include criteria and procedures for pregnancy interruption in both conditions, could be useful for the Obstetrics and Gynecology Societies in other countries.

When the country’s legislation does not penalize abortion when a woman’s life or health are at risk, the women’s own opinion on how much risk she is willing to accept should be the determining factor in the decision to interrupt the pregnancy.

Physicians should be informed that they could be held responsible in cases of
indirect maternal death (caused by a disease aggravated by the pregnancy) if they have refused a request for therapeutic abortion.

Broaden the conditions in which abortion is legally permitted to include cases of fetal malformation incompatible with life (as documented by a qualified specialist) and when the woman presents with conditions in which the pregnancy places her life at risk.

**Actions required to achieve these objectives:**

Obstetrics and Gynecology Societies should work with government health authorities to prepare and implement norms and guidelines which define the procedures necessary to assure sufficient public sector services, staffing and supplies for the promotion and protection of sexual and reproductive rights.

Work with professors of medical schools and schools responsible for training of professionals from health and related sciences, to include in their curricula content related to women’s sexual and reproductive rights. This should include gender and human rights concepts, respect for diversity, and the importance of not imposing their own personal values on the rights of women.

Include themes related to women’s reproductive and sexual rights in the continuing education activities promoted by the Obstetrics and Gynecology Societies in each country.

Work directly with gynecologists and obstetricians, particularly university professors, chairs of departments, service directors or professionals in executive positions in public and private institutions, in order to promote the implementation of services that respond to the needs of promoting, protecting and applying women’s reproductive and sexual rights.

Serve as a source of information to the media in order to disseminate correct scientific information related to women’s sexual and reproductive rights.

Establish alliances with public and private institutions and with national and international NGOs, concerned with these topics, in order to strengthen the effects of its actions.

Establish Committees on Sexual and Reproductive Rights in each Obstetrics and Gynecology Society and Federation with the participation of professionals from other disciplines in order to promote these rights and to ensure compliance with these recommendations.

**Association of Reproductive Health Professionals (ARHP). Abortion Statement.**

*Approved by ARHP’s Board of Directors on June 7, 2003. Recommended by ARHP’s policy committee on May 19, 2003.*

ARHP supports the legal right of a woman to obtain an abortion. ARHP supports the United States Supreme Court decision, *Roe v. Wade*, and opposes any legislation, regulation, or Constitutional amendment that weakens this decision and/or intervenes in medical decision making regarding abortion.

Regulations that prevent women in the military and female dependents of men in the military from obtaining abortions are a violation of rights guaranteed by the
All women, regardless of insurance status or coverage, must have full and equal access to abortion services. Private insurers should reimburse the cost of abortion services according to the same guidelines established for other, routinely-covered medical and surgical care. Publicly funded health services, such as Medicaid and health plans covering government employees and the military, must not discriminate against women by denying coverage for the provision of abortion services.

While parental involvement in the provision of reproductive health care services for minors is desirable and should be encouraged, it may not always be feasible or in the best interest of the minor, and it should not be legislatively required. It is vital that abortion and other reproductive health services for minors be accessible, safe, and confidential.

Women seeking medical advice on reproductive health issues must be given complete information on all reproductive choices, including pregnancy termination options without coercion. The decision to continue or terminate a pregnancy belongs to the pregnant woman. ARHP opposes the “global gag rule” regulation on the grounds that no health care provider should be prevented from giving information about safe and clinically appropriate options for women. Policies that prevent health care providers from discussing these options or providing related services violate free speech and jeopardize the lives and health of women and their families. ARHP opposes restrictions on reproductive health services and benefits imposed by faith-based hospitals and institutions.

ARHP encourages the investment of public and private funding for basic and clinical research to develop further improved abortion techniques. ARHP strongly supports educational programs that seek to increase individual and public knowledge about reproductive health so that unintended pregnancy and abortion will become less frequent.

Abortion education needs to be a standard component of medical education in all accredited institutions. Abortion training should be available to all, with exceptions only to meet the needs of individuals whose personal beliefs preclude them from providing abortion services. Health care providers who do not provide abortion services on moral or religious grounds have a professional obligation to provide their patients with a timely referral to another health professional known to provide such services. An individual provider’s religious or moral beliefs must not limit the scope or the quality of health care available to patients.


Originated by the Cabinet on Nursing Practice. Adopted by the ANA Board of Directors. Effective as of March 27, 1989.

Reproductive Health

Summary

The American Nurses Association (ANA) has historically advocated for the health care needs of all patients, including services related to reproductive health. ANA believes that health care clients have the right to privacy and the right to make decisions about personal health care based on full information and without
coercion. Also, nurses have the right to refuse to participate in a particular case on ethical grounds. However, if a client’s life is in jeopardy, nurses are obligated to provide for the client’s safety and to avoid abandonment.

As health care providers, nurses have a long and proud history of support for a fair and equitable health care delivery system in which all Americans have access to basic health service, including services related to reproductive health. The foundation of such a system rests on the broader social rights of privacy, free speech, freedom of choice, confidentiality between client and provider, and equity of access to essential service.

The American Nurses Association (ANA) believes that abortion is largely a symptom of social failure. The controversy over abortion is just one of many stages on which the critical social issues of access to care, freedom of choice, and the right to privacy are being played out.

The American Nurses Association cannot support initiatives that ignore individual human rights, decrease access to care, or increase the potential for adversity in the human condition. Should the Supreme Court of the United States rule to reverse the 1973 Roe v. Wade decision, a serious situation of unequal access could be created. States would predictably choose to take differing positions on the legality and financing of abortion. Therefore, many women would inevitably rely on illegal procedures performed in clandestine systems, resulting in a return to high mortality and morbidity.

ANA believes that the health care client has the right to privacy and the right to make decisions about personal health care based on full information and without coercion. It is the obligation of the health care provider to share with the client all relevant information about health choices that are legal and to support that client regardless of the decision the client makes. Abortion is a reproductive alternative that is legal and that the health care provider can objectively discuss when counseling clients. If the state limits the provision of such information to the client, an unethical and clinically inappropriate restraint will be imposed on the provider and the provider-client relationship will be jeopardized.

Just as the client has rights, the nurse also has rights, including the right to refuse to participate in a particular case on ethical grounds. However, if the nurse becomes involved in such a case and the client’s life is in jeopardy, the nurse is obliged to provide for the client’s safety, to avoid abandonment, and to withdraw only when assured that alternative sources of nursing care are available to the client.

The fact that thousands of American women are seeking abortion is a symptom, not the disease. The treatment lies in addressing the problems underlying a deteriorating social fabric. Health care providers have the right and responsibility to seek viable solutions to problems that signal social failure, such as ineffective family planning, deficient prenatal care, drug and alcohol abuse, domestic violence, unsuccessful parenting, sexually transmitted disease, and inadequate child care.

As one of the major national health care provider organizations, the American Nurses Association believes it has a responsibility to continue its advocacy for a
healthier nation. To this end, ANA has established a task force to address health and social problems and policies that have contributed to the abortion-related concerns confronting society today. Policy recommendations from this task force will provide future direction for ANA programs in the legislative and regulatory arenas as well as those programs that address nursing practice.
Reproductive Rights Appendix C: Common Regulatory and Administrative Barriers to Obtaining Safe Abortion

Information and access barriers
Women and health professionals do not know when abortion is permitted by law or where to obtain legal abortion services.

Multiple authorizations by doctors or other authorities are required before a woman can obtain an abortion.

Spousal consent or parental notification or consent is required for married or young women.

Rape and incest victims are required to press charges against the aggressor, obtain police reports, court authorization, or complete other medically unnecessary steps to qualify for abortion.

Laws or health system regulations arbitrarily place time limits on when in pregnancy abortion can be performed.

Subgroups of women, such as adolescents or migrant women, are not permitted to have abortions or are discriminated against.

Service delivery barriers
A range of methods of abortion is not made available by the health system.

New abortion methods are not approved by regulatory bodies.

A narrow range of institutions (such as hospitals, rather than primary care clinics) is approved to perform abortions.

Only physicians are allowed to provide abortion.

Health professionals are allowed to exempt themselves from abortion care on the basis of conscientious objection without referring the woman to an available and willing provider.

Confidentiality is not assured to the woman seeking abortion.

A waiting period is required between the request for and provision of abortion or clients are placed on a waiting list.

Service delivery standards overmedicalize abortion (for example, by requiring use of ultrasound, inpatient facilities, general anesthesia, operating theater, etc.).

Official and under-the-table charges reduce access, especially for poor women and adolescents who do not have access to funds.

(Adapted from Hord, 2001)
Community Linkages

Key Topics in This Module:
- Importance of creating links with communities
- Community assessments
- Strategies for working with communities

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

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

The above definitions stress the similarities and shared interests of community members. In reality, however, although agreement and shared interests exist in all communities, differences of opinion and conflict also exist. These differences can have a significant impact on the health and well-being of community members, especially women. The issue of abortion, in particular, can be very sensitive and a source of conflict within a given community. Studies have documented that both overt and subtle harassment by community members of health workers who provide abortion care has a negative impact on women’s access to services (Varkey et al., 2001). It is important that providers be aware of the possible effects that community opposition to induced abortion could have upon other services provided by a health facility. At the same time, providers should also identify allies who can help promote women’s access to high-quality abortion-care services.

Abortion-care providers and health-facility staff need to take an active role in building partnerships with community members. To establish community links,
health workers can identify problems, inform and consult community leaders and representatives, provide guidance on what can be done at both the health-facility and community levels, and offer suggestions for community involvement. At the same time, community members can also be proactive in defining community perspectives and problems and proposing suitable solutions. Together, these partners can develop appropriate sensitization messages regarding reproductive health and safe abortion services.

It is important to note that, in most cases, providers are also community members themselves and thus have multiple perspectives and roles, including those of advocates, health educators and role models. Additionally, there are almost always power dynamics within the medical system and vis-à-vis community members of which health-care workers should be cognizant. Providers should treat all women in the community equally and respectfully regardless of their marital status, age or decisions about pregnancy.

2.0 Community Assessment

Many community residents—including women, health-care providers, community leaders, family members and others—have a vested interest in the health, safety and well-being of local women and families. It is very important to tap community members’ knowledge and it is critical to listen to what women say about health-related issues. Health-care providers can begin to create links by identifying and talking with key individuals who often represent the shared interests of broader communities:

- Government officials
- Leaders of women’s groups
- Leaders of youth groups
- Law-enforcement officials
- Traditional medicine healers
- Health-committee members
- Leaders of men’s groups
- Religious leaders
- Traditional birth attendants
- Community-based health workers

Dialogue with community

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

General elements of such a survey might include:

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

Specific abortion-related questions might include:

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

3.0 Programmatic Strategies

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

**Increase Awareness and Education**

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

**Prevention and Education**

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

**Service Provision**

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

(For more information see Appendix A: Potential Audiences and Topics for Information, Education and Communication on Abortion.)

### 3.2 Ensure Immediate Treatment of Complications

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

### 3.3 Monitor Service Delivery

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

3.4 Prevent Infection

Neighborhoods surrounding health-care facilities may be concerned about exposure to infectious waste, including products of conception. Health managers should share with community leaders the health facility’s protocols for infectious-waste disposal and work with them to ensure that the public’s health is protected. Health-care workers can also educate women and community members about actions they might take to prevent the spread of infections while in the health-care facility, at home or in the community.

The improper processing and disposal of medical instruments, including abortion-related instruments, is a public-health risk, particularly in settings characterized by untrained providers and unhygienic conditions. The risk of infection can be reduced when:

- Used medical instruments are disposed of appropriately, rather than discarded in places like open dumps to which the public has access
- Health-care workers follow proper instrument-processing techniques and do not carry pathogens from the facility into the broader community

(See the Infection Prevention module for more information.)

3.5 Advocate for Improved Policies

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

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

For more specific guidance on advocacy issues, see Making Safe Abortion Accessible: A Practical Guide for Advocates, listed in the Additional Resources section of this module.

4.0 Summary

- Partnerships between health-facility staff and communities can play a key role in reducing maternal mortality and morbidity by strengthening the delivery of high-quality, woman-centered abortion services.
- Providers should be aware of their role in the community as role models and leaders, while working in partnership with community members to advance women’s health.
- Community-assessment surveys can inform providers and other stakeholders about general health conditions and about specific abortion-related issues.
- Providers and staff members at health facilities can raise public awareness
about the reproductive rights of women and critical health issues facing the community and provide accurate information on sexuality and reproductive health, particularly abortion care.

- Early referral for abortion complications and follow-up care are critical steps in reducing maternal morbidity and mortality, and communities can take steps to help prevent delays in getting women with obstetrical emergencies to life-saving health services.

- Health facilities that involve the community in monitoring service delivery can better ensure that community needs are met and that woman-centered abortion-care services are accessible.

- Communities surrounding health-care facilities may be at risk for exposure to infectious waste, and health managers have a responsibility to ensure that proper protocols for infection prevention are followed.

- Communities and health staff can work together to advocate that authorities prioritize sexual and reproductive health and rights, provide necessary services and adopt policies that serve women's needs.

Additional Resources


Bibliography


### Community Linkages Appendix A: Potential Audiences and Topics for Information, Education and Communication on Abortion

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<th>Audience</th>
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<th>Communication Venues and Media</th>
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| Adolescent and adult women; their partners, family members or guardians; teachers, women's groups, men's groups, adolescent groups, student groups, community groups, unions and apprentice groups including clubs based on sports, social exchange, theatre/arts, etc. Taxi drivers, pharmacists, other local informants such as traditional midwives or birth attendants | **Unwanted pregnancy:** Signs and symptoms of pregnancy and where to go for assistance; importance of seeking care early; pregnancy complications and where to go for assistance; Dangers of unsafe abortion  
**Abortion:** Abortion laws and service policies; where, how and at what cost abortion care can be obtained; different abortion techniques and their relative merits; how to recognize abortion complications and where and when to seek help; quick return to fertility after abortion; community role in emergency care in recognition and transport  
**Contraception:** Information about modern methods of contraception (including emergency contraception), including safety and effectiveness; where and how methods can be obtained | **Venues:**  
Health service facilities  
Schools and universities  
Workplace  
Youth centers  
Women's centers  
Group meetings  
Markets  
**Media:**  
Newspapers, magazines, posters, flyers, radio, TV, talks, dramas |
| Health system officials, legislators and other policymakers  
Professional associations (medical, legal, etc.)  
Members of media  
Non-traditional leaders such as film and sports stars | Prevalence, health and resource impact of unsafe abortion and unwanted pregnancies on women and families  
Women's rights regarding abortion  
Relevant access issues and the impact on health and resources  
Relative costs of providing emergency treatment for unsafe abortion compared with those of elective abortion and contraception  
Relative safety of early abortion and the new/different techniques  
Need to legislate for funding of high-quality RH health services for women | **Venues:**  
Conferences  
Governmental hearings  
**Media:**  
Conversation, research reports for meetings and legislative hearings, communications to the staff of these officials, workshops, letter-writing campaigns, all other print and electronic media |
| Traditional and religious leaders | Importance of educating constituents to prevent and seek help with unwanted pregnancies  
Where and how contraception and other RH services can be obtained  
Relative costs to families and the community of maternal morbidity and mortality due to unwanted pregnancy and unsafe abortion  
Relative safety of early safe abortion  
Current abortion law and service policies  
How to counsel about pregnancy care and availability of family planning | **Venues:**  
Formal and informal community and religious meetings  
Workshops by health professionals  
**Media:**  
Conversation, dramas, talks, print and electronic media |
### Community Linkages

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<th>Audience</th>
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<td>Importance of confidentiality and early care</td>
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<td>How to get trained to provide abortion care</td>
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McInerney, et. al., 2001
Uterine Evacuation Methods

Key Topics in This Module:

- **Methods for evacuating the uterus:**
  - vacuum aspiration
  - medications (pharmacological agents)
  - sharp curettage

- Possible risks and side effects, cost and benefits of these methods

1.0 Introduction

Uterine evacuation is the removal of the contents of the uterus. There are several methods for accomplishing uterine evacuation in the first trimester, including: vacuum aspiration, medications (pharmacological agents) and sharp curettage. Within these categories there are various techniques and agents that can be used, depending on the training and skills of the staff 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.

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

According to the World Health Organization (WHO) in the 2003 Safe Abortion: Technical and Policy Guidance for Health Systems, vacuum aspiration and medication abortion are preferred over sharp curettage for uterine evacuation in the first trimester. However, many settings still use the sharp-curettage method. The WHO guidelines state that since sharp curettage carries greater risk, it should be used only when vacuum aspiration and medication abortion are not available. Therefore, health managers should make all possible efforts to replace sharp curettage with vacuum aspiration or medication abortion.

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

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1 For more information about the distinctions in these methods and the language used to describe them, see Weitz et al., 2004, listed in the Additional Resources section at the end of this module.
In the second trimester, there are a few methods used for uterine evacuation. With appropriate training and skills, vacuum aspiration can also be used for second-trimester uterine evacuation through 15 weeks since the LMP. The preferred methods for any length of pregnancy in the second trimester are: dilatation and evacuation (D&E), which uses a combination of vacuum aspiration and forceps, or medication abortion using the administration of mifepristone followed by repeated doses of misoprostol. In some settings, misoprostol alone is safely used, but with lower efficacy than the combined regimen. For more information on second-trimester abortion, see the Clinician’s Guide for Second-Trimester Abortion (Ipas, 2002).

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

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

For statistics on abortion complications, see Appendix A: Complications Data.
2.0 Vacuum Aspiration

Vacuum aspiration is considered an essential service by many national and international authorities. WHO and the International Federation of Gynecology and Obstetrics (FIGO) issued a joint statement in 1997 declaring: “Properly equipped hospitals should…adopt the aspiration method [of uterine evacuation], selecting manual vacuum and/or electric vacuum according to the expertise available” (FIGO/WHO Task Force, 1997).

Description

Vacuum aspiration is a method by which the contents of the uterus are evacuated through a plastic or metal cannula that is attached to a vacuum source. The primary difference between vacuum-aspiration options is the source of the vacuum. Manual vacuum aspiration (MVA) uses a hand-held, portable aspirator, whereas electric vacuum aspiration (EVA) employs an electric pump. Although these sources provide equivalent suction at the initiation of the procedure, the level of vacuum provided by the MVA aspirator decreases as the cylinder fills with blood and tissue. An electric pump provides a continuous, constant level of suction.

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

Clinical safety and effectiveness

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

Cost

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

Acceptability to women

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

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

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

In rare cases, these conditions can result in secondary infertility or other serious injury or, in some cases, death.
2.1 Manual Vacuum Aspiration (MVA)

In an MVA procedure, a hand-held plastic 60cc aspirator providing a vacuum source is attached to a canula and hand-activated to suction out the uterine contents. To perform the MVA procedure, a canula of the appropriate size, depending on uterine size, is inserted through the cervix into the uterus. The canula is attached to a vacuum-charged aspirator. Then the vacuum is released by depressing the buttons on the aspirator. The canula 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 canula into the cylinder.

MVA is safe and effective, can be performed by trained midlevel providers and, because it does not require electricity, can be used in decentralized, rural settings with intermittent electrical supplies (Baird and Flinn, 2001). As with vacuum aspiration in general, MVA services can be provided in a clinic setting on an ambulatory, outpatient basis, requiring fewer facility resources and reducing cost of care. Particularly in settings where instruments can be reused, the cost per procedure can be relatively low. Reduced waiting times and increased local availability of care also make this an acceptable method for many women. MVA creates little noise during the procedure, which some women find preferable (Bird et al., 2001). (See the Uterine Evacuation Procedure with Ipas MVA Plus® for more detailed information on MVA.)

2.2 Electric Vacuum Aspiration (EVA)

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

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

3.0 Medication Abortion

Description

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

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

Misoprostol alone may be useful where mifepristone is not available and studies to identify ideal regimens are ongoing. Pending definitive recommendations,
guidance on the use of misoprostol alone may be useful to providers given the widespread use of the drug in many settings globally. (See Appendix C: Abortion Induction With Misoprostol in Pregnancies up to Nine Weeks since the LMP of the Medication Abortion module.)

Clinical safety and effectiveness

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

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

Cost

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

Acceptability to women

Studies show that medication abortion is acceptable to many women in a variety of settings, including where resources are limited. The non-invasive aspect of medication abortion, as opposed to a vacuum-aspiration procedure, is often cited as a significant benefit. Some women also perceive medication abortion as a more private and natural method. (For more information, see the Medication Abortion module.)

4.0 Sharp Curettage

Description

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

Clinical safety and effectiveness

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

Cost

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

5.0 Summary
- There are several means of accomplishing uterine evacuation.
- The three main methods of first-trimester uterine evacuation are vacuum aspiration, medications (pharmacological agents) and sharp curettage.
- The two main methods of second-trimester evacuation are dilatation and evacuation (D&E) and medications (pharmacological agents).
- Vacuum aspiration and medication abortion are the preferred methods of uterine evacuation in the first trimester because they have been proven safer than sharp curettage.
- Mifepristone followed by the prostaglandin misoprostol is the most effective medication method up to nine weeks since the LMP; regimens beyond nine weeks are being studied.
- 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.

Additional Resources


Bibliography


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Geyman, John P., Lynn M. Oliver and Sean D. Sullivan. 1999. Expectant, medical, or surgical


## Uterine Evacuation Methods

### Appendix A: Complications Data

#### Complications of First-Trimester Induced Abortion by Method of Uterine Evacuation

<table>
<thead>
<tr>
<th>Study Description</th>
<th>Country</th>
<th>Duration of Pregnancy (Weeks)</th>
<th>Number of Procedures</th>
<th>Total Complications (%)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Vacuum Aspiration (VA)</td>
<td>Manual Vacuum Aspiration (MVA)</td>
</tr>
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<td>Goldberg et al. / 2004</td>
<td>U.S.</td>
<td>≤10</td>
<td>...</td>
<td>1002</td>
</tr>
<tr>
<td>Dean et al. / 2003</td>
<td>U.S.</td>
<td>≤10</td>
<td>...</td>
<td>41</td>
</tr>
<tr>
<td>Paul et al. / 2002</td>
<td>U.S.</td>
<td>&lt;6</td>
<td>750</td>
<td>...</td>
</tr>
<tr>
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<td>≤8</td>
<td>...</td>
<td>91</td>
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<tr>
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<td>France</td>
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<td>683</td>
<td>...</td>
</tr>
<tr>
<td>Westfall et al. / 1998</td>
<td>U.S.</td>
<td>≤12</td>
<td>...</td>
<td>1677</td>
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<td>&lt;6</td>
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<td>Sweden</td>
<td>≤18</td>
<td>...</td>
<td>...</td>
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<td>...</td>
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<td>≤12</td>
<td>54,155</td>
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<td>≤6</td>
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<td>Nathanson / 1972</td>
<td>U.S.</td>
<td>≤12</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>Tietze et al. / 1972</td>
<td>U.S.</td>
<td>≤16</td>
<td>52,962</td>
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*continued on page 52*
### Uterine Evacuation Methods Appendix A: Complications Data

**Complications of First Trimester Induced Abortion by Method of Uterine Evacuation (Continued)**

<table>
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<tr>
<th>Study Description</th>
<th>Uterine Perforation (%)</th>
<th>Cervical Injury (%)</th>
<th>Infection $^6$ (%)</th>
<th>Excess Blood Loss $^7$ (%)</th>
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<td>VA $^4$ MVA EVA SC</td>
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<td>Hemlin et al.</td>
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<td>... 2.20 2.27</td>
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<td>... 3.46 ...</td>
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<td>0.75 ...</td>
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<td>... 1.59 ...</td>
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<td>1.54 2.03 ... 1.71</td>
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<td>... 1.50 ...</td>
<td>... ... 0.21</td>
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<td>Tietze et al.</td>
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<td>0.93 ... 0.79</td>
<td>0.97 ...</td>
<td>1.42 0.82 ... 1.54</td>
</tr>
</tbody>
</table>

### NOTES

1. Studies with less than 500 women excluded except those comparing EVA to MVA
2. Total complications as defined by author; definitions vary across studies
3. Data on incomplete abortion as a complication is not included in this analysis
4. Manual versus electric vacuum aspiration not specified or data not disaggregated
5. Upper gestational limit not specified
6. Infection definitions vary from the presence of fever to diagnosis of sepsis
7. Excess blood loss data includes delayed/postabortal bleeding in studies authored by Edwards et al., Laufe, Andolsek et al. and Tietze et al.
Monitoring to Improve Services

Key Topics in This Module:
- Effective monitoring systems
- Use of monitoring data to improve services
- Steps to establish a monitoring system

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

2.0 What Is Monitoring and Why Is It Important?

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

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

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

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

Monitoring is a way of:
- Assessing the strengths and weaknesses of services
- Developing and implementing an action plan to strengthen areas of service needing improvement
- Reassessing services to ensure that changes have had the desired results
The following table provides brief examples of facility-level monitoring that can be accomplished without complex information-gathering or analysis tools. These examples illustrate that monitoring works best when it is carried out over a period of time, with ongoing evaluations and updated improvement plans. Note that actual improvement plans would be far more specific, including details on when, where, how and by whom the recommended steps would be carried out.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Current Monitoring Data</th>
<th>Previously Collected Data</th>
<th>Improvement Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of clients receive individualized counseling with a counselor.</td>
<td>65% of clients receive individualized counseling with a counselor.</td>
<td>Compared with data one year prior, individualized counseling has increased 40%.</td>
<td>Private counseling spaces will be expanded and additional counselors trained to increase individualized counseling.</td>
</tr>
<tr>
<td>Essential supplies to high-level disinfect MVA instruments available 100% of the time.</td>
<td>Instrument-processing chemicals are available 70% of the time. Deliveries of these chemicals are often one to three weeks late.</td>
<td>Compared with data six months prior, availability of instrument-processing chemicals increased 10%.</td>
<td>While an increase in availability is positive, the goal is 100% availability. An administrative change will be made to order instrument-processing chemicals well in advance to ensure adequate supplies despite late deliveries.</td>
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</tbody>
</table>

### 3.0 Keys to Effective Monitoring Systems

**Monitoring is most effective when it:**

...is integrated into routine work

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

...uses simple indicators

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

...is participatory and open

When the monitoring process is genuinely inclusive of all health-care staff members, they are more likely to feel a sense of ownership of the results, as well as of any improvement processes. Staff inclusion in the process of defining high-quality services also helps to clarify performance expectations. Staff members should be trained to use monitoring tools and processes, accompanied by supportive supervision, so that they can incorporate monitoring into their responsibilities. Finally, sharing the results of monitoring efforts with staff illustrates for them which aspects of services are effective and which need improvement.
...is conducted in an ethical manner

All monitoring efforts should be conducted in a manner that is respectful to both women and providers. The privacy and confidentiality of women must be respected at all times. No woman should feel pressured to participate in monitoring efforts. Informed consent must be obtained before women are interviewed or any provider-client interactions are observed. (See Appendix A: Written Consent Form – Interview and Appendix B: Written Consent Form – Observation for examples.)

...is not punitive

For monitoring to be most effective, it must be a non-judgmental, non-punitive process. Monitoring is most effective when members of the service-provision team monitor themselves and the information gathered is used as a basis for reward and recognition among team members.

4.0 Four Steps of Effective Monitoring

Monitoring involves four basic steps:

1. **Planning**: establishing standards of quality, selecting information-collection methods and indicators of those standards, and ensuring staff and managerial support for the monitoring process

2. **Information gathering**: collecting information about services

3. **Analysis**: comparing the current state of services with quality and performance standards and with longitudinal changes in service quality

4. **Action planning**: developing improvement plans to address any problems that have been identified through the monitoring process
1. Planning
Before initiating data collection, develop a monitoring plan that specifies how information will be collected, shared and analyzed. It is important to contact and garner the support of all administrators, managers and providers who will be affected by the process.

A lead monitor or monitoring team should be selected and trained to gather, analyze and share information. With the input of staff and managers, the team should determine the aspects of services to be monitored. The team should use performance standards to establish criteria against which current services will be compared, and develop or adapt checklists and other tools to guide observations, interviews and records review. Checklists should include the features and processes essential to the delivery of high-quality care, including the availability of supplies, use of preferred medical techniques and quality of counseling. (See Appendix C: Sample Clinical Protocols Checklist for MVA Abortion as an example.)

Using Indicators
Indicators are quantitative measurements that help in measuring more complex, qualitative processes or activities. Examples of indicators may include:

- Number and type of procedures performed
- Estimated uterine size in weeks since the last menstrual period (LMP) for each procedure performed
- Number and type of complications
- Number and percentage of women desiring contraception who receive a contraceptive method
- 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

The following table illustrates aspects of abortion services that could be monitored. The indicators and information sources listed are examples, not an exhaustive list. Sources and collection methods may vary among facilities, depending on the type of information that is regularly collected and the ways in which that information is recorded. The questions provided are examples of what might be asked via checklists, questionnaires or exit interviews. The monitoring team should plan out what services they will monitor and how they will monitor them.

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

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

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

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

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

Consent must be obtained before conducting any interviews or observations. When initiating interviews or observations, monitors 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. (See Appendix A: Written Consent Form – Interview and Appendix B: Written Consent Form – Observation for examples.)

Monitors must ensure that the privacy and confidentiality of women is respected throughout the interview and observation processes. Clients’ names and unique identifying information should not be included on data forms.

3. Analysis

The analysis of monitored data involves compiling and reviewing the findings to reveal problem areas, develop improvement plans and assess progress in improving care. The objective is to identify those areas that are most in need of attention and to develop plans for strengthening those problem areas. The review of monitored data presents an opportunity for health-care staff to openly discuss the facility’s strengths and weaknesses.

The assessment of quantitative data will involve tabulation and statistical analysis. Qualitative information, such as interviews, can be used to complement quantitative information. For example, quantitative information may reveal that client visits consistently increase on a certain day of the week; qualitative information may provide information about why this is occurring. Qualitative information adds detail to analyses and provides information about aspects of services that cannot be captured quantitatively.

The data that were collected during the information-gathering process should be compiled for review by the monitoring team. From this data, the group should be able to identify problem areas and issues of concern, as well as areas of strength and competency.

Once the staff has a better understanding of the problems, they can delve deeper
into the underlying causes of the identified problems. Health-care staff must ask the question, “What factors have contributed to these problems?” For example, poor-quality counseling services might stem from a lack of staff training in counseling and a client-intake process that leaves insufficient time for counseling. The staff review may also identify causes that are more pervasive—for instance, an underlying belief that counseling is not an important part of services.

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

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

The improvement plan should then be discussed with staff members who are not on the monitoring team, but who may play a direct role in its implementation. Once everyone who will be involved has been informed, the monitoring team should present its findings and proposed solutions to the entire staff. This is an opportunity to obtain valuable staff feedback about the monitoring process and the improvement plan.

It is important to share positive findings with staff, including areas of strength and competency and any improvements that have been made. Staff contributions that have led to improved services should be recognized so that staff members can celebrate their successes.

5.0 Summary
- Monitoring, or the routine tracking of services, is essential to ensuring 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.
- Monitoring should not be an overly complex or punitive process.
- The four stages of monitoring are planning, information gathering, analysis and action planning.

Additional Resources

Bibliography


Monitoring Appendix A: Written Consent Form – Interview

Statement requesting to interview woman after receipt of abortion services:

Interviewer:

Hello, my name is __________, and I am working with a team that is monitoring service quality. We would like to help improve the services provided by this facility and thus would like to find out your views about the services you received.

I would like to ask you a few questions about the discussions you had with the staff here and the procedure you have just undergone. I will not write your name on the data-collection form. Everything you tell me will be kept strictly confidential and will be shared only with other team members. No one will be able to identify you from the information we collect. Your participation is voluntary, and you do not have to answer questions you do not want to answer.

Do I have your permission to continue?

Client:

Yes, you have my permission.

Signature ____________________________________________
Date _______________________________________________

Witness _____________________________________________
Date _______________________________________________

Name of Facility ______________________________________
Monitoring Appendix B: Written Consent Form – Observation

Statement requesting to observe woman during her abortion:

Interviewer:

Hello, my name is___________, and I am working with a team that is monitoring service quality. We would like to help improve the services provided by this facility by observing the care you will receive.

I will not write your name on the data-collection form. Everything I observe will be kept strictly confidential and will be shared only with other team members. No one will be able to identify you from the information we collect. Your participation is voluntary, and you do not have to allow me to observe if you do not want to. If you do not wish to participate, this will not affect the care or services you receive today.

Do I have your permission to continue?

Client:

Yes, you have my permission.

Signature ____________________________________________
Date _______________________________________________

Witness _____________________________________________
Date _______________________________________________

Name of Facility ______________________________________
### Checklist for MVA Abortion

Date: ___________________ Start time of observation: ____________________ End time of observation: _____________________
Observer’s Name: ________________________________ Provider’s Name: _____________________________________________
Facility: _________________________________________________________________________________________________

**Instructions:** Place a checkmark “✔” in the “Cases” column if each step is performed satisfactorily, an “X” if it is not performed satisfactorily, or N/O if not observed. (Note the each checklist can be used to assess five different cases/procedures.)

**Satisfactory (✔):** Performs the step or task according to the standard procedure or guidelines.

**Unsatisfactory (X):** Unable to perform the step or task according to the standard procedure or guidelines.

**Not Observed (N/O):** Step or task not observed if or when it was performed.

<table>
<thead>
<tr>
<th>Cases</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>1. <strong>Receive client and obtain medical history:</strong></td>
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<tr>
<td>2. <strong>Counsel:</strong></td>
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<td>3. <strong>Examine:</strong></td>
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<td>4. <strong>Determine pain management:</strong></td>
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<td>5. <strong>Prepare the woman:</strong></td>
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<td>6. <strong>Prepare instruments:</strong></td>
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<tr>
<td>7. <strong>Perform cervical antiseptic prep:</strong></td>
<td></td>
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<tr>
<td>8. <strong>Perform paracervical block:</strong></td>
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<tr>
<td>9. <strong>Dilate cervix:</strong></td>
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<td></td>
<td></td>
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<tr>
<td>10. <strong>Insert cannula:</strong></td>
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<tr>
<td>11. <strong>Suction uterine contents:</strong></td>
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<tr>
<td>12. <strong>Inspect tissue:</strong></td>
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<td>13. <strong>Perform any concurrent procedures:</strong></td>
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<td>14. <strong>Take immediate post-procedure steps, including instrument processing:</strong></td>
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<tr>
<td>15. <strong>Monitor status and provide instructions:</strong></td>
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**OBSERVER COMMENTS:**
Counseling

Key Topics in This Module:

- Definition of abortion counseling
- Characteristics and techniques of effective counseling and communication
- Privacy, confidentiality and informed decisionmaking
- Counselors’ values, attitudes and beliefs
- Special populations of women

1.0 Introduction

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

All women receiving abortion care have the right to high-quality counseling, regardless of their medical or psychological circumstances. Effective counseling, an integral part of high-quality abortion care, provides an opportunity to assess the woman’s ability to cope as well as helping her explore her feelings and comprehend the information she needs to make informed decisions. It is essential to provide complete, accurate and easy-to-understand information that assists the woman in understanding and considering her medical options.

Counseling helps providers identify when women need special care because of emotional distress or personal circumstances. The most immediate benefits of counseling are more effective client-provider relationships, care that is comforting to the woman and greater overall client satisfaction with the healthcare encounter (Baker, 1999).

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

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

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

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

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

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

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

Providers should adapt the counseling process as needed for each woman. They must remain mindful of any circumstances that may limit a woman's ability to make independent decisions or to comprehend the information and, therefore, give informed consent. Such circumstances include situations where the woman:
- is under pressure from her partner or family members to have an abortion
• has difficulty communicating due to language barriers
• is hard of hearing or deaf
• is cognitively disabled or mentally ill
• is very young
• has experienced a traumatic event (for example, has been subjected to violence or has had an unsafe abortion)

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

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

The circumstances of abortion care can create several counseling challenges. First, the woman may have conflicting feelings about her pregnancy, the outcome of the pregnancy and other life circumstances. Second, if the woman is in emotional distress, she may be temporarily unable to fully comprehend her situation. Finally, the woman and counselor may have different values or cultural and language backgrounds that create barriers to mutual understanding.

Because a woman may have infrequent contact with the health-care system, counseling is an excellent opportunity for providers to determine the entire scope of her physical and emotional needs and to refer her to appropriate services.

(For more information on counseling specific to medication abortion, refer to the Medication Abortion module.)

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

In a counseling setting, informed decisionmaking refers to the process by which a woman makes decisions of her own free will after she understands complete and accurate information. The counselor should inform the woman that any medical and personal information discussed during counseling is confidential, and then ensure that this information is not released without the woman’s voluntary authorization. Offering the woman respectful, confidential counseling in a private setting will contribute to her sense of dignity and the overall quality of her care.

6.0 Counselors’ Values, Attitudes and Empathy
Effective counselors remain open and nonjudgmental even when their personal beliefs differ from, or even conflict with, those of their clients. Such counselors can have a beneficial impact on women’s emotional and physical health. Conversely, counselors who allow their biases to affect their interactions can have a negative effect on women’s emotional and physical well-being. Counselors should strive to practice empathy, which is the ability to understand another person’s feelings and point of view and to communicate this understanding to the person. Empathy does not mean “feeling sorry” for the person. Rather, empathetic abortion counselors imagine how they would feel and how they would like to be treated if they were in the woman’s situation, while understanding that the woman’s feelings may differ from their own.

Clients respond most favorably to counselors who:

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

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

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

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

7.1 Woman-Centered, Two-Way Communication
Woman-centered counseling is structured completely around the woman’s needs and concerns. When counseling a woman, the counselor should take into account her emotional state, medical condition, cultural and religious background, ability to understand medical terms and level of general understanding. A counselor can assess the woman’s most pressing needs by asking her what her greatest concerns are and then use those concerns as the starting point for counseling.

Counseling always involves two-way communication between the health-care provider and the woman. Each person spends time talking, listening, and asking and answering questions. In general, effective counselors listen more and talk less.

7.2 Active Listening
Active listening is the key to establishing trust and rapport with a client, and involves more than just hearing. A counselor who is practicing active listening uses multiple senses to gather relevant information, convey understanding and encourage the woman to talk about her feelings and circumstances. A counselor who does not employ active listening, on the other hand, communicates a lack of interest and may alienate the woman.

In order to provide high-quality abortion care, counselors need to:
• Identify their values and attitudes with regard to sexual- and reproductive-health care
• Separate their values from those of clients
• Recognize how their attitudes could negatively or positively affect counseling
• Receive counseling training, if available

A counselor can show attentiveness while the woman talks by interjecting phrases such as “I see” or “I understand” and by making encouraging sounds, facial expressions and gestures. However, counselors should resist the temptation to offer statements that seem reassuring initially, but ultimately make women feel unsupported or offer false reassurance. For example, saying to a
woman “don’t worry,” “you’ll feel better soon,” or “everything will be fine” can make her feel that her concerns have been dismissed or invalidated.

7.3 Verbal Communication: Open-Ended Questions and Reflecting Feelings

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

Counselors should avoid asking open-ended questions that begin with “why,” as this may be perceived as judgmental. For example, a counselor might ask a woman, “Why do you feel relieved about having had an abortion?” The implied judgment is that a woman who has had an abortion should not feel relieved.

The counselor can follow up the woman’s response to an open-ended question with a statement that reflects understanding of the woman’s feelings and concerns. If the counselor is unsure whether she has understood the woman correctly, she can add a question at the end of the statement, such as, “Is that correct?” This gives the woman the opportunity to confirm or correct the counselor’s understanding. Also, in order to ensure that all the woman’s concerns are addressed, it may be helpful to ask her what other questions she has or what else she would like to discuss.

7.4 Nonverbal Communication

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

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

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

8.1 Feelings About Pregnancy
News of pregnancy can invoke a range of emotions, including joy, fear, sadness,
guilt, relief and disappointment. The counseling session may be the first opportunity the woman has had to speak honestly about her feelings regarding her pregnancy. Her emotional response to her abortion may largely hinge on how she felt about being pregnant in the first place.

If the woman wanted to be pregnant but needed to terminate the pregnancy for medical or other reasons, she may feel a great sense of loss or guilt. If the woman did not want to be pregnant, she still may experience a sense of loss and a range of other strong emotions about seeking an abortion.

8.2 Information and Options
When a woman requests an abortion, she usually has carefully considered her options and decisions prior to seeking care. However, for various reasons discussed earlier in this module, women may want more information on which to base their decision or they may not have fully considered their decision to seek an abortion. For the purpose of informed consent, it is important that counselors always review the woman’s medical condition and the basic options available to her:

- continue the pregnancy to term and parent or release the child for adoption
- terminate the pregnancy

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

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

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

- what will be done during and after the procedure
- what she is likely to experience—for example, menstrual-like cramps or pain
- how long the procedure will take
- which pain management options she can choose
- what side effects, risks and complications are associated with the method
- what kind of aftercare and follow-up is needed
If the woman chooses medication abortion, the counselor should explain that in the unlikely event the method fails, the provider will need to complete the abortion with another method, preferably vacuum aspiration.

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

8.4 Feelings About Potential for Future Pregnancy

Some women are frightened by myths they have heard about abortion causing

<table>
<thead>
<tr>
<th></th>
<th>Vacuum Aspiration</th>
<th>Mifepristone &amp; Misoprostol</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is it?</strong></td>
<td>A uterine evacuation procedure that uses electric or manual suction instruments inserted into the uterus.</td>
<td>Medications that taken together cause the uterine lining to detach and uterine contractions to expel the pregnancy, usually avoiding an invasive procedure.</td>
</tr>
<tr>
<td><strong>How does it work?</strong></td>
<td>Uterine contents are evacuated from the uterus through a cannula into a handheld manual vacuum aspirator or electric pump.</td>
<td>Mifepristone prevents progesterone from supporting the pregnancy. Misoprostol causes uterine contractions that expel the pregnancy.</td>
</tr>
<tr>
<td><strong>When can it be used?</strong></td>
<td>From detection of pregnancy up through 12 weeks since the LMP (throughout first trimester).</td>
<td>Varies with the protocol; often from detection of pregnancy through 63 days (nine weeks) since the LMP.</td>
</tr>
<tr>
<td><strong>Where can it be used?</strong></td>
<td>Procedure is done in a medical office or clinic.</td>
<td>Some of the process may occur at home.</td>
</tr>
<tr>
<td><strong>How effective is it?</strong></td>
<td>98% to 100% effective</td>
<td>98% to 100% effective</td>
</tr>
<tr>
<td><strong>What are the side effects and complications?</strong></td>
<td>Common side effects include abdominal cramping or pain and bleeding that resembles menstruation. Rarely, vagal reaction may occur. Rare complications include cervical or uterine injury, perforation, excessive bleeding, pelvic infection, acute hematometra, or failed or incomplete abortion.</td>
<td>Side effects include nausea, vomiting, diarrhea, abdominal cramping or pain, fever or chills, vaginal bleeding, dizziness and, rarely, anemia. Occasionally, medication abortion can fail to terminate the pregnancy, requiring completion, preferably using vacuum aspiration. There is a possible, but rare, need for blood transfusion.</td>
</tr>
<tr>
<td><strong>How is it typically used?</strong></td>
<td>Procedure time is 3 to 10 minutes. The woman is usually able to leave within an hour. Local anesthesia is commonly used to control pain, though stronger pharmacological approaches may also be options. Pregnancy tissue is examined and procedure completion is immediately confirmed, necessitating only one clinic visit.</td>
<td>Mifepristone is given orally at a clinic visit. Shortly thereafter, the woman takes misoprostol, either vaginally or orally, and then the abortion usually occurs within 24 hours, but can take up to several days. A follow-up visit is scheduled to confirm the abortion is complete.</td>
</tr>
<tr>
<td><strong>What happens if the procedure fails?</strong></td>
<td>Re-evacuation is performed.</td>
<td>Vacuum aspiration is performed, or sharp curettage is performed when vacuum aspiration is not available.</td>
</tr>
</tbody>
</table>

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

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

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

### 9.0 Making Referrals

By providing appropriate referrals to women, counselors are performing an important service that should not be underestimated. Counselors can unintentionally do more harm than good if they attempt to counsel women about subjects in which they lack expertise or training. Counselors should also be prepared to refer women if they cannot remain nonjudgmental and impartial in counseling them. In situations in which a counselor feels uncomfortable or is unable to adequately address the client’s needs, it is best to refer the woman to a different counselor.

Counselors should identify common concerns that women may raise and create a resource list for referrals. They can create the list by researching and identifying local resources and then update it periodically. The counselor should also assure the woman that she can return to the original facility for additional referrals if she has trouble accessing the referred resource or if it is does not meet her needs.

The referral process will also be more effective if the facility creates referral protocols. For example, one essential protocol is to create and maintain a referral logbook in which counselors can write each client’s name, the service to which she was referred and any follow-up care that took place. It is also a good idea for counselors to routinely ask each woman if it is safe for her to receive written referral information. For some women, it may be dangerous to receive information that may be found by someone else. In such situations, the counselor can work with the woman to find an alternative way to provide her with the...
A referral is needed when:
- The problem or issue being discussed with the woman is beyond the counselor’s knowledge or skills
- The counselor and other staff at the facility cannot answer questions being raised by the woman
- The counselor has a conflict of interest or personal values that make it difficult for them to be impartial or nonjudgmental
- The woman’s needs are beyond the capacity of the health-care facility
- The woman stops communicating with the counselor

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

information. (See Appendix E: Sample Clinical Referral Forms in the Uterine Evacuation Procedure with Ipas MVA Plus® module.)

10.0 Closing a Counseling Session

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

11.0 Special Populations

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

Appendix A: Additional Special Populations offers information on how counselors can meet the specific needs of women with repeat abortions; women who have experienced violence; women living with HIV/AIDS; adolescents; women engaged in commercial sex work; women with cognitive and developmental disabilities and mental illness; refugees and displaced persons; women who
have experienced female genital cutting; and women who partner with women.

12.0 Summary

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

Additional Resources


The Family Health Service Project (Nigeria), MotherCare/John Snow, Inc. and Johns Hopkins University. 1993. Interpersonal communication and counseling curriculum for midwives. Arlington, VA, MotherCare/John Snow, Inc.


Ipas. 2003. Sexual violence working group resources. Available online at


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**Bibliography**

American College of Obstetricians and Gynecologists (ACOG) Task Force on Female Circumcision/Female Genital Mutilation. 1999. *Female circumcision/female genital mutilation: Clinical management of circumcised women*. Washington, DC, ACOG.


Counseling


Counseling Appendix A: Additional Special Populations

(See Contraceptive Services Appendix C: Contraceptive Counseling for Special Populations for more information.)

Women With Repeat Abortions

If a woman does not desire pregnancy yet has experienced repeated unwanted pregnancies, the counselor can talk with her about why this is occurring. Some women will not have an explanation as to why they choose not to use contraception. In some cases, there may be an underlying problem that prevents the woman from adequately protecting herself from unwanted pregnancy, including myths about contraception, coercive sex, abusive sexual relationships or unresolved emotional conflicts. The counselor can help the woman explore any unresolved emotional issues, such as low self-esteem or trauma from severe abuse, that may be contributing to unwanted pregnancy. 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 counselors will encounter women who have experienced sexual violence. Women who have experienced such violence—which includes rape, sexual assault, coercive sex, incest and involuntary prostitution—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. By expressing empathy and compassion, counselors can help survivors of violence overcome the feelings of shame, fear or worthlessness that commonly follow sexual violence. These emotions can all place women at greater risk for further abuse. Women who have experienced violence are also prone to suffering from low self-esteem and engaging in consensual sexual activity at a younger age and high-risk sexual behaviors.

Health workers must be cognizant of their own limitations in assisting women experiencing violence and, whenever possible, refer women to others specialized in addressing these women’s needs. At times, however, providers may recognize that a woman could be under immediate threat and may be able to assist her in protecting herself. Caution must be taken in this situation, however, because in some instances efforts to help a woman may in fact put her in more immediate danger.

For a woman in an abusive relationship, having a personal safety plan can help her deal with violence, even if she is not ready to leave the relationship. The plan can also help her to leave safely if she chooses to get out of the situation. Ideally, the woman should be referred to a counselor experienced in domestic-violence issues. The counselor and the woman can construct an individualized safety plan based on the woman’s needs and the culture she lives in. Anyone counseling a woman who is at risk of sexual violence needs to be aware that in some instances a partner discovering evidence of such a plan could put the woman in more danger.

Special counseling considerations include:

- An unwanted pregnancy may be the result of rape or incest
- A spontaneous abortion could have been caused by physical abuse
- 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
Counselors can help women feel more comfortable answering questions about violence by introducing the subject in some of the following ways:

- “Because violence is present in many women’s lives, we now ask all our clients about abuse.”
- “Many of the women I see are dealing with violence at home. Because some are afraid to bring up the subject, I’ve started to ask about it routinely. Has this ever been a problem for you?”
- “As you probably know, it is not uncommon for a woman to be emotionally, physically or sexually abused at some time in her life, and this can affect her health. Has this ever happened to you?”
- “Has your partner ever hit you, physically hurt you or made you feel threatened or afraid?”
- “Has your partner or anyone else ever forced you to have sex when you didn’t want to?”

(Adapted from Population Information Program, 1999)

In counseling a woman who has experienced sexual violence, an effective counselor will:

- Assess the woman’s ability to make appropriate decisions at the time of counseling
- Evaluate the woman’s need for further assessment and treatment for the physical or psychological effects of violence
- Help the woman consider the likelihood of the violence continuing
- Help the woman make a plan for her immediate safety, if needed
- Refer the woman to a counselor trained in working with domestic violence and/or other appropriate services, such as health-care or legal services

woman in greater danger than she presently is. On the following page is one example of a possible safety plan that could be shared with a woman, if appropriate.

Women Living With HIV/AIDS

Women receiving abortion care who are HIV-positive need specific information, support, counseling, medical care and other services. If counselors have not undergone extensive HIV training, they should refer HIV-positive women to appropriate services, where available. HIV-positive women should be offered information that can help them better understand their condition and improve their own health, as well as the health of their sexual partners and children.

If HIV-specific services are not available, the counselor can at least discuss the following issues with HIV-positive women:

- Using certain medications that may be available locally can slow the effects of the disease
- Boosting the immune system can improve the body’s capacity to fight HIV and other infections
- Consistently and correctly using barrier methods, such as male and female condoms, every time intercourse occurs can help prevent HIV transmission to others
- Engaging in unprotected sexual intercourse with an uninfected partner poses a
risk of HIV transmission to that partner

- Engaging in unprotected sexual intercourse with an infected partner poses a risk of infection with a different strain of HIV and other STIs
- Using dual protection, either through the simultaneous use of condoms and other methods or through the consistent and correct use of condoms alone with emergency contraceptive pills as a back-up, is recommended for HIV-positive women who do not desire pregnancy, as well as for disease prevention
- Carrying a future pregnancy to term and breastfeeding may result in an HIV-positive infant, although the risks may be greatly reduced with antiretroviral therapy

(Adapted from WHO, 2000)

**Things You Can Do to Stay Safe:**

- Identify one or more neighbors you can tell about the violence, and ask them to seek help if they hear a disturbance in your home.
- If an argument seems unavoidable, try to have it in a room or an area that you can leave easily. Stay away from any room where weapons might be available.
- Practice how to get out of your home safely. Identify which doors, windows, elevator or stairwell would be best.
- Have a packed bag ready, containing spare keys, money, important documents and clothes. Keep it all at the home of a relative or friend, in case you need to leave your own home in a hurry.
- Devise a code word to use with your children, family, friends and neighbors when you need emergency help or want them to call the police.
- Decide where you will go if you have to leave home and have a plan to get there—even if you do not think you will need to leave.
- Use your instincts and judgment. If the situation is dangerous, consider giving the abuser what they are demanding to calm them down. You have the right to protect yourself and your children.

(Adapted from Population Information Program, 1999)

**Adolescents**

Adolescents seeking abortion services are likely to have fewer resources than adult women, as well as less accurate information about their bodies, pregnancy and contraception. Frequently they do not have the support of their partners or parents, and they may face legal barriers to accessing reproductive-health care. For these reasons, they are more likely to experience isolation and emotional stress and to delay seeking services.

Adolescents may say or do what they believe the counselor wants to hear or see, rather than what they feel is best for them. It is important that adolescents feel they can honestly express their emotions and decisions with the counselor. The counselor can ensure this by showing support and understanding and taking extra care to express openness and compassion with adolescent women. Personal judgments about adolescent sexual activity should not affect the interaction.

Counselors can help adolescents explore their feelings about future sexual activity and fertility goals. If the adolescent does not want to engage in sexual activity,
she may need to be counseled on how to negotiate this with partners and resist advances, especially from adult men. If she has experienced sexual violence, counselors can refer her to appropriate services for longer-term counseling.

If the adolescent desires pregnancy, the counselor can inform her of where to go for prenatal care. For adolescents who do not desire pregnancy, this counseling contact could be critical in helping her limit her future risks for unwanted pregnancy and STIs, including HIV. It provides an opportunity for the counselor to inform the adolescent about the full range of contraception, including emergency contraception, and STI-prevention methods available, and to provide her with or refer her for contraceptive counseling. (See the Contraceptive Services module for more information.) Adolescents may also need help learning how to negotiate contraceptive and condom use with partners. It is helpful for counselors to refer young women to specialized reproductive-health programs, such as adolescent sex-education or peer-counseling programs, if they are available.

Women Who Engage in Commercial Sex

Women’s reasons for engaging in commercial sex, as well as their feelings and perceptions about these activities, vary widely. Counselors’ assumptions about women’s sexual activities, partner choices, types of relationships (intimate versus commercial) or power to negotiate within sexual relationships can negatively affect the counseling session. Counselors can be most effective by gaining information about the woman’s personal circumstances and then meeting her needs.

When counseling a woman who engages in commercial sex, an effective counselor will:

- Ascertain the woman’s plan to continue engaging in commercial sex
- Instruct the woman about ways to protect her health and well-being, to the degree possible, if she intends to continue engaging in commercial sex
- Offer referrals to any services that are available to assist the woman, should she express the desire to get out of commercialized sex work
- Help the woman assess her sexual and reproductive health and risk for sexually transmitted infections (STIs), including HIV/AIDS, and refer her for screening, treatment and prevention services
- Refer the woman to additional community-based health-care, counseling and financial services as needed

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. The counselor should start by speaking with the woman in reassuring tones and asking her if she would like her companion, if she has one, to help her answer questions and stay with her during exams and any procedures. It is important to honor the woman’s decisions regarding privacy and who she wishes to be present during counseling, exams
and procedures. Even if she prefers that her companion participate in the counseling session, the counselor should still direct questions and conversation to the woman.

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. To improve communication, counselors can:

- Use simple, easy-to-understand language
- Ask the woman to repeat concepts back in her own words to ensure that she understands
- Talk in a private, quiet area that is away from auditory and visual distractions
- Use illustrations whenever possible
- Reassure the woman that she is not at fault or in any trouble
- Provide examples whenever possible

Some types of cognitive disabilities and mental illness can contribute to the woman feeling highly anxious. In some cases she may or may not respond well to touch or to sitting or standing close to the counselor.

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.

**Women in Refugee and Displaced Settings**

Refugee and displaced women may be dealing with many different emotional stresses related to safety and personal-security issues; institutional, societal and personal violence; displacement from family, culture and home; lack of food; lack of access to comprehensive medical care; and insecurity about the future. Many women have been victims of violence during the initial period of displacement, while many others continue to experience violence in their present location. It is important when counseling refugee and displaced women to let them guide the counseling process. Some refugee or displaced women may have developed coping techniques that impede discussion, while others will welcome the opportunity to speak and be heard.

Counselors working with refugees and displaced persons should consider the following:

- Differences in cultural, ethical and religious beliefs are likely to exist between the refugee or displaced woman and the counselor. It is important to be aware
of these differences during counseling.

- Language differences are often a key barrier to care for refugee women. Where language differences are a barrier, a female translator—preferably someone provided by the facility rather than a friend or relative of the woman—should be available before the woman begins her counseling and clinical care.

- For many refugee and displaced women, abortion care is a referral service. Other reproductive-health services may be limited in many refugee and displaced settings. Do not assume that follow-up care, contraceptive supplies or referral health-care services are readily available to the woman where she normally seeks care.

- There is likely to be a wide spectrum for wanted and unwanted pregnancies in refugee and displaced settings. Some women who have lost children and family members are eager for new children to restore family lines, while others may wish to avoid childbirth entirely due to the uncertainty of refugee life.

- Among refugee or displaced women who have been victims of violence, some women may fear the stigmatization of an induced abortion, while others may refuse to continue a pregnancy resulting from violence, at any cost to their life or health.

**Women Who Have Experienced Genital Cutting**

Counselors may encounter women who have undergone female genital cutting (FGC) or female genital mutilation (FGM). As defined by the World Health Organization: “Female genital mutilation, often referred to as ‘female circumcision,’ comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons” (WHO, 2000). The four broad categories of FGC are outlined in *Clinical Assessment Appendix B: Female Genital Cutting (FGC).*

Women may not want to bring up the subject of FGC with their counselor or may not realize that it will affect their abortion care. If counselors suspect that a woman has undergone FGC, they might say something like, “Many women from your region of origin have experienced FGC, a practice where parts of the genitals are removed, sewn together or otherwise altered. Is this something you have experienced?” If the woman has undergone genital cutting, it is very important that the counselor use sensitivity when questioning her about it and not assume that all women have the same experience with FGC. The counselor can gently inquire whether the cutting has affected the woman’s emotional, physical or sexual life in any way, and can review basic information about female reproductive anatomy, the menstrual cycle and what to expect during a pelvic examination.

Psychological trauma can be attributed to the high levels of pain that the woman experienced during and after FGC, to the fact that many procedures are done to the woman without prior warning and to the loss of sexual sensation that many women experience after the procedure. In some cases, the woman may feel betrayed by her family, female relatives and friends. In other cases, FGC may be part of a larger cultural experience that has positive significance for the woman. Counselors can explore the woman’s feelings by asking her open-ended questions about her experience.
**Deinfibulation Counseling**

If a woman has been infibulated such that the vaginal opening has been stitched or narrowed and needs to undergo a deinfibulation procedure to re-open the vagina for an abortion, it will be important in the counseling session to:

- Explain that the deinfibulation procedure entails cutting open the stitching in the woman’s genital area.
- Clearly inform the women that a deinfibulation procedure will entail the use of local or general anesthesia that could make her numb and/or unconscious. Assure her that her pain will be managed adequately and then ensure that it is.
- Inform the woman that the deinfibulation procedure could induce memories of her infibulation. Assure her that she will have emotional support throughout the procedure.
- Explain that the deinfibulation procedure is necessary to do a pelvic exam to fully assess her physical condition. The pelvic exam is necessary to assess and manage conditions such as incomplete abortion, hemorrhage, infection and intra-abdominal injury, all of which could lead to permanent disability or even death if not treated.
- Acknowledge and discuss any concerns she has about deinfibulation. For example, it is possible that she may be ostracized by her partner, family or community.
- Discuss the benefits of deinfibulation including decreased incidence of dysmenorrhea, dyspareunia, chronic urinary-tract infections, vaginitis and intrapartum complications.
- Discuss the rare risks of the deinfibulation procedure, which include bleeding and infection.
- Explain that she may experience urination differently after the procedure; instead of a trickle she may experience a flow.
- Counsel the women about reinfibulation, informing her that this procedure is not clinically recommended. Explain that the medical community sees the practice of infibulation as unsafe to the health of women and their potential offspring.
- Obtain voluntary informed consent from the woman for the procedure after all her questions and concerns are answered.

(See *Clinical Assessment Appendix B: Female Genital Cutting (FGC)* for more information.)

**Women Who Partner With Women**

Counselors should not assume that women seeking abortion services only have male sexual partners. There are various reasons why a woman who partners with women would seek abortion services. She may have had consensual sexual intercourse with a man or she may have been the victim of sexual violence. Also, some women engage in sexual relationships with both men and women. The circumstances surrounding the pregnancy will vary, as will the woman’s feelings about the abortion. Counselors should not assume that the pregnancy was unwanted or discount the woman’s risk for a future pregnancy.
Depending on cultural norms, it may be very difficult for the woman to disclose the fact that she partners with women or that her family structure does not fit a heterosexual model. Counselors can make it easier by assuring the woman that the conversation is confidential, by ensuring that confidentiality, and by showing respect for the woman’s choices, partner and family structure.
Contraceptive Services

Key Topics in This Module:

- Postabortion contraceptive counseling and method provision
- Service-delivery models
- Elements of effective contraceptive counseling
- Medical appropriateness of contraceptive methods following an abortion
- Emergency contraception (EC)
- Specialized situations for counseling or referrals

1.0 Introduction

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

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

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

In general, all methods of contraception, including intrauterine devices (IUDs) and

The term “contraception” is used in this module rather than “family planning.” While the term “family planning” is more culturally acceptable in some settings, many women receiving contraceptive services are simply trying to avoid getting pregnant as opposed to planning a family. Using the term “contraception” helps remind counselors not to make assumptions about women’s reproductive intentions.
hormonal methods, can be considered for use after a first-trimester abortion. However, when providing contraception to a woman, her medical eligibility for each method needs to be considered.

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

2.0 Importance of Contraceptive Counseling and Method Provision After an Abortion

The goal of contraceptive counseling as part of abortion services is to work with the woman to identify factors that led to the abortion. The counselor helps the woman decide if she wants to use a contraceptive method and, if she does, assists her in choosing an appropriate method. An effective contraceptive counselor keeps in mind the woman’s personal needs, reproductive goals and clinical condition.

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

3.0 Models of Service Delivery

There are many people who, with proper training, can provide contraceptive counseling and method provision. Options include training one or two staff members for this role, training additional staff members, or relying on staff from a local family-planning service. Community volunteers can also be trained to provide these services, as long as strict confidentiality protocols are enforced.
Contraceptive counseling and method provision can take place at various points and in different ways during abortion services. Service-delivery models include:

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

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

4.0 Women’s Fertility Goals Following an Abortion

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

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

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

4.1 Contraceptive Failure

Counselors will encounter women who have terminated unwanted pregnancies that resulted from contraceptive failure. The reasons for method failure vary: the method itself was not effective; the woman did not use the method appropriately; the woman discontinued use because of personal, family, social or cultural reasons; or the health system failed to reach the woman with appropriate and reliable services.
Failure of the contraceptive:
- No method is 100% effective. Even when a modern method of contraception is used correctly and consistently, some women will become pregnant.

Failure to use the method or failure to use it correctly:
- The woman cannot consistently afford contraceptives.
- The woman forgets to take or use her method consistently.
- The woman is influenced by popular myths about contraception, including the belief that contraception can cause infertility.
- The woman experiences unacceptable side effects and discontinues use.
- The woman’s husband, mother-in-law or other family member does not approve of her using contraception.
- Religious leaders in the woman’s community do not support the use of contraceptive methods.
- The woman had non-consensual sex.

Failure of the health system:
- Family-planning counselors do not adequately explain to the woman how to use the method.
- National reproductive-health policies limit access to contraception for some women, including unmarried women and adolescents.
- Contraceptive methods are too expensive for the woman to purchase.
- Family-planning clinics do not have the woman’s chosen method or do not stock it reliably.
- Contraceptive services are not located in the woman’s community or the clinics are not open at times convenient for the woman.
- Contraceptive-service protocols limit access to a sufficient supply of methods—for example, dispensing only a one-month supply of contraceptive pills at any given time.

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

At the beginning of a contraceptive-counseling session, the provider should assure the woman that the information that will be discussed is confidential. After the session, the provider should follow professional protocols that protect the confidentiality of the woman’s information. This includes not releasing the woman’s information without her consent and not discussing her situation in the presence of others.

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

6.0 Involvement of Partners

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

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

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

7.0 Essential Elements of Contraceptive Counseling

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

The GATHER technique for contraceptive counseling is used widely in family-planning settings. The letters in GATHER stand for Greet, Ask, Tell, Help, Explain and Refer. The following steps have been adapted from the GATHER technique and are critical to effective contraceptive counseling.

Establish rapport

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

Assess the woman’s needs

The counselor should use open-ended questions, discuss the factors that led to the need for an abortion and determine if the pregnancy was unplanned. If the woman was using contraception to prevent pregnancy, the counselor should help assess whether there were particular reasons the method failed.
Explain human reproduction, if necessary
Some women who seek an abortion may not fully understand the basics of how they became pregnant or how contraception prevents pregnancy.

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

Assess the woman’s individual situation
The counselor should consider both the woman’s clinical condition and her personal situation and discuss in a sensitive manner any potential barriers to the successful use of contraception. The counselor and the woman can then find ways to resolve or work around those barriers. (For more information, see Appendix A: Individual Factors and Counseling Recommendations and Rationales.)
Explain characteristics of available methods
It is important to determine which contraceptive methods are available and accessible to a woman, both at the facility and within her community. The counselor should explain the characteristics, use, side effects and effectiveness of the methods available, and let her know where she can obtain them.

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

Ensure that the woman understands how the method she selected works
The woman should understand the effectiveness, side effects and contraindications of the method she has chosen. The counselor can help her develop a plan for continued use and encourage her to return if the first method becomes unacceptable to her, if she wants to change to a new method or if she wishes to stop using contraception for any reason.

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

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

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

However, there are some notes of caution:
- It is recommended that women not have sexual intercourse until any complications are resolved and their chosen contraceptive method becomes effective.
- Natural family planning, or the fertility-awareness method, can be used after a woman has had at least one post-abortion menses, provided that before this pregnancy she had normal menstrual cycles (WHO 2004).
- Some medical conditions require a delay in the use of certain methods. For example, if a diaphragm or cervical cap is the woman’s choice and her uterine size is larger than 12 weeks from lingering effects of pregnancy (not from fibroids), provision of these methods should be delayed since the fitting may not be accurate. It is advisable to delay the fitting until the uterus has returned to pre-pregnancy size, which usually takes six weeks. Another contraceptive method should be offered to the woman for use in the interim.
Women should also understand that, except for female sterilization, which is considered permanent, they can switch to another temporary method in the future.

Based on WHO data, the following section discusses which methods are appropriate or inappropriate for various clinical conditions. (See Appendix B: Guidelines for Selection of Contraception by Method.)

The contraceptive methods referred to include:

- Barrier methods such as male and female condoms, spermicides, diaphragms and cervical caps
- Hormonal methods such as combined oral contraceptives, progestin-only oral contraceptives, combined injectables, progestin-only injectables, implants, skin patches and vaginal rings
- Intrauterine methods such as IUDs and intrauterine systems (IUS)
- Fertility awareness-based methods such as basal body temperature and calendar methods
- EC, which must be used within five days after unprotected intercourse and includes insertion of an IUD or a specific regimen of contraceptive pills
- Surgical methods such as male and female sterilization

8.1 Uncomplicated Abortion
All modern contraceptive methods can be used immediately.

8.2 Abortion With Complications: Infection
In cases where an infection is evident or presumed, the provider should advise the woman to avoid intercourse until the infection is resolved or ruled out. When complete abstinence is not realistic, certain methods are not recommended. Female sterilization is not appropriate until infection is either ruled out or resolved, as the presence of infection may increase the risk of postsurgical infection. Intrauterine methods are not appropriate until infection is resolved because insertion may substantially worsen the condition.

8.3 Abortion With Complications: 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, IUD, IUS, spermicides and barrier methods other than the male condom. In these cases, the provider must make a clinical judgment about which methods to recommend for interim use.

8.4 Abortion With Complications: Excessive Blood Loss
Excessive blood loss may require a delay in the use of female sterilization and IUDs, depending on the severity of the loss. For sterilization, delay is recommended if laboratory tests or clinical signs indicate anemia.

9.0 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.

There are two types of EC:

- **Intrauterine device (IUD):** When inserted within five to seven days after unprotected intercourse, a copper IUD is 99 percent effective in preventing pregnancy (WHO, 2000; Dunn et al., 2003).

- **Emergency contraceptive pills (ECPs):** are 75 to 95 percent effective when used within five days after unprotected intercourse (Ellertson et al., 2003; Grimes, 2002; Rodrigues et al., 2001; TFPMFR, 1998).
  
  – To be most effective, ECPs should be started as soon as possible after unprotected intercourse.
  
  – Although either progestin-only pills (POPs) or combined estrogen-progestin oral pills (COCs) may be used, POPs are more effective and produce fewer side effects.
  
  – When taken within 24 hours of unprotected intercourse, progestin-only ECPs have been found to reduce the risk of pregnancy by 95 percent.
  
  – When taken within 72 hours of unprotected intercourse, ECPs that contain progestin-only reduce the risk of pregnancy by 89 percent, while ECPs that contain both estrogen and progestin reduce the risk of pregnancy by 75 percent.

### 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 1.5mg of levonorgestrel taken within five days of unprotected intercourse (von Hertzen et al., 2002). In countries where pills containing 1.5mg of levonorgestrel are not available, two pills of 0.75mg 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 1.5mg of levonorgestrel.

- **COCs:** Two doses of 0.1mg (100mcg) of ethinyl estradiol plus either 0.5mg of levonorgestrel or 1.0mg of norgestrel taken 12 hours apart but within 120 hours after unprotected intercourse (Ellertson et al., 2003).

Women should be advised that the progestin-only regimen has the highest effectiveness and fewest side effects.

### 10.0 Special Contraceptive-Counseling Issues
Some women will have extenuating circumstances or situations in their lives that can impact their contraceptive needs. For example, women may have tested positive for the human immunodeficiency virus (HIV) or may be experiencing violence. For these women, the same contraceptive-counseling principles of respect, compassion and openness apply. Additionally, counselors may need specialized knowledge to help women deal with their situations. Counselors who
Condoms for both females and males

are unqualified to work with certain client populations should seek additional training or refer women to providers who can offer high-quality contraceptive services specific to the situation. (See Counseling Appendix A: Additional Special Populations for more information.)

Information is provided in Appendix C: Contraceptive Counseling for Special Populations on how counselors can meet the specific contraceptive needs of the following special populations: women with repeat abortions; women who have experienced violence; women living with HIV/AIDS; adolescents; women engaged in commercial sex work; women with cognitive and developmental disabilities and mental illness; refugees and displaced persons; women who have experienced female genital cutting; and women who partner with women.

11.0 Summary

• Every woman receiving abortion care should be offered contraceptive counseling and, if she desires, a contraceptive method.

• Access to contraceptive services that are conducted with privacy, confidentiality and informed consent is a basic human right.

• There are several possible service-delivery models for providing contraceptive services, depending on the capacity of the facility and skills of the provider.

• Women receiving abortion care may have a history of contraceptive use that includes failure of the contraceptive, incorrect use or non-use of their chosen method or failure of the family-planning system.

• To be effective, contraceptive counselors must establish trust with the woman, strive to understand her personal needs and tailor the counseling session to meet those needs.

• Counselors need to be knowledgeable about the range of contraceptive methods and consider each woman’s medical eligibility for various methods, including EC.

• Counselors 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.

Additional Resources


**Bibliography**


Barnett, Barbara and Jane Schueller. 2000. *Meeting the needs of young clients: A guide to providing reproductive health services to adolescents*. Research Triangle Park, NC, FHI.


Blumenthal, Paul and Noel McIntosh. 1995. *Pocket guide for family planning service providers*. Baltimore, JHPIEGO.


Contraceptive Services Appendix A: Individual Factors and Counseling Recommendations and Rationales

Note that more than one factor may apply.

<table>
<thead>
<tr>
<th>If the woman…</th>
<th>Recommendations</th>
<th>Rationales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not want to be pregnant soon</td>
<td>Consider all temporary methods.</td>
<td>Seeking an abortion usually suggests that the woman does not want to be pregnant at this time.</td>
</tr>
<tr>
<td>Is under stress or in pain</td>
<td>Consider all temporary methods. Do not encourage use of permanent methods at this time. Provide referral for continued contraceptive care.</td>
<td>Stress and pain interfere with making free, informed decisions, and this is not usually a good time for a woman to make a permanent decision.</td>
</tr>
<tr>
<td>Was using a contraceptive method when she became pregnant</td>
<td>Assess why contraception failed and what problems the woman might have had using the method effectively. Help the woman choose a method that she will be able to use effectively. Ensure that she understands how to use the method, get follow-up care and resupply, discontinue use and change methods.</td>
<td>Method failure, unacceptability, ineffective use or lack of access to supplies may have led to the unwanted pregnancy. These factors may still be present and may lead to another unwanted pregnancy.</td>
</tr>
<tr>
<td>Has stopped using a method</td>
<td>Assess why the woman stopped using contraception, including side effects or lack of access to resupply. Help the woman choose a method that she will be able to use effectively. Make sure she understands how to use the method, get follow-up care and resupply, discontinue use and change methods.</td>
<td>Unacceptability or lack of access may have led to unwanted pregnancy. These factors may still be present and may lead to another unwanted pregnancy.</td>
</tr>
<tr>
<td>Has a partner who is unwilling to use condoms or will prevent use of another method</td>
<td>If the woman wishes, include her partner in counseling. Protect the woman’s confidentiality in all instances, even if she does involve her partner. Discuss methods that the woman can use without her partner’s knowledge, such as injectables. Do not recommend methods that the woman will not be able to use effectively.</td>
<td>In some instances, involving the male in counseling will lead to his use of and support for contraception; however, if the woman, for whatever reasons, does not want to involve a partner, her wishes should be respected.</td>
</tr>
<tr>
<td>Wants to become pregnant soon</td>
<td>Do not try to persuade her to accept a method. Provide information or a referral if the woman needs other reproductive-health services.</td>
<td>If the woman has had a spontaneous abortion or a medically indicated abortion, she may want to become pregnant again soon.</td>
</tr>
</tbody>
</table>

(Adapted from Leonard and Ladipo, 1994.)
### Contraceptive Services Appendix B: Guidelines for Selection of Contraception by Method

<table>
<thead>
<tr>
<th>METHOD</th>
<th>TIMING AFTER ABORTION*</th>
<th>ADVANTAGES</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Fitted Barriers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latex and vinyl male/female condoms†;</td>
<td>May be used immediately</td>
<td>• No method-related health risks</td>
<td>• In typical use, less effective than IUD or hormonal methods</td>
</tr>
<tr>
<td>vaginal sponge and suppositories such</td>
<td>after abortion</td>
<td>• Inexpensive</td>
<td>• Requires use with each incident of intercourse</td>
</tr>
<tr>
<td>as foaming tablets, jelly or film</td>
<td></td>
<td>• Good interim method if initiation of another method must be postponed</td>
<td>• Requires continued motivation</td>
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<tr>
<td></td>
<td></td>
<td>• No medical supervision required</td>
<td>• Resupply must be available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Latex and vinyl condoms provide protection against RTIs and STIs (HBV</td>
<td>• May interfere with intercourse</td>
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<tr>
<td></td>
<td></td>
<td>and HIV/AIDS)</td>
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<td></td>
<td></td>
<td>• Easily discontinued</td>
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<td></td>
<td></td>
<td>• Effective immediately</td>
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<tr>
<td>**Fitted Barriers Used With</td>
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<tr>
<td>Spermicides**</td>
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<td></td>
<td></td>
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<tr>
<td>Diaphragm or cervical cap with foam</td>
<td>Diaphragm can be fitted</td>
<td>• No method-related health risks</td>
<td>• Less effective than IUD or hormonal methods</td>
</tr>
<tr>
<td>or jelly</td>
<td>immediately after abortion</td>
<td>• Inexpensive</td>
<td>• Requires use with each incident of intercourse</td>
</tr>
<tr>
<td></td>
<td>Delay fitting cervical</td>
<td>• No medical supervision required</td>
<td>• Requires continued motivation</td>
</tr>
<tr>
<td></td>
<td>cap until bleeding has stopped</td>
<td>• Some protection against RTIs and STIs (HBV and HIV/AIDS)</td>
<td>• Resupply of spermicides must be available</td>
</tr>
<tr>
<td></td>
<td>and uterus has returned to</td>
<td>• Easily discontinued</td>
<td>• Associated with urinary-tract infections in some users</td>
</tr>
<tr>
<td></td>
<td>pre-pregnancy size</td>
<td>• Effective immediately</td>
<td>• Requires fitting by trained service provider</td>
</tr>
<tr>
<td><strong>Oral Contraceptives</strong></td>
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<tr>
<td>Combined and progestin-only</td>
<td>May be used immediately</td>
<td>• Highly effective</td>
<td>• Requires continued motivation and daily use</td>
</tr>
<tr>
<td></td>
<td>after abortion</td>
<td>• Can be started immediately, even if infection is present</td>
<td>• Resupply must be available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Can be provided by non-physicians</td>
<td>• No protection against STIs/HIV</td>
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<tr>
<td></td>
<td></td>
<td>• Does not interfere with intercourse</td>
<td>• Effectiveness may be lowered with long-term use of certain</td>
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<td></td>
<td></td>
<td></td>
<td>medications, including rifampin, dilantin and griseofulvin</td>
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</tbody>
</table>

*This information applies to methods after first-trimester abortion.

† Male and female condoms are the only methods that provide protection against transmission of STI/HIV; they can be used in conjunction with all other methods.
**Emergency Contraceptive Pills**

- **Timing After Abortion**: May be used immediately after abortion
- **Advantages**:
  - Important back-up method when contraception fails (for example, condom breaks), when no method is used or when sex is forced
  - Highly effective
  - Can be provided by non-physicians
  - Does not require daily attention from user; stays in vagina for three weeks once inserted
  - Can be inserted by user
- **Remarks**:
  - 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
  - Resupply must be available
  - Effectiveness may be lowered with long-term use of certain medications such as rifampin, dilantin and griseofulvin
  - For the first cycle, if applied later than 24 hours after menstrual period starts, back-up method must be used for seven days

**Vaginal Rings**

- **Timing After Abortion**: May be used immediately after abortion
- **Advantages**:
  - Highly effective
  - Can be provided by non-physicians
  - Does not require daily attention from user; stays in vagina for three weeks once inserted
  - Can be inserted by user
- **Remarks**:
  - Resupply must be available
  - Effectiveness may be lowered with long-term use of certain medications such as rifampin, dilantin and griseofulvin

**Skin Patches**

- **Timing After Abortion**: May be used immediately after abortion
- **Advantages**:
  - Highly effective
  - Can be started immediately, even if infection is present
  - Can be provided by non-physicians
  - Does not interfere with intercourse
  - Does not require daily attention from user; applied once a week
  - Applied by user
- **Remarks**:
  - Resupply must be available
  - Effectiveness may be lowered with long-term use of certain medications such as rifampin, dilantin and griseofulvin
  - For the first cycle, if applied later than 24 hours after menstrual period starts, back-up method must be used for seven days

*This information applies to methods after first-trimester abortion.*
<table>
<thead>
<tr>
<th>METHOD</th>
<th>TIMING AFTER ABORTION*</th>
<th>ADVANTAGES</th>
<th>REMARKS</th>
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</thead>
</table>
| **Progestin-Only Injectables**    | May be given immediately after abortion | • Highly effective  
• Can be started immediately, even if infection is present  
• Can be provided by non-physician  
• Does not interfere with intercourse  
• Not user-dependent, except for remembering to get the injection every two or three months  
• No supplies needed by user | • May cause irregular bleeding, especially amenorrhea; excessive bleeding may occur in rare instances  
• Delayed return to fertility after stopping use  
• Must receive injections every two or three months |
| **DMPA, NET-EN**                  | May be appropriate for use if the woman wants to delay choice of a longer-term method | | |
| **Combined Injectables**          | May be given immediately after abortion | • Highly effective  
• Can be started immediately, even if infection is present  
• Can be provided by non-physician  
• Does not interfere with intercourse  
• Not user-dependent, except for remembering to get the injection every two or three months  
• No supplies needed by user | • May cause heavy and/or irregular bleeding initially, especially for the first few months; then regular monthly bleeding usually resumes  
• Delayed return to fertility  
• Must receive injections every two or three months |
| **Progestin-Only Implants**       | May be inserted immediately after abortion | • Highly effective  
• Long-term contraception  
• Immediate return to fertility on removal  
• Does not interfere with intercourse  
• No supplies needed by user | • May cause irregular bleeding, especially spotting, or amenorrhea  
• Trained provider required to insert and remove  
• Cost-effectiveness depends on how long used |

*This information applies to methods after first-trimester abortion.*
### Contraceptive Services Appendix B: Guidelines for Selection of Contraception by Method (continued)

<table>
<thead>
<tr>
<th>METHOD</th>
<th>TIMING AFTER ABORTION*</th>
<th>ADVANTAGES</th>
<th>REMARKS</th>
</tr>
</thead>
</table>
| **IUD/IUS‡** | IUD/IUSs can be inserted after abortion, provided the risk or presence of infection can be ruled out | • Highly effective  
• Long-term contraception; effective for five to 10 years, depending on the type  
• Immediate return to fertility following removal  
• Does not interfere with intercourse  
• No supplies needed by user  
• Requires only monthly checking for strings by user  
• Only one follow-up visit needed unless there are problems | • May increase menstrual bleeding and cramping during the first few months  
• Complications can 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 |

| **Female Voluntary Sterilization (VS)** | Technically, VS procedures usually can be performed immediately after an abortion unless infection or severe blood loss is present. If infection is present, do not perform until fully resolved | • Permanent method  
• Highly effective  
• Once completed, no further action required  
• Does not interfere with intercourse  
• No change in sexual function  
• No long-term side effects  
• Immediately effective | • Adequate counseling and fully informed consent are required before VS procedures  
• Slight possibility of surgical complications  
• Requires trained staff and appropriate equipment |

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*This information applies to methods after first-trimester abortion.

‡See the Contraceptive Services module for information on emergency contraceptive IUDs.
<table>
<thead>
<tr>
<th>METHOD</th>
<th>TIMING AFTER ABORTION*</th>
<th>ADVANTAGES</th>
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</tr>
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</table>
| Fertility Awareness (Natural Family Planning) | Not recommended for immediate use; 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 | • No cost associated with method  
• No method-related health risks  
• No medical supervision required  
• Easily discontinued  
• Effective immediately | • Unreliable immediately after abortion  
• 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 |

(Adapted from: Blumenthal and McIntosh, 1995; Benson et al., 1992; Paul et al., 1999; Stewart et al., 2001; WHO, 2004.)

*This information applies to methods after first-trimester abortion.
†Male and female condoms are the only methods that provide protection against transmission of STI/HIV; they can be used in conjunction with all other methods.
‡See the Contraceptive Services module for information on emergency contraceptive IUDs.
Contraceptive Services Appendix C:
Contraceptive Counseling for Special Populations

(See Counseling Appendix A: Additional Special Populations for more information.)

Women With Repeat Abortions
If a woman does not want to become pregnant and has experienced repeat 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 repeat 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, 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 how to access and use EC. It may be beneficial to provide ECPs in advance.

Women Living With HIV/AIDS
The following information should be presented when discussing contraception with an HIV-positive woman:
• Male and female condoms help protect against HIV transmission and need to be used correctly each time intercourse occurs.
• If the woman engages in unprotected sexual intercourse with an infected partner, she may become infected with a different strain of HIV or other sexually transmitted infections (STIs).
• Dual protection is recommended. This practice consists of either the simultaneous use of male or female condoms for STI/HIV protection with another, more effective contraceptive method for pregnancy prevention, or the consistent and correct use of male or female condoms for both pregnancy prevention and disease protection with EC as a back-up method for pregnancy prevention.

Counselors should also make sure the woman understands her right to have an abortion and her right to bear children, as well as the risk of mother-to-child transmission of HIV and the possibility of reducing that risk with antiretroviral therapy. Health-care providers should know the locations of voluntary testing and counseling (VCT) sites, and should be familiar with policies on antiretroviral therapies in their country.
Adolescents

It is important that providers do not deny young women access to contraception because of their age or marital status and that they do not interpret consent laws in a vague or overly conservative way. Providers should bear in mind that pregnancy, especially in very young women, may be the result of rape or ongoing sexual abuse. In those cases, referrals to community services should also be made.

If the young woman wishes to avoid sexual behavior, counsel her on how to resist sexual advances from peers and adult males. Abstinence—the complete avoidance of sexual behavior that can result in pregnancy—may be an option for some adolescents, but should not be presented as the only option.

Thorough counseling is essential, given that it may be more difficult for adolescents to use contraceptive methods consistently and correctly as their lifestyles, experiences and expectations differ greatly from those of older women.

Contraceptive counselors should consider the following factors when talking to adolescent women:

- A method that does not require a daily regimen may be more acceptable to some adolescents.
- Evidence shows that dissatisfaction with the side effects of contraception leads many adolescents to discontinue using their chosen method.
- Personal factors, such as sporadic patterns of intercourse or the need to conceal sexual activity and contraceptive use, may influence method choice.

The following information should also be presented when discussing contraception with adolescent women:

Medical Eligibility for Adolescents

Providers should bear in mind that age alone does not constitute a medical reason for denying any method to an adolescent. Most of the eligibility criteria that apply to older women also apply to young women. However, providers counseling adolescents should consider the following:

- Some medical conditions that require a restriction in the use of a method, such as cardiovascular disorders, are rare in adolescents.
- While there are no medical reasons that make adolescents ineligible for sterilization, it is not usually recommended as there is a greater chance for regret than with older women.
- In the case of progestin-only injectables, some concerns related to the loss of bone density in women below 18 years have arisen. Studies have shown that the bone density loss is reversible in older women once the method is discontinued, but it is not yet known if it is reversible in adolescents (Schwingl et al., 1999; Petitti et al., 2000).
- Adolescents are at a higher risk of contracting STIs, including HIV. For this reason, the use of an intrauterine device (IUD) or intrauterine system (IUS) should be carefully considered. Dual protection is recommended for those not in mutually monogamous, long-term relationships.
• Dual protection, which helps to prevent disease transmission, is particularly important for adolescents. Counselors should recommend dual protection through the use of a male or female condom in combination with another method or the use of a condom with EC as back-up.

• Young women often have less power in their relationships and may need help developing skills they can use to persuade partners to use condoms.

• The concept of EC should be discussed and, if appropriate, the counselor can provide ECPs in advance. Adolescent women may be more likely to engage in unplanned or sporadic sex, and knowledge of and access to EC can be critical in helping them prevent unplanned pregnancy.

Women Who Engage in Commercial Sex
Contraceptive counselors may counsel women who engage in commercial sex, even if the women do not identify themselves or their work in this way. Counselors should be empathetic and respectful, bearing in mind that many women are forced to work in the sex industry because they have limited options with regard to economic or family situations.

The following information should be presented when discussing contraception with women who engage in commercial sex:

• Counselors should recommend the use of dual protection, through the simultaneous use of condoms and another method, for protection against both STIs and unwanted pregnancy. If male condom use is not feasible for the woman, she may want to consider the use of female condoms, if available.

• Counselors should advise against using an IUD or IUS, as the woman is at increased risk of having or contracting an STI.

• The woman should be informed on how to access and use EC. It may be beneficial to provide the woman with ECPs in advance.

Women With Cognitive and Developmental Disabilities and/or Mental Illness
The counselor should begin by assessing what knowledge and experience the woman already has regarding contraception. The counselor 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 counselors should emphasize that they must be used every time she engages in intercourse if she wants to prevent pregnancy and STIs.

• The counselor should demonstrate the method—using actual condoms, diaphragms or cervical caps—and/or use illustrative instructions.
• Counselors 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 a permanent or semi-permanent method such as female sterilization or IUD/IUS insertion be performed 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, counselors 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 counselor should make an extra effort to ensure that she clearly understands what she is consenting to and what her choices are.

Women in Refugee and Displaced Settings

Many refugee and displaced women lose access to medical-care services and supplies, including contraceptives. It is important to recognize that many of these women may have previously been using contraceptives. Using assessments or existing studies, counselors should find out as much as possible about the methods and protocols used in the woman’s country or region of origin. This information will greatly improve the counselor’s ability to provide useful, meaningful information, as certain methods may be more familiar and acceptable to her than others.

The following information should be considered when discussing contraception with women in refugee and displaced situations:

• Medical settings for refugees or displaced persons often do not carry a full range of contraceptive supplies; therefore, it is most beneficial to base counseling on the methods available.

• In situations where flight from war, migratory population movement, repatriation or relocation is imminent, counselors are advised to develop a protocol that addresses the woman’s long-term contraceptive needs. The provider and woman can discuss the benefits and drawbacks of each method according to her individual preferences and situation.

• Poverty, high population density and limited medical provision can all contribute to the increased risk of exposure to STIs and HIV. In addition, refugee and displaced women must contend with other factors such as population migration, increased violence and military troop movements. For these reasons, it is important that counselors stress the need for women to use barrier methods whenever possible.

• Adolescent girls are among the most vulnerable in refugee or displaced settings, and special efforts should be made to provide adolescents with contraceptive information and methods.

• Counselors should be knowledgeable about the availability of EC in the refugee or displaced setting and should counsel women on the availability of ECPs and directions for their use. ECPs should be provided in advance when possible.
Woman Who Have Experienced Genital Cutting
Counselors should be aware that women who have experienced female genital cutting (FGC) may need health education reviewing the basic female reproductive anatomy, the menstrual cycle and how various contraceptive methods work.

Women who live in cultures and geographic areas where FGC is practiced may not have the same decisionmaking power and negotiating opportunities as men. This may affect a woman’s ability to accept and use a contraceptive method. If the woman consents, involving her partner in the method selection may aid in this process.

The following information should be considered when discussing contraception with women who have experienced FGC:

- Because women who have undergone certain forms of FGC are at higher risk for infection and hemorrhage, certain methods—such as IUDs and IUS—are not advisable for these women.
- Women who have undergone FGC may be at a higher risk of contracting HIV because of the unsanitary conditions under which the procedures are often conducted. Sometimes contaminated razors and knives are used on multiple women or girls, increasing the risk of infection.
- Barrier methods, such as male and female condoms, may decrease the risk of infecting partners with HIV.
- If the woman indicates that she will seek out a reinfibulation procedure, certain contraceptive methods would not be advisable. For example, an IUD would be difficult or impossible to remove if a woman is reinfibulated. Diaphragms also would not be an advisable option for such women.

(See Clinical Assessment Appendix B: Female Genital Cutting (FGC) for more information.)

Women Who Partner With Women
Counselors should not make contraceptive-related assumptions about women who state that they have female sexual partners. Women who partner with women may also engage in sexual relationships with men, be at risk for STI/HIV and unwanted pregnancy, desire a future pregnancy, and/or need contraceptive information and methods. Counselors should engage in an open discussion with the woman to determine her risks and needs.
Infection Prevention

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

Health-care facilities are prime settings for infection transmission because of the presence of numerous and varying types of infectious agents. Health-care workers are exposed to infectious agents and contaminated materials as part of their daily work, while clients are exposed when they receive health-care services. In addition, families and communities may be affected when clients and health-care workers unwittingly carry infections home from the health-care facility.

Most formally trained health-care workers are knowledgeable about infection-prevention techniques. It is the health-care worker’s responsibility to take correct and consistent measures to guard against the spread of infection, using appropriate hygiene and infection-prevention techniques and behaviors.

This module addresses the application of infection-prevention principles in abortion-care settings.

2.0 Infection Transmission
Although they may not be visible without a microscope, microorganisms are on and within the body, on medical instruments and equipment, and on every surface. Each microorganism has a specific route of transmission from one person to another. A pathogen is any microorganism that can cause infection and lead to disease. Airborne pathogens travel through the air and bloodborne pathogens are primarily transmitted through blood and certain other body fluids. Each pathogen requires specific prevention measures, depending on how it is transmitted. This module focuses on preventing infections from bloodborne pathogens that are primarily transmitted through exposure to blood and other body fluids in a health-care setting.

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

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

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

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

**3.0 Elements of Infection Prevention**

Because infectious agents are transmitted in different ways, infection-prevention protocols are employed broadly to prevent infections regardless of their transmission routes. Health-care workers are required to use *standard precautions*, also called *universal precautions*, during contact with all clients and other workers, as a person may carry infection without showing any noticeable signs or symptoms.

The use of standard precautions minimizes the risk of pathogen transmission among health-care workers and clients. In particular, standard precautions are intended to minimize infection transmission from contaminated sharp instruments that can penetrate the skin, and from infected blood or body fluids that can splash into the eyes or other mucous membranes or enter the body through a cut or broken skin.

Standard precautions involve infection-control measures that are designed to block transmission between the person and potentially infectious body fluids. These measures include proper handwashing techniques and wearing barriers such as gowns, gloves, aprons, masks, eyewear and footwear. Standard precautions should be applied in all situations where health-care workers anticipate contact with blood; any body fluid; secretions and excretions other than perspiration, regardless of whether they contain visible blood; non-intact skin; and mucous membranes.
Health-care workers should treat the blood and body fluids of all persons as potential sources of infection, independent of diagnosis or perceived risk. Standard precautions should be followed with all clients and all workers, regardless of their presumed infection status or diagnosis, and there is no reason to treat individuals with known bloodborne diseases differently.

In addition, all workers who risk exposure to blood or other body fluids should be vaccinated against HBV to reduce their risk of infection by that virus.

### Essential Elements of Infection Prevention:
- Handwashing
- Personal protective barriers
- Proper handling and disposal of sharp instruments and items
- Proper handling and processing of instruments and materials
- Aseptic technique
- Environmental cleanliness
- Proper disposal of infectious waste

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

Health-care workers should wash their hands by rubbing them together with clean, flowing water and soap. A brush may be used to clean hands thoroughly. It is essential to use fresh water because microorganisms can thrive in a container of water used by multiple people. When running water is not available by faucet, spigot or pump, one person can pour fresh water from a container, enabling another person to wash. Because shared and reused towels can transmit pathogens, it is ideal to use disposable towels or a clean towel each time handwashing occurs. Large towels can be cut into smaller towels or hands can be air-dried to conserve resources.

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

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

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

The proper handling and disposal of sharps can significantly reduce this risk:
• Do not carry hypodermic needles.
• Set aside a specific area to keep sharp objects during procedures.
• Announce the presence and passage of any “sharps.”
• Dispose of needles and syringes immediately without recapping, removing, cutting or bending them.
• Dispose of sharp instruments and items quickly and safely in designated, puncture-resistant containers (see Appendix A: Sharps container for box assembly instructions).
• Locate these containers wherever sharps are used.

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

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

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

Antiseptic preparation
Prior to any invasive procedure, the point of entry or affected body area must be cleaned with an antiseptic. The health-care worker should ask the woman about
any allergic reactions to antiseptics before selecting an antiseptic solution. During vacuum-aspiration procedures, post-procedure infection can be caused by the introduction of a woman’s resident vaginal flora into her uterus. Therefore, it is critical to remove microorganisms normally present in the vagina and cervix prior to inserting an instrument. The provider should ensure that the perineal area is clean, and swab the cervix and, if desired, the vagina with a water-based (not alcohol-based) antiseptic solution, such as Betadine®, using sponge forceps and gauze or cotton wool. The cervix should not be cleaned with the same gauze used for cleaning the vagina.

**No-touch technique**

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

It is possible to introduce pathogens, especially vaginal ones, into the uterus when passing an instrument into the uterine cavity. In the case of vacuum-aspiration procedures, the use of no-touch technique means that no instrument that enters a woman’s uterus comes in contact with a contaminated surface before insertion through her cervix. Specifically, the tenaculum, cannula or dilator tips should not touch the providers’ gloves, the woman’s vaginal walls, or unsterile parts of the instrument area.

**Properly processed instruments**

All reusable medical instruments must be properly processed between clients. The techniques for properly processing instruments are discussed in the Instrument Processing section of the Uterine Evacuation Procedure with Ipas MVA Plus® module.

(Also, for more information about aseptic technique for uterine evacuation, see the Uterine Evacuation Procedure with Ipas MVA Plus® module.)

### 3.6 Environmental Cleanliness

Because health-care workers can spread infection when touching clinic surfaces and clients, it is important that everything in the clinical setting, including clients, instruments and equipment, be kept clean and dry.

Any chemical that kills microorganisms is called a *germicide*. *Antiseptics* are weaker germicides that are used for cleaning clients. Strong germicides used for cleaning equipment and processing instruments are called *disinfectants*. Ideally, a disinfectant of 0.5 percent chlorine solution can be used for cleaning rooms and equipment, although it is acceptable to use soap and water. **Note:** Glutaraldehyde and chlorine are hazardous substances. If processing instruments or for environmental use, take necessary precautions such as using personal protective equipment. Refer to the manufacturer’s safety instructions to establish safe use (See Appendix B: Mixing Instructions to Produce 0.5% Chlorine Solution.) Attempting to disinfect a room by fumigating or fogging is not only ineffective in preventing the spread of pathogens, but is also toxic and expensive.

**At the beginning of each clinic session:**

- Wipe all horizontal surfaces with a clean cloth, including procedure tables, chairs, trolley tops, lamps and counters
• Mop floors with a clean mop to remove any dust that may have accumulated overnight

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

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

3.7 Disposal of Infectious Waste
Any disposable material that has come in contact with body fluids should be considered infectious waste and disposed of properly. Infectious waste can include human tissue, such as products of conception (POC), body fluids, and materials containing blood or body fluids, such as bandages, surgical sponges, hypodermic and suture needles, scalpel blades, blood tubes and pipettes. Disposable medical instruments must also be considered infectious waste and disposed of appropriately.

Some local protocols dictate that a health facility’s infectious waste be removed by a second party, such as a private company or government organization, and disposed of off-site. Wherever infectious waste is deposited, it must always be contained and, ideally, incinerated.

All infectious waste must at least be secured and contained. It is unacceptable to store infectious waste in open containers or throw waste into an unsecured open pile; this exposes the community to infection. Contaminated sharp items should be placed in containers made from material that is not easily perforated, such as heavy cardboard or plastic.

Disposing of infectious waste, including POC:
• Burning solid infectious waste in an incinerator or oil drum is the best option; open burning in a secured area is an acceptable alternative.
• Burying solid infectious waste on-site, as long as it is secured behind a fence or wall away from any water source, is the next best option. As waste is added, cover it with 10 to 30cm (four to 10 inches) of soil.
• Liquid infectious waste should be poured down a sink or drain connected to an adequately treated sewer or pit latrine; burial with other infectious waste is an acceptable alternative.

Products of conception resulting from medication abortion should be disposed of in the same way as other infectious waste. If a woman passes the POC at home, she should dispose of them by whatever appropriate means are available to her, such as pouring them down a toilet that is used for feces or other infectious waste or by burying them away from a water source. If another person is going to dispose of the waste, he or she should use the precautions noted in this module for handling infectious waste.

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

5.0 Summary
• Health-care facilities are prime settings for infection transmission to health-care workers, clients and community members because of the presence of numerous and varying 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.
• Hands are the most common vehicle for infection transmission.
• The essential elements of infection prevention are handwashing, 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 vacuum aspiration are antiseptic preparation, no-touch technique and properly processed instruments.

• All infectious waste should be incinerated or, at the least, secured and contained properly.

• If a health-care worker is exposed to blood or other body fluids, follow appropriate procedures for the management of occupational exposures.

Additional Resources


Bibliography


Infection Prevention Appendix A: Sharps Container

Instructions for making a sharps container
Infection Prevention Appendix B: Mixing Instructions to Produce 0.5% Chlorine Solution
(Mix according to the strength of the locally available brand of bleach)

<table>
<thead>
<tr>
<th>CHLORINE COMPOUND</th>
<th>AVAILABLE CHLORINE IN COMPOUND</th>
<th>TO PRODUCE 0.5% SOLUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sodium Hypochlorite Solution (Bleach)*</td>
<td>3.5% (Africa, JIK; Nepal, Robin; Jamaica, Ajax)</td>
<td>Mix 10mL bleach with 60mL water (1 part bleach to 6 parts water)</td>
</tr>
<tr>
<td></td>
<td>5% (France &amp; Vietnam, Eau de Javel; Canada &amp; USA, Clorox; household bleach; Peru, Clorox)</td>
<td>Mix 10mL bleach with 90mL water (1 part bleach to 9 parts water)</td>
</tr>
<tr>
<td></td>
<td>6% (Mexico, Blanqueador)</td>
<td>Mix 10mL bleach with 110mL water (1 part bleach to 11 parts water)</td>
</tr>
<tr>
<td></td>
<td>10% (UK, Chloros; Peru, Liguria)</td>
<td>Mix 10mL bleach with 190mL water (1 part bleach to 19 parts water)</td>
</tr>
<tr>
<td></td>
<td>15% (France, Extrait de Javel; UK, Chloros)</td>
<td>Mix 10mL bleach with 290mL water (1 part bleach to 29 parts water)</td>
</tr>
<tr>
<td>Calcium Hypochlorite</td>
<td>70%</td>
<td>Dissolve 7 grams calcium hypochlorite in 1L water</td>
</tr>
<tr>
<td>NaDCC (Sodium Dichloroisocyanurate)</td>
<td>60%</td>
<td>Dissolve 8.5g NaDCC in 1L water</td>
</tr>
<tr>
<td>NaDCC-Based Tablets (Sodium Dichloroisocyanurate)</td>
<td>1.5g per tablet</td>
<td>Dissolve 4 tablets in 1L water</td>
</tr>
<tr>
<td>Chloramine (Tosylchloramide sodium)</td>
<td>25%</td>
<td>Dissolve 20g in 1L boiled water</td>
</tr>
</tbody>
</table>

(Adapted from Tietjen et al., 1992)

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

Key Topics in This Module:
- Complete clinical assessment including psychosocial assessment and physical examination
- Laboratory testing and ultrasound exams
- Conditions such as ectopic pregnancy and reproductive-tract infections
- Considerations of special populations

1.0 Introduction
Prior to performing an abortion procedure, it is essential to assess a woman’s situation from her medical history, physical examination and, in some cases, laboratory tests, and to conduct a psychosocial assessment. This allows the provider to properly diagnose the woman’s clinical status and to help determine her best options. Although the clinical-assessment process for women seeking abortion is rarely complicated, it does sometimes reveal specific pre-existing conditions that may require special attention or management. The first step in clinical care for a woman seeking an abortion is to determine that she is indeed pregnant. If she is pregnant, the next step is to determine the length of the pregnancy.

The assessment should be conducted in private—in a place where the woman and provider cannot be seen or overheard by others—so that the provider can meet with the woman alone to discuss her situation and perform an examination. The components of a complete clinical assessment are:
- client history
- psychosocial assessment
- physical examination, including pelvic exam
- optional collection of specimens and the ordering of any lab investigations

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

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

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

- First day of LMP
- Signs and symptoms of pregnancy
- Bleeding or clotting disorders
- Drug allergies
- History of previous pregnancies—for example, ectopic pregnancy, miscarriage, abortion, live births or fetal deaths
- Any recent abortion-related care
- Any recent medications taken, including misoprostol or herbal remedies
- Known medical conditions
- Physical or cognitive disability, including mental illness
- Surgical history
- Sexual history
- HIV status and presence of sexually transmitted infection (STI)
- History of contraceptive use
- History of alcohol or drug use, including smoking

### Pre-Existing Conditions

If any of the following conditions are found, it may be necessary to refer the woman to an appropriate 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.

<table>
<thead>
<tr>
<th>Pre-Existing Condition</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>• Methergine, an ergotamine derivative, should ONLY be used with caution in hypertensive clients for treatment of postabortal atony. It should be avoided in clients with blood pressure greater than 160/100.</td>
</tr>
</tbody>
</table>
| Seizure disorder       | • 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 interfere with some forms of combined hormonal contraception. |
### 3.0 Psychosocial Assessment

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

It is also important to note any cognitive disabilities or mental illness or

<table>
<thead>
<tr>
<th>Condition</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>• If hematocrit or hemoglobin very low, be prepared to treat appropriately.</td>
</tr>
<tr>
<td>Blood-clotting disorders</td>
<td>• If the woman has an active clotting disorder, proceed with caution, preferably in a facility that is able to treat women who are hemorrhaging.</td>
</tr>
<tr>
<td>Diabetes</td>
<td>• High blood-glucose levels are not dangerous, but ketoacidosis should be avoided.</td>
</tr>
<tr>
<td></td>
<td>• Insulin dose will probably not be changed if vacuum aspiration is performed under local anesthesia.</td>
</tr>
<tr>
<td>Heart disease</td>
<td>• If symptomatic or severe disease, vacuum aspiration may be performed in an operating room and monitored with the assistance of an anesthetist.</td>
</tr>
<tr>
<td>Asthma</td>
<td>• 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.</td>
</tr>
<tr>
<td></td>
<td>• The woman should be stable and not having an acute asthmatic attack prior to abortion procedure.</td>
</tr>
<tr>
<td>Suspected ectopic pregnancy</td>
<td>• Evaluate, treat or refer according to local protocol.</td>
</tr>
<tr>
<td>Cervical stenosis</td>
<td>• Consider either performing vacuum aspiration under ultrasound guidance, using an agent such as misoprostol or laminaria to prepare the cervix prior to procedure, or waiting until the woman is eight weeks since the LMP.</td>
</tr>
<tr>
<td>Alcohol or drug abuse</td>
<td>• Be prepared for low pain threshold.</td>
</tr>
<tr>
<td></td>
<td>• Consider use of narcotic analgesic and parenteral sedative.</td>
</tr>
</tbody>
</table>

*(Adapted from Dickson-Tetteh et al., 1998)*

**Prior Self-Administration of Misoprostol**

Self-administration of misoprostol to terminate a pregnancy is seen frequently in some settings. Current data do not indicate the need for any specialized treatment, but providers should be aware of the clinical effects and side effects that may accompany prior misoprostol use. In addition, women should be counseled about potential teratogenicity if the pregnancy is allowed to continue.

Although women may have no side effects from misoprostol, nausea and diarrhea can occur; these effects may be more common or more severe with higher doses. The effect of misoprostol varies with the length of the pregnancy. If misoprostol has been used to terminate a pregnancy greater than 12 weeks, providers should be alert to the potential for heavy bleeding, which may be stopped by vacuum aspiration.

Cervical dilatation may not be needed in vacuum aspiration when misoprostol has been used to initiate an abortion because misoprostol ripens the cervix.

Information on the unsupervised use of misoprostol to induce abortion generally spreads by word-of-mouth. Therefore, it may be useful to inform women that excessive doses of misoprostol or using it unsupervised in the second trimester—when serious bleeding can occur—should be avoided.

*(See the Medication Abortion module for more information.)*
indications that the woman has been subjected to violence. Providers should encourage the woman to discuss the circumstances that led to her seeking care:

- When did she suspect she was pregnant?
- Is there anything she feels the provider needs to know?
- Does she have a history of drug use or abuse?
- Does she have a stable family environment and support system?
- Is she subject to violence?

4.0 Physical Examination

Accurately determining the length of the pregnancy is a critical factor in both selecting an abortion method and preventing complications. Risks associated with induced abortion are low when it is conducted by trained providers; however, risks do increase with length of pregnancy. In induced abortion care, miscalculation of length of pregnancy is a significant cause of complications. Bimanual pelvic examination and recognition of other signs of pregnancy are usually adequate indicators; other laboratory tests such as human chorionic gonadotropin (hCG) and ultrasound may also be useful for confirmation of pregnancy, but are not necessary for the provision of first-trimester abortion. Before beginning any uterine evacuation procedure, it is critical to estimate the uterine size as accurately as possible.

4.1 General Health

The physical exam should begin with a general health assessment that includes:

- Checking and recording the woman’s vital signs, such as pulse and blood pressure
- Noting signs of general health, including weakness, lethargy, anemia or malnourishment
- Checking the woman’s abdomen for masses and tenderness

4.2 Pelvic Examination

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

Verbal reassurance

Explain to the woman what to expect before beginning the pelvic exam. If this is her first pelvic exam, she may be anxious, and it is particularly important to let her know what you are doing and to reassure her. In all cases, it is important to describe to the woman what she will feel. (For more examples of verbal reassurance, see the Uterine Evacuation Procedure with Ipas MVA Plus® module.)

Positioning the woman

- Help the woman move into the lithotomy position
- Ensure that she is protected and well-supported
- Use drapes or linens to make sure her privacy is protected
- Attend to any special anatomical or physical needs, including disability, arthritis or injuries
- Attend to any IV lines or other critical items

Potential Adverse Effects of Underestimating Length of Pregnancy:

Vacuum aspiration

- longer procedure time; more bleeding; greater risk of infection
- greater risk of cervical trauma
- increased risk of uterine perforation and intra-abdominal injury
- increased anesthesia risks if more powerful pain medications are required
- surgical care compromised if transfer is required
- rapport with woman compromised; staff confidence undermined
- increased economic costs and legal risks

Medication abortion

- higher risk of failure
- greater discomfort
- heavier bleeding

(Adapted from Policar et al., 1999)
Speculum exam
The speculum exam can be performed during the clinical assessment or during preparation for the uterine evacuation procedure. Before inserting the speculum, inspect the external genitalia and perineum. Note whether there are ulcers or signs of STIs on the external genitalia.
- Warm the speculum if possible; this can be done under the exam light.
- Gently insert a speculum of the appropriate size and inspect the cervix and vaginal canal carefully.
- Check for bleeding. If present, check the amount and source of the bleeding.
- Note if the blood or any discharge has an odor. Infection is sometimes indicated by a foul odor.
- Note any pus or discharge from the cervical os. Active cervical infection present at the time of a uterine evacuation procedure increases the chance of postabortal infection.
  - If infection is present or suspected, take samples for culture, if possible.
  - Even if it is not possible to confirm the type of infection using laboratory tests, antibiotics should be administered before evacuating the uterus if active infection is present. (See Appendix A: Provision of Antibiotics for more information.)
  - Women with advanced HIV and others who may have compromised immune systems may need more aggressive treatment for possible infection.
- Note any cervical lesions; visual inspection of the cervix can help identify cervical dysplasia. (See the Additional Resources section of this module for more information.)

Bimanual exam
The provider should perform a bimanual exam to assess the size, consistency and position of the uterus and adnexa. Signs of pregnancy, including softening of the cervical isthmus and softening and enlargement of the uterus, are detectable during the bimanual exam as early as six to eight weeks since the LMP. With two fingers of one hand inserted into the vagina and the other hand palpating the abdomen, compare the size of the uterus with the history of amenorrhea.

Dorsal Position
Where leg supports are not available, the dorsal or “frog-leg” position can be used. In this position, the woman’s pelvis should be raised by placing a stack of blankets or linens under her lower back or upper buttocks.

Lithotomy position

Perform bimanual exam
Abnormalities

- **Fibroids** are benign pelvic tumors whose growth may be stimulated during pregnancy. Fibroids may obstruct or distort the uterine cavity, making it more difficult to perform an abortion using vacuum aspiration.

- **Molar pregnancy** is an abnormal pregnancy characterized by the overgrowth of villi. In complete molar pregnancies, hydropic villi fill the uterus and there is no fetus present. It is also possible that a partial mole can be present, along with a fetus. Women with molar pregnancy may present scant to heavy vaginal bleeding, nausea, vomiting and/or lower abdominal pain. Vacuum aspiration can be performed to resolve the condition, but usually requires a significant amount of evacuation to remove the copious amount of grape-like tissue. Molar pregnancies require special follow-up to ensure that all the pregnancy tissue has been evacuated. Although exact protocols vary, this is typically done with serial pregnancy tests.

If the uterus is *smaller* than expected, it may indicate:

- The woman is not pregnant
- Inaccurate menstrual dating; ovulation later than estimated by LMP
- Ectopic pregnancy
- Abnormal intrauterine pregnancy, including spontaneous abortion and gestational trophoblastic neoplasm (molar pregnancy)

If the uterus is *larger* than expected, it may indicate:

- Inaccurate menstrual dating; ovulation earlier than estimated by LMP
- Multiple pregnancies
- Uterine abnormalities such as fibroids or bicornuate uterus
- Gestational trophoblastic neoplasm (molar pregnancy)
- Normal variation between women at a given length of pregnancy, especially among multiparous women

Note that in cases of gestational trophoblastic neoplasm, the uterus is usually larger.

If uncertain about the size of the uterus, or if the uterus feels equal to or larger than 12 weeks since the LMP, it may be helpful to use ultrasound, if available, or to ask another provider to check the uterine size by bimanual exam. Some scenarios that make it difficult to accurately assess uterine size or position include uterine fibroids, retroverted position of the uterus, obesity, full bladder, or the woman not relaxing her abdomen.

For procedures involving vacuum aspiration, it is also important during the bimanual exam to assess the shape and position of the uterus.

5.0 Laboratory Tests

In most cases, providers only need the information obtained from a woman’s history and physical examination to confirm pregnancy and determine length of pregnancy; however, if the typical signs of pregnancy are unclear and the provider is unsure about whether the woman is pregnant, laboratory tests are helpful. Urine pregnancy tests are becoming more accessible and cheaper worldwide. According to WHO’s 2003 *Technical and Policy Guidelines for Safe Abortion*, “obtaining such tests should not hinder or delay uterine evacuation.”

Hemoglobin or hematocrit tests to detect anemia may be helpful in areas where anemia is prevalent in order to help providers prepare for unexpected hemorrhage at the time of or following the abortion. The need for routine Rhesus (Rh) isoimmunization has not been proven by clinical studies (WHO, 2003). Where Rh immunoglobulin is 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 vacuum aspiration and, in the case of medication abortion, at the time of the administration of medical abortifacients.

Cervical cytology tests may be available in some facilities and an abortion-related visit may be an opportunity to screen for cervical cancer in settings where it is prevalent. This and similar types of reproductive-health laboratory services may be offered to women where available, but are not required to perform an abortion safely and should not be a precondition for provision of abortion care. (See the Additional Resources section of this module for more information.)
6.0 Ultrasound Exam and Ectopic Pregnancy

Ultrasound may be helpful for accurate dating when there is a discrepancy revealed by the bimanual exam, but is not a requirement for the provision of an early abortion (WHO, 2003). Where it is available, it can be used along with quantitative b-hCG measurements to help detect ectopic pregnancies. An ectopic pregnancy occurs when a fertilized egg attaches itself outside of the uterus, most often in a fallopian tube. It can be challenging to identify or rule out ectopic pregnancies. Providers must ensure that women referred for pelvic ultrasound to rule out a suspected ectopic pregnancy are sent to a sonographer experienced in visualizing early pregnancy. Uterine evacuation methods, whether vacuum aspiration or medication methods using misoprostol and mifepristone, cannot terminate an ectopic pregnancy. A woman with an early ectopic pregnancy may be asymptomatic. If she does have symptoms, they might include:

- Uterine size that is smaller than expected
- Sudden, intense and persistent lower abdominal pain or cramping, usually one-sided, that may be accompanied by:
  - irregular vaginal bleeding or spotting
  - palpable adnexal mass
- Fainting or dizziness that persists more than a few seconds, possibly indicative of internal bleeding; internal bleeding is not necessarily accompanied by vaginal bleeding
- No POC after a vacuum-aspiration procedure

When ectopic pregnancy is suspected or diagnosed, it must be followed up urgently. An ectopic pregnancy can be life-threatening; the woman 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 saves women’s lives and helps preserve their future fertility.

(See the Medication Abortion module for more information.)

7.0 Reproductive-Tract Infections

The administration of antibiotics to women at the time of an abortion using vacuum aspiration helps reduce their risk of infection (Sawaya et al., 1996). If prophylactic antibiotics are not available, however, vacuum aspiration should still be performed (WHO, 2003). (See Appendix A: Provision of Antibiotics for recommended doses.)

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

For medication abortion, prophylactic antibiotics are unnecessary. See the Medication Abortion module for more information.
8.0 Special Populations to Consider During Clinical Assessment

Providers should be particularly cautious when physically examining adolescents or women who have experienced violence. Adolescents may have never had a clinical pelvic exam and may be particularly apprehensive. Women who have experienced violence may be afraid or uncomfortable about being touched in their genital area. Women who have undergone female genital cutting (FGC) will likely need a deinfibulation procedure prior to physical examination. (See Appendix B: Female Genital Cutting for more information.)

There are often no physical signs of violence against women. However, providers should be alert to the following signs, while understanding that these signs can also be present outside the context of violence:

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

These signs may indicate the need for further discussion and screening for violence by providers or counselors to determine if a woman is in a dangerous situation. If this proves to be the case, providers should do what they can to help the woman before she leaves their care. Referrals to any existing resources should be made before she leaves the facility, as many women may not return for follow-up appointments. (See Appendix A: Additional Special Populations of the Counseling module for more information.)

9.0 Summary

- During the clinical assessment, the provider should meet with the woman in private to discuss her situation and to perform examinations.
- Clinical assessment for abortion should include taking a client history, performing a psychosocial assessment, conducting a physical exam, collecting any needed specimens and ordering any laboratory services necessary.
- Any pre-existing conditions that may trigger or exacerbate certain complications should be recorded in the client history.
- Providers can make a psychosocial assessment of the woman during the history-taking and general physical examination, determining, for example, if she has experienced violence.
- The accurate determination of the length of the pregnancy is a critical factor in both selecting an abortion method and preventing complications.
- The physical examination involves assessing the women’s general health and performing a pelvic exam.
- Although laboratory tests are not required for the provision of routine abortion, they can be helpful if typical signs of pregnancy are unclear and the provider is unsure about whether the woman is pregnant.
• Ultrasound is not required for the provision of early abortion services, but may be helpful for accurate dating when there is a discrepancy in the bimanual exam and for detecting ectopic pregnancies.

• Where possible, antibiotics should be administered at the time of a vacuum-aspiration abortion to help reduce women’s risk of post-procedure infections.

Additional Resources


Bibliography

American College of Obstetricians and Gynecologists (ACOG) Task Force on Female Circumcision/Female Genital Mutilation. 1999. Female circumcision/female genital mutilation: Clinical management of circumcised women. Washington, DC, ACOG.


Clinical Assessment Appendix A: Provision of Antibiotics

Although rare, uterine infection after an uncomplicated and safe abortion is possible. Therefore, the administration of prophylactic antibiotics to all women who undergo vacuum aspiration is recommended to help reduce their risk of infection. Therapeutic antibiotics should be administered to all women who are suspected of having an infection or have been diagnosed with an infection. Providers should note that women who may be immunocompromised, including those with known HIV infection, may require more aggressive treatment.

Providing prophylactic antibiotics

Even if infection has not been diagnosed and is not suspected, the provision of perioperative prophylactic antibiotics for women undergoing uterine evacuation can significantly reduce the risk of infection (Sawaya, 1996). Ideally, the first dose should be administered 30 minutes prior to the procedure. One recommended prophylactic regimen is: 100mg doxycycline orally two times daily for three to seven days.

Providing therapeutic antibiotics

If infection has been diagnosed or is suspected, a woman undergoing a vacuum-aspiration procedure should receive a combination of antibiotics. One recommended therapeutic regimen is:

- Ampicillin 2g IV every six hours plus
- Gentamicin 5mg per kg of body weight IV every 24 hours plus
- Metronizadole 500mg IV every eight hours

Once started, intravenous therapy should be continued until the woman has no fever for at least 24 hours. Intravenous therapy should be followed by oral medication. Examples of recommended regimens of oral antibiotics to follow intravenous antibiotic therapy are:

- Tetracycline 500mg orally four times daily for 10 to 14 days or
- Doxycycline 100mg orally two times daily for 10 to 14 days

(Adapted from WHO, 2000b)
Clinical Assessment Appendix B: Female Genital Cutting (FGC)

Forms of female genital cutting (FGC) range from cutting the tip of the clitoris to removing the entire clitoris and the folds of the labia. In some cases, the wound is sewn closed, leaving only a small opening for urine and menstrual blood to flow through. FGC may hinder performing a proper pelvic exam and uterine evacuation.

In cases of infibulation, the provider may have to open the sealed vagina. In this situation, the woman must give her voluntary, informed consent. The woman should be counseled before the procedure takes place and should be administered adequate pain management, including verbal reassurance plus medications. (See the Counseling module for more information.)

There are many short- and long-term health consequences of FGC. Infection may have occurred at the time the FGC was performed, resulting in the development of a tight fibrotic barrier in the lower vagina that inhibits the introduction of the speculum. Furthermore, a very narrow vaginal opening may not allow a speculum to pass.

Deinfibulation Procedure

In cases where the woman has undergone infibulation, the provider will most likely have to perform a deinfibulation procedure, making an inverted Y incision to open the stitching for the purposes of a pelvic exam and for uterine evacuation. Some women may have previously experienced an unsafe partial deinfibulation procedure.

General anesthesia may be needed for several reasons. For instance, some women may experience traumatic psychological flashbacks during deinfibulation and may prefer general anesthesia over other alternatives. Though rare, risks of the deinfibulation procedure include bleeding and infection. Benefits of the deinfibulation procedure include decreased incidence of dysmenorrhea, dyspareunia, chronic urinary-tract infections, vaginitis and intrapartum complications.
Steps for the deinfibulation procedure:

- Obtain informed consent.
- Prepare the woman: clean the surgical area thoroughly with soap and water and swab with an antiseptic solution.
- Insert a Kelly clamp below the infibulation scar to assess the length of the incision.
- Palpate the clitoral region to ascertain if a buried clitoris is present.
- Place two Allis clamps on the posterior portion of the scar.
- Make an anterior incision with Metzenbaum or Mayo scissors, taking great care not to incise a buried clitoris.
- Evacuate and strip the internal elements of any sebaceous material.
- Repair any vesicovaginal or rectovaginal fistulas, if resources and her condition allow.
- Complete the anterior incision.
- Place interrupted absorbable sutures.
- Catheterization can be performed once surgery is completed.

Providers should give the woman post-care instructions, including taking a warm sitz bath two to three times daily for one week and avoiding sexual intercourse for at least two weeks, depending on her condition. The woman should be discharged with ample analgesic medication and informed that her urine stream will feel different—instead of a trickle, she will experience a flow. A postoperative check-up should be scheduled as soon as possible according to her condition, resources and desires.

Once the woman is deinfibulated, continue the pelvic exam and uterine evacuation procedure, if needed. Her pain level and general condition should be monitored very closely at all times, with appropriate care adapted to her situation.
If the woman indicates interest in being reinfibulated, the provider should inform
her that reinfibulation is not clinically recommended and explain that the medical
community sees the practice of infibulation as unsafe to the health of women
and their potential offspring. Reinfibulation is a harmful practice that may have
serious health repercussions or may not be legally permitted. WHO views FGC as
a violation of human rights.
Uterine Evacuation Procedure with Ipas MVA Plus®

1.0 Introduction

Several circumstances require uterine evacuation. According to the World Health Organization (WHO), vacuum aspiration is a preferred method for uterine evacuation (WHO, 2003).

The objective of this module is to explain the features of the Ipas MVA Plus® aspirator and Ipas EasyGrip® cannulae used for uterine evacuation, as well as provide information about the care and use of these instruments. The module will also explain the various steps of a manual vacuum aspiration (MVA) procedure using the Ipas MVA Plus® aspirator and Ipas EasyGrip® cannulae, within a woman-centered care context.

The module is organized into sections on the following five main topics:

- **Instrument features, care, use and processing:** Information on Ipas MVA Plus® and Ipas EasyGrip® cannulae parts and features, processing, reassembly, maintenance, storage and handling.

- **Pain management:** The concepts and goals of pain management as an essential component of MVA, sources of pain during an MVA procedure, designing a pain-management plan, and methods of pain control.

- **Uterine evacuation with Ipas MVA Plus®:** Precautionary information, steps for performing uterine evacuation with MVA, solutions to potential instrument technical problems.

- **Post-procedure care:** Immediate post-procedure steps, information on monitoring recovery, and discharge procedures and instructions.

- **Follow-up care:** Clinical and psychosocial elements, contraceptive services and referrals.

2.0 Instrument Features, Care, Use and Processing

Ipas MVA Plus® and Ipas EasyGrip® cannulae are safe, effective instruments designed to meet women's abortion-care needs.

**Key Topics in This Section:**
- Features of the Ipas MVA Plus® and Ipas EasyGrip® cannulae
- Functioning and maintenance of Ipas MVA instruments
- Instrument processing and storage

Information in this section is based on the product labeling for the Ipas MVA Plus® aspirator and Ipas EasyGrip® cannulae.

Ipas, a nonprofit agency, manufactures and distributes MVA instruments worldwide. Any funds generated from the sale of these instruments are used to
support woman-centered reproductive-health programs and increase women’s access to high-quality care.

This section focuses on the Ipas MVA Plus® and Ipas EasyGrip® cannulae. Other models of Ipas instruments are similar. To assist providers who may have several models of instruments readily available, the differences in instrument processing that are important to maintaining the effectiveness of the devices are briefly noted. (For a complete comparison of instrument characteristics, see Appendix A: Comparison of Ipas Instruments.)

2.1 Description of Ipas MVA Instruments

MVA instruments consist of a manual vacuum source (aspirator) that 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.

**Description of aspirators**

The Ipas MVA Plus® aspirator provides a vacuum of 24 to 26 inches (609.6 to 660.4mm) 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 60cc cylinder for holding evacuated uterine contents. The Ipas MVA Plus® is compatible with Ipas EasyGrip® cannulae, flexible Karman cannulae, and cannulae from other major manufacturers.
Ipas aspirators are designed for multiple use. Aspirators are clean when shipped and must be clean when used; further processing is optional.

The Ipas MVA Plus® aspirator is made of steam-autoclavable materials and was designed specifically to allow steam contact with all surfaces when disassembled. It can also be processed with cold sterilization or high-level disinfection.

**Description of cannulae**

Ipas EasyGrip® cannulae are compatible with the Ipas MVA Plus® aspirator and the Ipas Double-Valve aspirator, but they do not fit the Ipas Single-Valve aspirator. Ipas EasyGrip® cannulae, depending on size, have either one aperture (9, 10 and 12mm sizes) or two apertures (4, 5, 6, 7 and 8mm 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 adapters are needed with Ipas EasyGrip® cannulae. There are six dots on each cannula, with the first located 6cm from the end and the other dots at 1cm intervals. The dots indicate the location of the main aperture.

Ipas EasyGrip® 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 Ipas EasyGrip® 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.

In the United States and a number of other countries, Ipas EasyGrip® cannulae and flexible Karman cannulae are labeled for single use and should be discarded after use. Where regulations allow, these cannulae are reusable after undergoing sterilization or high-level disinfection.

Each cannula is sterilized with ethylene oxide (ETO) after packaging. The shelf life for packaged cannulae is three years. Cannulae must be sterile or high-level disinfected (HLD) when reused.

Ipas EasyGrip® cannulae are made of steam-autoclavable materials. Autoclaving will damage flexible Karman cannulae. All Ipas cannulae can be processed with cold sterilization or high-level disinfection.

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 Ipas MVA Plus® Aspirator and Ipas EasyGrip® Cannulae**

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

**2.3 Contraindications, Warnings and Precautions**

Endometrial biopsy should not be performed in cases of suspected pregnancy. There are no known contraindications for other clinical indications.
As with any uterine evacuation procedure, one or more of the following may occur during or after an MVA procedure: 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. (See the Complications module for more information.)

Any life-threatening conditions that are present when a woman seeks care should be addressed immediately. These include: shock, hemorrhage, cervical or pelvic infection, sepsis, perforation or abdominal injury, as may occur with incomplete abortion or with clandestine abortion. Uterine evacuation is an important component of definitive management in these cases and once the woman is stabilized, the procedure should not be delayed. History of blood dyscrasia may be a factor in the woman’s care.

The provider should not perform uterine evacuation until the size and position of the uterus and cervix have been determined. Large fibroids or uterine anomalies may make it difficult to determine the size of the uterus and hard to perform intrauterine procedures, including MVA. (See the Clinical Assessment module for more information.)

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

### 2.4 Functioning of the Ipas MVA Plus® Aspirator

Appropriate client preparation, counseling and informed consent should be performed 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.

Specific guidance on performing uterine-aspiration procedures is included later in this module.

#### 2.4.1 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.

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**Ipas 3mm cannulae for endometrial biopsy**

The Ipas 3mm cannula intended use and clinical indication is endometrial biopsy in gynecology patients. Applications for endometrial biopsy may include cases of:

- Infertility
- Abnormal uterine bleeding
- Amenorrhea
- Screening for endometrial infections
- Screening for endometrial cancer

Ipas 3mm cannulae have two apertures and a winged base. Each cannula is sterilized with ethylene oxide (ETO) after packaging and will remain sterile as long as the package is intact. Shelf life for packaged cannulae is three years. An adapter is required for use with the Ipas Double-Valve aspirator and the Ipas MVA Plus® aspirator. No adapters are required for use with the Ipas Single-Valve aspirator.

Ipas 3mm cannulae are single-use devices. After use, treat soiled cannulae as infectious waste.
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.

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.

4. 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:
   - Is the plunger O-ring intact, rather than nicked or damaged, free of foreign bodies and positioned in the groove?
   - Is the cylinder firmly placed in the valve?
   - Has the plunger O-ring been properly lubricated, over-lubricated, or not lubricated at all?

6. Then create a vacuum and test it again. If the vacuum is still not retained, discard and use another aspirator.

2.4.2 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.

2.5 Processing Ipas Instruments
With the worldwide increase of infectious agents such as the human immunodeficiency virus (HIV), hepatitis B (HBV) and other infectious microorganisms that can be transmitted in a clinical setting, health workers must be vigilant about protecting their clients, themselves, their families and their communities. Many of these microorganisms live in blood, other body fluids and excretions and on body surfaces, and they can continue to live on every item that they come in contact with, including instruments used for MVA procedures. Microorganisms that can live on medical instruments include endospores and bacteria, which have a hard outer coating and are difficult to destroy. (See the Infection Prevention module for more information.)

As mentioned previously, Ipas aspirators are multiple-use devices. In the United States and a number of other countries, Ipas EasyGrip® cannulae and flexible Karman cannulae are labeled for single use and should be discarded after use. Where regulations allow, these cannulae are reusable after undergoing sterilization or high-level disinfection.
Refer to the chart below to determine a protocol for processing.

The four basic steps for processing contaminated Ipas MVA Plus® aspirators and Ipas EasyGrip® cannulae are:

- Decontamination soak
- Cleaning
- Sterilization or high-level disinfection
- Storage

### Processing Options for Ipas Instruments

For all Ipas cannulae, sterilization or high-level disinfection are the only acceptable methods of processing. For Ipas aspirators, cleaning is an acceptable method of processing; further processing is possible, if desired.

The chart on page 141 shows common processing methods for Ipas instruments. Using inappropriate methods may damage the instruments and render them unusable.

(See Appendix B: Methods for Processing Ipas MVA Plus® Aspirator and Ipas EasyGrip® Cannulae for more information on the processing methods for these Ipas instruments.)
## 2.6 Standard Precautions

It is important to follow standard precautions for infection prevention when processing instruments. Even following a decontamination soak, instruments will retain harmful microorganisms.

- Always wear gloves when handling blood or other body fluids.
- Use personal protective barriers, such as gowns or face protection, when a given part of the body may be exposed to blood or other body fluids.
- Consider all blood and other body fluids from every person to be infectious.
- Guard against skin punctures from sharp instruments.
- Wash hands immediately before and after contact with contaminated items, even if gloves were worn.

(See the *Infection Prevention* module for more information.)

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

### Processing Ipas Instruments

<table>
<thead>
<tr>
<th>Instrument</th>
<th>How supplied</th>
<th>Minimum level of processing required for use</th>
<th>Processing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Steam autoclave</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sterilization</td>
</tr>
<tr>
<td>Ipas MVA Plus® aspirator</td>
<td>Clean</td>
<td>Cleaning</td>
<td>Yes</td>
</tr>
<tr>
<td>Ipas Double-Valve aspirator</td>
<td>Clean</td>
<td>Cleaning</td>
<td>No</td>
</tr>
<tr>
<td>Ipas Single-Valve aspirator</td>
<td>Clean</td>
<td>Cleaning</td>
<td>No</td>
</tr>
<tr>
<td>Ipas EasyGrip® cannula</td>
<td>Sterile (ETO)</td>
<td>Sterilization or high-level disinfection</td>
<td>Yes</td>
</tr>
<tr>
<td>flexible Karman cannula</td>
<td>Sterile (ETO)</td>
<td>Sterilization or high-level disinfection</td>
<td>No</td>
</tr>
</tbody>
</table>

*Glutaraldehyde and chlorine are hazardous substances. If processing instruments or for environmental use, take necessary precautions such as using personal protective equipment. Refer to the manufacturer’s safety instructions to establish safe use.
2.7 Decontamination Soak
Following the procedure, all instruments to be reused should be kept wet until they can be cleaned. A 0.5% chlorine solution can be used. Soaking instruments immediately after use removes some material and makes them easier to clean by preventing material from drying on them. For easy accessibility, the container used for the decontamination soak should be kept close to the procedure area—for example, on the bottom shelf of the instrument trolley. Soaking in a disinfectant, however, does not make items safe to handle with bare hands. It is essential to wear gloves and face protection.

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

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

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

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

2.8.1 Disassembly of Ipas Instruments
Ipas aspirators must be disassembled for processing, and they must be correctly assembled after processing in order to function properly.

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

2.8.2 Steps in Cleaning
Disassemble instruments before cleaning.
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 parts and plunger using a soft-bristle brush, being careful not to splash.

3. Clean each item until no tissue or blood is visible upon careful inspection, then rinse.

4. Allow items to dry.

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

2.9 Sterilization and High-Level Disinfection

Sterilization or high-level disinfection of instruments further inactivates microorganisms.

Sterilization effectively eliminates all microorganisms, including endospores. High-level disinfection eliminates all microorganisms except endospores.

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

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

**Ipas cannulae must be sterile or HLD at the time of use.**

High-level disinfection or sterilization according to one of the options below is required to reuse Ipas cannulae and can also be done for aspirators.

- Steam autoclave instruments at 121°C (250°F) with a pressure of 106kPa (15 lbs/in²) for 30 minutes.
Note: Ipas Double-Valve and Single-Valve aspirators and flexible Karman cannulae will crack or melt if autoclaved.

- Sterilize using glutaraldehyde. Soak the clean instruments in glutaraldehyde (Cidex or a similar product) for 10 hours. Follow the manufacturer’s recommendations for the product used. (All Ipas aspirators can withstand glutaraldehyde processing.)

- High-level disinfect using glutaraldehyde. Soak the clean instruments in glutaraldehyde (Cidex or a similar product) for 20 minutes. Follow manufacturer’s recommendations for the product used.

- High-level disinfect using a 0.5% chlorine solution. Soak the clean instruments in a 0.5% chlorine solution for 20 minutes.

- High-level disinfect by boiling. Place the clean instruments in water at a rolling boil for 20 minutes.

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

2.9.1 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.

Paper wrap
3. Process instruments in the steam autoclave for 30 minutes at 121°C (250°F).
4. Cool all instruments before using.

### 2.9.2 Steps to Sterilize Using Glutaraldehyde

1. Completely immerse the instruments so that the solution fills them completely.
2. Soak in glutaraldehyde solution for the time recommended by the manufacturer—for example, 10 hours for Cidex.
3. Remove with sterile gloves or forceps.
4. Rinse all parts with sterile water. Do not use tap water to rinse.
5. Dry with a sterile cloth, 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 becomes cloudy. Do not use below 25°C (77°F).

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

### 2.9.3 Steps to High-Level Disinfect 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, 20 minutes for Cidex.
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.
6. Change the solution according to manufacturer’s instructions—every 14 days or sooner if the solution becomes cloudy.

### 2.9.4 Steps to High-Level Disinfect Using a 0.5% Chlorine Soak

1. Completely immerse instruments so that the solution fills them completely.
   Use a plastic (non-metal) container.
2. Soak in a 0.5% chlorine solution for 20 minutes.
3. Remove from solution using 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.

### 2.9.5 Steps to High-Level Disinfect by Boiling

1. Place the instruments in water at a rolling boil. Items do not need to be fully immersed.
2. Boil for 20 minutes.

3. Remove using 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.

In addition to these options for sterilization and high-level disinfection, Ipas EasyGrip® cannulae can be sterilized with ethylene oxide (ETO). The Ipas MVA Plus® aspirator should not be processed with this method. Do not boil Ipas Single-Valve or Double-Valve aspirators.

2.10 Assembly and Lubrication of the Aspirator

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

1. Place the valve liner in position inside the valve by aligning the internal ridges. Close the valve until it snaps in place.

2. Snap the cap into place on the end of the valve.

3. Push the cylinder into the base of the valve.

4. Place the plunger O-ring in the groove at the end of the plunger and lubricate it by spreading one drop of lubricant around the O-ring with a fingertip. Silicone, which is not sterile, is provided with the aspirator; other non-petroleum-based lubricants can also be used.

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

5. When reassembling the aspirator, ensure that the plunger is introduced straight into the cylinder and not introduced at an angle.

6. Squeeze the plunger arms and fully insert the plunger into the cylinder.

7. Move the plunger in and out to lubricate the cylinder.

8. Insert the tabs of the collar stop into the holes in the cylinder so that the plunger cannot be pulled out of the cylinder.

Always check that the aspirator retains a vacuum before using it. (See section 2.4.1 for instructions on how to check for vacuum retention.)

2.11 Storage of Instruments

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

Instruments should be kept in dry, covered, HLD or sterile containers with tight-fitting lids, protected from dust and other contaminants. Ideally, instruments that
have been processed by wet methods—such as soaking in glutaraldehyde or chlorine or boiling in water—should be used daily. If they are not used in that time period, they should be reprocessed. Items that have been processed using wet methods are more prone to microbial growth; there is often no efficient way to dry items that have been processed by wet methods. Reaching into storage containers repeatedly using transfer forceps also invites contamination.

### 2.12 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

### Summary

- The 60cc Ipas MVA Plus® aspirator comprises a cylinder, plunger and valve body.
- Ipas EasyGrip® cannulae are available in 4, 5, 6, 7, 8, 9, 10 and 12mm sizes, and do not require adapters.
- Ipas 3mm cannulae are for single-use in endometrial biopsy procedures and require an adaptor when used with the MVA Plus® aspirator.
- Cannulae must be sterile or HLD at the time of use; aspirators must be clean, but can also be sterile or HLD.
- Protocols for processing must be appropriate for the specific aspirators and cannulae in use.
- Processing options for sterilizing or high-level disinfecting instruments are: autoclaving, sterilizing using glutaraldehyde, high-level disinfecting using glutaraldehyde, high-level disinfecting using 0.5% chlorine and high-level disinfecting by boiling.
- 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.
- Instruments that are worn out or damaged should be discarded or replaced.

### Disinfectants Used in Processing Ipas Instruments

Any chemical that kills microorganisms is a germicide. Strong germicides called disinfectants are used for cleaning equipment. Weaker germicides called antiseptics are used on people. Generally, antiseptics should not be used for cleaning or processing instruments and equipment, as they are not strong enough to be effective. The following agents should not be used for instrument processing: formaldehyde solution, which is toxic; formalin chambers, which are ineffective; and hydrogen peroxide, which is light sensitive.

A 0.5% chlorine solution can be used for the decontamination soak and high-level disinfection of instruments, and can also be used as a general all-purpose cleaning solution for the clinical equipment and environment. This mixture of sodium hypochlorite (bleach) or other chlorine compounds, such as calcium hypochlorite, is a strong disinfectant for many objects, as well as typically inexpensive. The correct concentration can easily be mixed using a locally available agent and water. (See Appendix B: Mixing Instructions to Produce 0.5% Chlorine Solution in the Infection Prevention module for more information.)

Health-care workers should use different buckets of 0.5% chlorine solution for soaking, high-level disinfecting and general cleaning. The same bucket of solution should not be used for more than one purpose.
3.0 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.

Key Topics in This Section:
- Major sources of pain and methods of pain management
- Pain management plan
- Non-pharmacological pain management
- Medications used for pain control
- Post-procedure pain management

3.1 Sources of Pain for Women Receiving Abortion Care
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 (Dean et al., 2003). Generally, there are three sources of discomfort during uterine evacuation with MVA—anxiety, cervical dilatation and uterine cramping—and each source requires a different pain-management strategy.

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.

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 cramping
In almost all instances, women will experience some pain and cramping caused by the abortion procedure. Both cervical dilatation and the insertion of instruments into the uterus can be painful, and uterine contraction is typical after any uterine evacuation procedure.

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 paracetamol, ibuprofen or other nonsteroidal anti-inflammatory drugs (NSAIDS) or narcotics, can be administered for pain relief.

3.2 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 during abortion care 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 gentle clinical technique.

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.

(See Appendix C: Approaches to Pain Management During MVA for more information.)

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.

### 3.3 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 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 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. Some providers use the term “verbacaine” or “vocal anesthetic” for the process of verbal reassurance. 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 measures she would prefer during the procedure. 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. Music, acupuncture and hypnosis are additional methods that may promote relaxation.

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.

### 3.4 Pharmacological Methods for Pain Management

The amount and type of pain medication used during MVA for abortion care varies. Providers should take into account the woman’s comfort and safety while trying to minimize clinical risk. 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:

1. **Analgesics** alleviate the sensation of pain in the receptors of the spinal cord and brain.

2. **Anesthetics** numb all physical sensation locally, regionally or generally. Local anesthesia interrupts the awareness of pain from a small area in the body. Regional anesthesia is delivered through the spinal or epidural route and blocks all sensation below a particular point on the spinal column. General anesthesia affects the pain receptors in the brain and renders the woman completely unconscious.
3. **Anxiolytics** depress the functions of the central nervous system and are used to decrease anxiety and to induce relaxation and sometimes amnesia.

### 3.5 Post-Procedural 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 paracetamol or a non-steroidal anti-inflammatory 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. (See Section 5.0 of this module for more information.)

For more information about pain-medication options, see Appendix C: Approaches to Pain Management During MVA.

### Summary

- The three major sources of discomfort and pain during uterine evacuation with MVA are anxiety, cervical dilatation and uterine cramping.
- Verbal reassurance and respectful, supportive care by staff throughout the procedure helps to reduce anxiety and decrease pain, and should be a standard part of abortion care.
- Pain and discomfort during an MVA procedure can be reduced using a combination of verbal support, oral medications, paracervical block and gentle clinical technique.
- 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.

### 4.0 Uterine Evacuation Procedure

**Key Topics in This Section:**
- Precautions for performing an MVA procedure
- Steps for an MVA procedure
- Solving instrument technical problems

#### 4.1 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.
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 the Clinical Assessment module for more information.)

**4.2 Steps for Performing MVA**

**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. (See Sections 2.4.1 and 4.3 of this module for more information.)

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. (See Appendix D: Suggested Equipment and Supplies for Uterine Evacuation Procedure with Ipas MVA Plus® for more information.)

**Step 2: Prepare the woman**

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

Wash hands and put on appropriate barriers, including gloves.

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

Next, insert the speculum.

**Step 3: Perform cervical antiseptic prep**

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

**Step 4: Perform paracervical block**

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

After inserting the needle but before injecting any local anesthetic, always draw the plunger back slightly to ensure that the needle is not penetrating a blood vessel. If any blood is visible in the syringe, do not inject. Instead, move to a different injection site, and aspirate again before injecting.
Steps for Administering Paracervical Block:
Inject 1 to 2mL of anesthetic at the site where the tenaculum will be placed (usually 6 or 12 o’clock on the face of the cervix).

Next, place the tenaculum at the anesthetized site. Use slight traction to move the cervix and define the transition of smooth cervical epithelium to vaginal tissue. This transition marks the site of further injections around the cervix. Compared to cervical tissue, vaginal mucosa is more elastic and appears folded.

Inject 2 to 5mL of lidocaine into each injection site at 3, 5, 7 and 9 o’clock. In addition, some clinicians inject at 11 and 1 o’clock. Other clinicians choose to inject only at 12, 4 and 8 o’clock. Inject to a depth of 2.5 to 3.8cm (1 to 1.5 inches), using a slow technique to decrease any pain to the woman.

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

**Step 5: Dilate cervix**
Cervical dilatation is required in most, but not all, cases. Dilatation is not needed when the cervix allows a cannula of appropriate size to fit snugly through the os. However, cervical dilatation is an essential step if the cervix is closed or is not yet sufficiently dilated. (See Section 2.0 of this module for more information about cannula sizes.)

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

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

Dilatation or cervical preparation may also be accomplished by administering osmotic dilators or pharmacological agents such as misoprostol, where available. (For more information, see Appendix E: Misoprostol as Cervical Preparation Agent for First-Trimester Vacuum Aspiration.)

**Step 6: Insert cannula**
While gently applying traction to the cervix, insert the cannula through the cervix, just past the cervical os and into the uterine cavity. Alternately, move the cannula slowly into the uterine cavity until it touches the fundus, and then withdraw it slightly. Rotating the cannula while gently applying pressure often helps insertion.

Do not insert the cannula forcefully through the cervical os into the uterus. Forceful movements may cause damage to the cervix or uterine perforation and...
damage to pelvic organs and blood vessels. Remain alert to signs that may indicate perforation throughout the procedure, and stop suction immediately if they appear.

**Step 7: Suction uterine contents**

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

Evacuate the contents of the uterus by gently and slowly rotating the cannula 180 degrees in each direction, using an in-and-out motion. Blood and tissue will be visible entering the cylinder of the aspiration device through the cannula. It is important not to withdraw the opening of the cannula beyond the cervical os, as this will cause the vacuum to be lost. If this happens, or if the aspirator is full, detach cannula from aspirator and re-establish the vacuum.

Be aware that 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:

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

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

**Step 8: Inspect tissue**

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

Inspect the tissue for these signs:

- The quantity and presence of products of conception (POC)
- Complete evacuation
- Molar pregnancy

If the visual inspection is not conclusive, the material should be strained, immersed in water or vinegar, and viewed with light from beneath. If indicated, tissue specimen may also be sent to a pathology laboratory.
Villi and decidua should be visible in the tissue and the amount of tissue should correspond to the uterine size. In cases of molar pregnancy, grape-like chorionic villi are usually seen.

If no 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 the 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.

Step 9: Perform any concurrent procedures
When the MVA procedure is complete, proceed with any contraceptive or other concurrent procedures to be conducted, such as inserting an IUD, performing female sterilization or repairing a cervical tear.

Step 10: Take immediate post-procedure steps, including instrument processing
When the uterine evacuation and any additional procedures are complete, providers should take the following steps:

- Immediately process or discard all instruments, including the aspirator and cannula, according to instrument-processing procedures. (See Section 2.0 of this module 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.

4.3 Solving Instrument Technical Problems
In most MVA procedures, the aspirator vacuum remains constant until the aspirator is approximately 80%, or 50mL, full. However, a decrease in vacuum may occur before the aspiration is complete for the following reasons: the aspirator is full, the cannula is withdrawn past the os prematurely, the cannula is clogged or there is a loss of vacuum due to incorrect assembly.
Aspirator is full
If the cylinder fills up so that suction stops, depress the buttons and detach the aspirator from the cannula. The cannula should be left in its current position, inserted through the cervical os. Empty the aspirator into a container by releasing the buttons, squeezing the plunger arms and pushing the plunger forward.

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

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

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

Cannula is clogged
If the cannula becomes clogged, ease it back toward, but not through, the external os of the cervix. This movement will often unclog the cannula. Alternately, depress the buttons, close the valve on the aspirator and withdraw the cannula from the uterus or remove the cannula without depressing the buttons. Remove the tissue with sterile or HLD forceps. If necessary, reinsert the cannula using no-touch technique, reattach the aspirator and continue the procedure. Never try to unclog the cannula by pushing the plunger back into the cylinder while the cannula is in the uterus.

Aspirator loses vacuum
If the aspirator does not seem to hold a vacuum at all, reassemble and test the vacuum of the instrument. Incorrect assembly is likely to cause loss of vacuum. (See Section 2.0 of this module for more information.)

Summary
• 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.
• It is recommended that providers administer a paracervical block to all women undergoing an MVA procedure for induced abortion.
• Cervical dilatation can be performed by using mechanical dilators or progressively larger MVA cannulae, by osmotic dilators or by pharmacological agents such as misoprostol.
• 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 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.

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.

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

5.1 Physical Monitoring
Immediately after the uterine-aspiration procedure has been completed, the woman’s vital signs should be taken. She should then be allowed to rest and continue her recovery while being monitored, either in the abortion-care area or in another designated location in the health facility, until her normal vital signs return. 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. The purpose of monitoring is to:

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

While the woman is recovering, the provider should closely monitor her physiological status, including vital signs, in accordance with facility protocols. The provider should evaluate the woman's bleeding at least twice before she is discharged to confirm that bleeding and cramping have decreased. Methods include asking the woman to describe her bleeding, looking for blood on her
clothes and assessing her appearance. Women who are experiencing excessive blood loss may appear pale and increasingly weak, possibly with diminished consciousness and abdominal pain. Prolonged, severe cramping and excessive bleeding are not normal.

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

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

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.

5.2 Other Physical Health Issues

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. While the follow-up appointment is an opportune time to provide health education and referral on these topics, if women are interested in this information and it is available, it can be provided during post-procedure care. See Section 3.5 for information about post-procedure pain management.

5.3 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. When a woman receives emotional support as an integral part of her medical care, she is better able to understand and accept her medical condition, the recommended care and possible health outcomes.

Studies have shown that when health-care staff demonstrate empathy and employ effective communication skills, clients are more satisfied with their health care (Murphy, 1997). These clients are more likely to experience a better overall recovery and to seek follow-up care, if needed. The more information a woman is given before, during and after her abortion procedure, the better equipped she is to care for herself.

Before discharge, the woman should be offered counseling support. The counselor can then refer her for other services, when appropriate, such as support services for women who have experienced violence. (See the Counseling module for more information.)

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

5.5 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, slowed bleeding and decreased abdominal pain.

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

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

Prior to discharge, the woman should receive post-procedure counseling and information, including:

- Instructions for taking any prescribed medications.
- Information about routine personal hygiene—for example, that bathing and showering are fine.
- Information about resumption of sexual activity and contraception:
  - After an uncomplicated abortion, the woman may have vaginal intercourse and insert tampons as soon as she desires to do so. If she wants to prevent future unwanted pregnancy, she should use an effective form of birth control when having intercourse. Conception can occur again within 10 days after a first-trimester abortion. (See the Contraceptive Services module for more information.)
- 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.
- Signs and symptoms requiring immediate emergency attention (see box).
- What to do and where to seek emergency care if complications occur.
  - Written or graphic instructions for obtaining emergency care, with 24-hour contact information and emergency phone numbers, if available.
- A list of counseling and other services at the facility or in the community, if appropriate.
- Date, time and location of follow-up visit.

(See Appendix G: Discharge Information Sheet for an example of discharge instructions.)

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

5.6 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 the Complications module for more information.)

Summary

- The purpose of post-procedure monitoring is to ensure that the woman is
recovering well, to detect and manage any complications, 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.
- 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.
- Every woman should be offered contraceptive counseling and, if desired, a contraceptive method or referral before being discharged from the facility.
- Providers should assist each woman with making arrangements for follow-up care before she leaves the facility.

6.0 Follow-Up Care

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

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

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

The purpose of the follow-up visit is two-fold:
- To address any lingering concerns, including unresolved physical complications, contraceptive services (including emergency contraception), or emotional issues
- To provide preventive care and referrals for other services not provided at the follow-up facility

Some women will have experienced complications during or after the abortion procedure. At the follow-up visit, providers should ensure that any existing
complications have been resolved and that no new complications have developed. Women who do present at their follow-up visit with acute medical problems should be assessed, stabilized immediately and then treated. If adequate care cannot be provided at the facility, women should be referred or transferred without delay. (See the Complications module for more information.)

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

6.1 Clinical Elements
The provider should first review information about the woman’s abortion care. If the woman received initial services from a different provider, the follow-up provider will need to obtain as much information about the procedure and woman’s physical status as possible. (See Appendix H: Sample Follow-Up Visit Medical Form.) Privacy and confidentiality protocols permit sharing of clinical information with a provider involved in the follow-up care of a woman, as long as she agrees.

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

- Reviewing any available medical records and referral documents with the woman.

- Assessing the general physical status of the woman:
  - vital signs
  - any bleeding experienced
  - current pain or cramps
  - pain medications taken, both past and present
  - fever
  - current contraceptive use
  - signs of physical abuse

- Conducting a pelvic examination to assess uterine size and tenderness and rule out retained POC or infection. If the woman is an adolescent or has been raped, special attention should be given to providing comfort during the exam, for example, by offering verbal reassurance and using a small speculum.

- Determining whether symptoms of pregnancy, such as nausea and breast tenderness, have decreased or continued, in order to rule out continuing pregnancy.

- Re-evacuating the uterus if the POC were not entirely removed.

- Evaluating for chlamydia, gonorrhea or other sexually transmitted infections (STIs) in cases where women experience unusual discomfort, cervical motion tenderness, pus-like or foul-smelling discharge, or other indications of STIs.
6.2 Psychosocial Elements

Women’s experiences with abortion services are both physical and emotional, and their emotional responses vary widely. They may have fears, including concerns about their health, fertility or the reaction of others to their abortion. The follow-up visit can be an excellent opportunity to provide emotional support, to answer questions, to continue any previous counseling and to identify women who need special care. Women who receive emotional support during their follow-up care may be better able to cope with their medical conditions and possible health outcomes.

It is possible that some women will have particular needs or concerns that were not addressed during their first visit, such as violence or involvement in commercial sex work. It is important that any special needs and concerns are identified and addressed during the follow-up visit. (See the Counseling module for more information on counseling special populations.)

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

- Evaluating the woman’s emotional status, level of support and referrals needed
- Assessing her fertility goals and need for contraception
- Providing counseling and an appropriate contraceptive method, if needed
- Giving referrals related to other health or social needs, if appropriate

(Adapted from Hern, 1984; Paul et al., 1999)

6.3 Contraceptive Services

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

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

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

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

The results of the clinical and psychosocial elements of a follow-up visit should be recorded in the woman's records. (See Appendix H: Sample Follow-Up Visit Medical Form.) If the woman receives follow-up care at another facility, results from that visit ideally should be obtained using referral or follow-up protocols and recorded by the facility that provided the initial abortion care.

6.4 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. (See Appendix F: Sample Clinical Referral Forms.) 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. (See the Counseling module for more information on making referrals.)

Receiving facilities should have processes in place for accepting women who are referred to them and, if they are outside a woman’s community, for reintegrating her into health facilities in her community for follow-up care. They should also provide feedback to the original, referring institution. (See the Community Linkages module for further information.)

Summary
- Follow-up care should generally take place within one week after an MVA procedure.
- The purpose of the follow-up visit is to address any lingering clinical and psychosocial issues and to provide preventive care and referrals.
• The follow-up visit is a suitable time for women to meet with counselors and receive individualized counseling for their needs and concerns.

• 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.

• Psychosocial elements of the follow-up visit include assessing the woman’s emotional status, fertility goals, level of support and need for referrals to other health or social services.

• Counseling services offered during the follow-up visit can help women with their physical and emotional recovery after an abortion.

• The follow-up visit is an ideal time to talk to women about their fertility and future childbearing plans, and to offer contraceptive services or information on healthy pregnancy, as appropriate.

• During the follow-up visit, providers can offer to link the woman to additional sexual- and reproductive-health services.

• Referral protocols and resource lists that provide simple, accurate and up-to-date information are essential components of an effective referral system.

Additional Resources


Bibliography

Instrument Processing

Uterine Evacuation Procedure with Ipas MVA Plus


Pain Management


MVA Procedure


Murphy, Elaine. 1997. Client-provider interactions (CPI) in family planning services: guidance from research and program experience. Washington, DC, PATH.


**Post-Procedure Care**


**Follow-Up Care**


# Uterine Evacuation Procedure with Ipas MVA Plus Appendix A: Comparison of Ipas Instruments

The charts below highlight design features and compatibility between Ipas aspirators and cannulae.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Ipas MVA Plus™</th>
<th>Ipas Double-Valve</th>
<th>Ipas Single-Valve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holding capacity</td>
<td>60cc</td>
<td>60cc</td>
<td>60cc</td>
</tr>
<tr>
<td>Suction capacity</td>
<td>24–26 inches (609.6–660.4mm) of mercury</td>
<td>24–26 inches (609.6–660.4mm) of mercury</td>
<td>24–26 inches (609.6–660.4mm) of mercury</td>
</tr>
<tr>
<td>Compatibility with Ipas cannulae</td>
<td>Compatible with Ipas EasyGrip® cannulae, all sizes, no adapters needed</td>
<td>Compatible with Ipas EasyGrip® cannulae, all sizes, no adapters needed</td>
<td>Not compatible with Ipas EasyGrip® cannulae</td>
</tr>
<tr>
<td></td>
<td>Compatible with all sizes of flexible Karman cannulae; 12mm does not require separate adapter</td>
<td>Compatible with all sizes of flexible Karman cannulae; 12mm does not require separate adapter</td>
<td>Compatible with flexible Karman cannulae sizes 4, 5 and 6mm only; no separate adapters needed</td>
</tr>
<tr>
<td>Common processing methods*</td>
<td>• Clean only</td>
<td>• Clean only</td>
<td>• Clean only</td>
</tr>
<tr>
<td></td>
<td>• Sterilization with steam autoclave for 30 minutes at 121°C (250°F) with pressure of 106 kPa (15 lbs/in²). DO NOT EXCEED 121°C (250°F).</td>
<td>• DO NOT USE IN STEAM AUTOCLAVE</td>
<td>• DO NOT USE IN STEAM AUTOCLAVE</td>
</tr>
<tr>
<td></td>
<td>• Sterilization with glutaraldehyde</td>
<td>• Sterilization with glutaraldehyde</td>
<td>• Sterilization with glutaraldehyde</td>
</tr>
<tr>
<td></td>
<td>• High-level disinfection by boiling</td>
<td>• DO NOT BOIL</td>
<td>• DO NOT BOIL</td>
</tr>
<tr>
<td></td>
<td>• High-level disinfection with glutaraldehyde</td>
<td>• High-level disinfection with glutaraldehyde</td>
<td>• High-level disinfection with glutaraldehyde</td>
</tr>
<tr>
<td></td>
<td>• High-level disinfection with chlorine</td>
<td>• High-level disinfection with chlorine</td>
<td>• High-level disinfection with chlorine</td>
</tr>
<tr>
<td>Valve design</td>
<td>Valve liner is removable by opening hinged valve body 2 valve buttons No valve O-ring</td>
<td>Valve liner is not removable 2 valve buttons Valve O-ring required</td>
<td>Valve liner is removable 1 valve button No valve O-ring</td>
</tr>
<tr>
<td>Cylinder design</td>
<td>Collar stop can be displaced or removed for processing</td>
<td>Collar stop must be removed for processing</td>
<td>Collar stop must be removed for processing</td>
</tr>
<tr>
<td>Plunger design</td>
<td>Plunger O-ring can be displaced or removed for processing Ergonomic handle</td>
<td>Plunger O-ring can be displaced or removed for processing</td>
<td>Plunger O-ring can be displaced or removed for processing</td>
</tr>
</tbody>
</table>

*Cleaning is sufficient for Ipas aspirators because they do not come into contact with the patient. They can be sterilized or HLD if desired.
### Appendices B: Methods for Processing Ipas MVA Plus® Aspirator and Ipas EasyGrip® Cannulae

#### Ipas EasyGrip® Cannulae

Note: Only sterilization or high-level disinfection are acceptable methods for processing Ipas EasyGrip® cannulae.

<table>
<thead>
<tr>
<th>Method</th>
<th>Agent</th>
<th>Time</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilize</td>
<td>Steam autoclave</td>
<td>Sterility is achieved at 121°C (250°F) for 30 minutes with pressure of 106 kPa (15 lbs/in²). Do not use other autoclave settings. Specifically, do not use higher temperature settings for shorter periods of time (known as “flash autoclaving”).</td>
<td>Steam must reach all surfaces of item. Cannulae should not touch and should be arranged to permit drainage. Ipas EasyGrip® cannulae, particularly the smaller sizes, may curve in steam autoclaves. To minimize this, Ipas recommends packaging them by wrapping in paper or linen. Cool before use.</td>
</tr>
<tr>
<td></td>
<td>2% Glutaraldehyde* (Cidex) Follow manufacturer’s instructions for mixing</td>
<td>10 hours</td>
<td>Items must be fully immersed. Discard 14 days after mixing or sooner if solution becomes cloudy. Do not use below 25°C (77°F).</td>
</tr>
<tr>
<td></td>
<td>Glutaraldehyde (other solutions) Follow manufacturer’s instructions for mixing</td>
<td></td>
<td>Items must be fully immersed. Usually discard 14 days after mixing or sooner if solution becomes cloudy.</td>
</tr>
<tr>
<td></td>
<td>Ethylene oxide Follow manufacturer’s instructions</td>
<td></td>
<td>Use only in a well-ventilated area; respiratory protection is required.</td>
</tr>
<tr>
<td>High-Level Disinfect</td>
<td>Boiling water</td>
<td>20 minutes at rolling boil</td>
<td>Items do not need to be fully immersed. Boiling may discolor cannulae without affecting their effectiveness. Grasping boiling hot cannulae with forceps may flatten the cannulae. Let the water cool and handle cannulae by the base end when removing.</td>
</tr>
<tr>
<td></td>
<td>2% Glutaraldehyde (Cidex) Follow manufacturer’s instructions for mixing</td>
<td>20 minutes.</td>
<td>Items must be fully immersed. Discard 14 days after mixing or sooner if solution becomes cloudy. Do not use below 25°C (77°F).</td>
</tr>
<tr>
<td></td>
<td>Glutaraldehyde (other solutions) Follow manufacturer’s instructions for mixing</td>
<td>20 minutes</td>
<td>Items must be fully immersed. Usually discard 14 days after mixing or sooner if solution becomes cloudy.</td>
</tr>
<tr>
<td></td>
<td>0.5% Chlorine*</td>
<td>20 minutes</td>
<td>Items must be fully immersed. Change solution daily or sooner if it becomes cloudy.</td>
</tr>
</tbody>
</table>

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

Note: Because the aspirator does not come into direct contact with the client, it can be used after cleaning, although it can be sterilized, high-level disinfected or mid-level disinfected if desired.

<table>
<thead>
<tr>
<th>Method</th>
<th>Agent</th>
<th>Time</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilize</td>
<td>Steam autoclave*</td>
<td>10 hours</td>
<td>Steam must reach all surfaces of item. Steam must be arranged so that their openings are not obstructed, to permit drainage. The collar stop must be completely removed, not held with the retaining clip. Cool before use.</td>
</tr>
<tr>
<td></td>
<td>2% Glutaraldehyde**</td>
<td>10 hours</td>
<td>Discard 14 days after mixing or sooner if solution becomes cloudy. Do not use below 25°C (77°F).</td>
</tr>
<tr>
<td></td>
<td>(Cidex)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Follow manufacturer’s instructions for mixing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Glutaraldehyde (other solutions)</td>
<td>Follow manufacturer’s instructions</td>
<td>Usually discard 14 days after mixing or sooner if solution becomes cloudy.</td>
</tr>
<tr>
<td></td>
<td>Follow manufacturer’s instructions for mixing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-Level Disinfect</td>
<td>Boiling water*</td>
<td>20 minutes</td>
<td>Items do not need to be fully immersed. Cool before use.</td>
</tr>
<tr>
<td></td>
<td>2% Glutaraldehyde (Cidex)</td>
<td>20 minutes</td>
<td>Discard 14 days after mixing or sooner if solution becomes cloudy. Do not use below 25°C (77°F).</td>
</tr>
<tr>
<td></td>
<td>Follow manufacturer’s instructions</td>
<td>20 minutes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Glutaraldehyde (other solutions)</td>
<td>20 minutes</td>
<td>Usually discard 14 days after mixing or sooner if solution becomes cloudy.</td>
</tr>
<tr>
<td></td>
<td>Follow manufacturer’s instructions for mixing</td>
<td>20 minutes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.5% Chlorine**</td>
<td>20 minutes</td>
<td>Change solution daily or sooner if it becomes cloudy.</td>
</tr>
</tbody>
</table>

*Caution: Never boil or steam autoclave the plungers from the Ipas Double-Valve or the Ipas Single-Valve aspirator as they will emit formaldehyde.

**Glutaraldehyde and chlorine are hazardous substances. If processing instruments, or for environmental use, take necessary precautions such as using personal protective equipment. Refer to the manufacturer’s safety instructions to establish safe use.
Uterine Evacuation Procedure with Ipas MVA Plus™ Appendix C: Approaches to Pain Management during MVA

<table>
<thead>
<tr>
<th>Source of Pain</th>
<th>Usual Dose and Timing</th>
<th>Half-Life/Duration of Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANXIETY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Verbal support</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| *Diazepam (Valium)* | • PO: 10mg 1 hour prior to procedure  
• IV: 2-5mg IV(c) 20 min prior to procedure  | 21-37 hours |
| *Meperidine (Demerol, Pethidine)* | • PO: 100-150mg 30-60 min prior to procedure(c)  
• IM: 50-125mg 15-30 min prior to procedure  
• IV: 25-50mg 5-15 min prior to procedure  | 4-6 hours |
| 300 mg acetaminophen with 30 mg codeine (Tylenol with codeine) | • PO: 1-2 tablets 1 hour prior to procedure | 3-6 hours |
| 500 mg acetaminophen with 5 mg hydrocodone (Vicodin) | • PO: 1-2 tablets 1 hour prior to procedure | 4-6 hours |
| Fentanyl (Sublimaze) | • IV: 50-100mcg 5-15 min prior to procedure (may repeat every 10-15 min, not to exceed 250 mcg(c)) | 30-60 min |
| Midazolam (Versed) | • IM: 0.07-0.08 mg/kg or about 5mg (using 5mg/mL dilution)  
• IV: 1-2mg initially, then 0.5-1.0mg IV every 5 min as needed, not to exceed 5mg(c) | 1-4 hours |
| Lorazepam (Ativan) | • PO: 1-2mg 30-60 min prior to procedure  
• IM: 0.05mg/kg up to a maximum of 4mg at least 2 hours before procedure  
• IV: 2mg given over 1 min  | • PO: 12 hours  
• IV: 6-8 hours  
• Rarely, can exceed 24 hours for IV and PO dosing |

| **CERVICAL DILATATION** | | |
| *Xylocaine (Lidocaine, Lignocaine)* | • 15-20mL of 0.5-1% solution in paracervical block  
• Not to exceed 4.5 mg/kg(a) | 60-90 min |

| **UTERINE MANIPULATION** | | |
| Ibuprofen (Naproxen, Advil) | • PO: 400-800mg 1 hour before procedure | 4-6 hours |
| *Acetaminophen (Tylenol, Paracetamol)*  
Ketorolac (Toradol) | • PO: 500-1000mg 30-60 min before procedure  
• PO: 20mg 1 hour before procedure (10mg for women weighing < 50kg)  
• IM: 80mg (30mg for women weighing < 50kg)  
• Give both IM and IV Toradol 30-60 min prior to procedure | 4-6 hours |

(Adapted from Castleman and Marr, 2002)

* = WHO Essential Drug List
(a) 1% lidocaine means there is 18mg/mL, and 20mL contains 200mg. Using 0.5% lidocaine (5mg/mL) results in half the total dosage of a 1% solution. The maximum dosage should not exceed 4.5mg/kg of lidocaine.
(b) Naloxone treats narcotic overdose. Generally one vial of naloxone contains 0.4 mg. Before using, mix one vial with 10mL saline, yielding 40mcg/mL. Then, give 1mL IV at a time and wait about two minutes to take effect. 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 at least several hours.
### Side Effect

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>—</td>
<td>• Non-pharmacologic. Woman is supported in the manner she prefers throughout the procedure. Provider must be attentive to her comfort, be respectful and supportive, constantly assess need to intervene. Women will experience increased health outcomes, including less pain. Pain management resources will be used optimally.</td>
</tr>
<tr>
<td>Blurred vision, dizziness, disorientation, pain and redness on injection</td>
<td>• If respiration is compromised: assist with breathing (oxygen, Ambu bag) and reverse with flumazenil(^d)</td>
</tr>
<tr>
<td></td>
<td>• Has a mild amnestic effect</td>
</tr>
<tr>
<td></td>
<td>• Occasionally, it may increase the patient’s anxiety</td>
</tr>
<tr>
<td></td>
<td>• Onset of action: 2-10 min when given IV</td>
</tr>
<tr>
<td>Drowsiness, light-headedness, weakness, nausea and vomiting, CNS and respiratory depression, hypotension, seizures</td>
<td>• If respiration is compromised: assist with breathing (oxygen, Ambu bag) and reverse with naloxone(^b)</td>
</tr>
<tr>
<td></td>
<td>• After IM injection, time to peak plasma levels can vary 3-5 fold between patients.</td>
</tr>
<tr>
<td>Drowsiness, light-headedness, weakness</td>
<td>• Liver and kidney toxicity especially in the presence of pre-existing disease</td>
</tr>
<tr>
<td>Drowsiness, light-headedness, weakness, nausea and vomiting, CNS and respiratory depression</td>
<td>• If respiration is compromised: assist with breathing (oxygen, Ambu bag) and reverse with naloxone(^b)</td>
</tr>
<tr>
<td></td>
<td>• 100mcg fentanyl = 10mg of morphine</td>
</tr>
<tr>
<td></td>
<td>• Onset of action: 2-7 min when given IV</td>
</tr>
<tr>
<td>Drowsiness, light-headedness, weakness, bradycardia, CNS and respiratory depression</td>
<td>• Has a mild amnestic effect</td>
</tr>
<tr>
<td></td>
<td>• Occasionally, it may increase the patient’s anxiety</td>
</tr>
<tr>
<td>Blurred vision, dizziness, disorientation (significantly less pain on injection than diazepam due to water solubility of midazolam)</td>
<td>• Aspirate before injecting to avoid vascular administration</td>
</tr>
<tr>
<td></td>
<td>• Mild reaction (itching, rash, hives): treat with 25-50mg diphenhydramine (Benadryl) IM or IV</td>
</tr>
<tr>
<td></td>
<td>• Intense reaction or respiratory distress: obtain IV access immediately. Treat with epinephrine 0.4mg subcutaneously and diazepam 5mg IV (pushed slowly), and support respiration with oxygen and a ventilating bag. If wheezing is present, an inhaler may be useful.</td>
</tr>
<tr>
<td></td>
<td>• Allergic reaction is very rare. Reactions that do occur are most likely due to methylparaben preservative in multidose vials. Preservative-free lidocaine allergy is extremely rare.</td>
</tr>
<tr>
<td>Buzzing in ears, dizziness, numbness of lips, mouth and tongue, metallic taste, seizures</td>
<td>• Do not use in women with active peptic ulcer disease or renal failure. Allergic reaction may occur in patients with nasal polyps, asthma or sensitivity to NSAIDs.</td>
</tr>
<tr>
<td></td>
<td>• Liver toxicity from overdose. Do not use in the presence of renal compromise.</td>
</tr>
<tr>
<td></td>
<td>• Probably as potent as morphine for pain relief (Maslanka et al., 1994)</td>
</tr>
<tr>
<td></td>
<td>• Do not use in women with active peptic ulcer disease or renal failure, or who are breastfeeding. Bronchospasm or other allergic reaction may occur in patients with nasal polyps, asthma or sensitivity to NSAIDs</td>
</tr>
<tr>
<td></td>
<td>• IV: 30mg over at least 15 seconds (15mg for women weighing &lt; 50 kg)</td>
</tr>
<tr>
<td></td>
<td>• Breakthrough pain should be managed with narcotics rather than increasing the Toradol beyond recommended doses.</td>
</tr>
</tbody>
</table>

\(a\) All narcotic and anxiolytic drugs given intravenously immediately before or during the procedure should be administered slowly and intermittently by a specially trained health care provider. Their effects, while rapid in onset, are not instantaneous. Side effects are most likely when they are used in combination. Using narcotics and anxiolytics together increases the risk of respiratory depression; accordingly, lower doses should be used than when these agents are given separately. Problematic side effects can be avoided by repeated small doses of these potent medications (Mergolis et al., 1993; Baird et al., 2002). These medications should be administered prior to the procedure so they are at their peak effect during the procedure, at the point where the woman is experiencing the most discomfort. If peak effect occurs after the procedure has ended, the patient is put at higher risk for excessive sedation.

\(b\) Flumazenil treats benzodiazepine overdose. Use 0.2mg IV every minute until respirations return. Do not exceed 1 mg. Its duration of action is one hour and it may wear off before the benzodiazepine; therefore, patients treated with flumazenil must be monitored closely for as long as the benzodiazepine may still be in their system.
Appendix D: Suggested Equipment and Supplies for Uterine Evacuation Procedure with Ipas MVA Plus®

- Personal protective barriers such as gloves, face protection
- Examination table with stirrups
- Strong light
- Ipas MVA Plus® aspirator
- Lubricant for aspirator
- Selection of Ipas EasyGrip® cannulae
- Speculum
- Tenaculum
- Small cup with sponge clamp and gauze
- Tapered mechanical dilators (Pratt or Denniston)
- 10cc syringe with #23 gauge spinal or hypodermic needle
- Sponge stick with gauze
- Medium basin
- Smooth forceps
- Strainer
- Clear basin
- Betadine® or other non-alcohol based antiseptic
- Xylocaine 0.5% without epinephrine (for paracervical block)
Appendix E: Misoprostol as Cervical Preparation for First-Trimester Abortion Using Vacuum Aspiration

Misoprostol has been demonstrated to be effective for cervical preparation prior to first-trimester abortion. Cervical preparation using misoprostol may make first-trimester abortions easier to perform. Further investigations are needed to establish the effect of cervical preparation using misoprostol upon abortion-related complications.

**Indications:**
- Client desires termination of pregnancy.
- Cervical preparation prior to vacuum aspiration. Cervical preparation is recommended for pregnancies over nine completed weeks for nulliparous women, for women younger than 18, for durations of pregnancies over 12 completed weeks, or for other situations in which the risk of perforation is increased.
- No known hypersensitivity to prostaglandins.

**Examples of Dose/Route/Timing:**

<table>
<thead>
<tr>
<th>Dose</th>
<th>Route</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>400 µg (two 200 µg tablets)</td>
<td>Vaginally</td>
<td>3–4 hours prior to suction aspiration</td>
</tr>
<tr>
<td>400 µg (two 200 µg tablets)</td>
<td>Orally</td>
<td>3–8 hours prior to suction aspiration</td>
</tr>
</tbody>
</table>

Vaginal route may provide more effective dilation with fewer systemic side effects.

**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 evacuation.
- 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.

**Literature Cited:**


Referrals:
One of the following forms should be completed for any woman who is referred for care to another health-care facility. Because the form describes the woman’s confidential medical information, including her history, the provider should ask her if she feels comfortable taking the form with her. If so, the woman should bring the form to the referral facility; if not, the provider should find an alternate means of ensuring that the referral facility receives the information.

Clinical Referral Form I
Client information
Name: ____________________________________________
Referred for: ______________________________________
Date and time of admission __________________________

Diagnosis:

History (reproductive history, including number of pregnancies, births, etc.):

Clinical condition (vital signs, findings of physical/pelvic examinations):

Initial treatment (fluids, drugs given, action to control bleeding, any other medical steps taken):

Assessment of woman’s condition/other information:

__________________________________________
Health professional (print name)
__________________________________________
Location (hospital, clinic)
__________________________________________
Signature
__________________________________________
Date
Referral Form II

Name and contact information of referral center or provider:

Client name:

Reason for referral:

☐ Follow-up appointment
☐ Contraception services
☐ Counseling
☐ Screening/treatment for sexually transmitted infection
☐ Screening for cancer
☐ Violence support services
☐ Other health or social services (specify)

Recent medical history:

________________________________________
Health professional (print name)

________________________________________
Signature

________________________________________
Location (hospital, clinic)

________________________________________
Date
How to Take Care of Yourself

- Resume normal, non-strenuous activities only when you feel comfortable doing so.
- Eat according to your normal customs and diet.
- Showering, tub bathing and swimming are permitted.
- Correctly and completely take the medications that you have been given:
  
  _______________________ is an antibiotic to prevent or treat infection.
  
  Take ____ pill(s) ____ times a day for ____ day(s) until all the pills are gone.
  
  _______________________ is for pain and discomfort.
  
  Take ____ pill(s) every ____ hour(s), as needed.
  
- Keep your follow-up appointment as scheduled on:______________________.
- Call the clinic (telephone number: ______________) or come in before then if you have concerns.
- If you have received a contraceptive method, start using it right away. It is possible to become pregnant within 10 days after an abortion. If you did not receive a contraceptive method but would like to use one, see your provider as soon as possible.

What to Avoid

- Do not engage in strenuous activity, such as heavy lifting, for two to three days.
- Do not have sex until your contraceptive method has had a chance to take effect, if you wish to avoid becoming pregnant. Avoid using a vaginal sponge, diaphragm or cervical cap until all bleeding has stopped.
- Do not douche for one week after the procedure. Routine douching is not recommended unless prescribed by your clinician.

What Is Normal

- Bleeding and cramping similar to a normal period for up to one week; spotting may occur for up to several weeks.
- Mild fatigue for a few days.
- There is no “normal” emotional reaction to an abortion procedure. Some women feel a sense of relief, while other women feel sad. If you experience strong emotions, it may help to talk with a trusted friend, relative or counselor about these feelings.

What Is Abnormal

- Fever
- Abdominal pain
- Nausea, vomiting
- Vaginal discharge that smells bad
- Dizziness, lightheadedness or fainting
- Severe cramping
- Bleeding that is much heavier than a normal period

Seek care immediately if you experience any of these abnormal symptoms.

Special Instructions

(Adapted from EngenderHealth, 2002b and Policar et al., 1999)
### Appendix H: Sample Follow-Up Visit Medical Form

| Name ____________________________________________________ Date ____________________________ |
| Contact information ______________________________________________________________________________ |

#### Abortion using vacuum aspiration:
| Date of procedure ____________________________ Name of provider and facility ______________________________ |

#### Medication abortion:
| Date of administration: mifepristone __________________________ misoprostol ____________________________ |

### Interview

| Current bleeding? | Yes __ No __ | Amount __________ | Duration __________ |
| Clots?            | Yes __ No __ | Size __________  | Bright blood __________ |
| Current pain/cramps? | Yes __ No __ | Location ___ Mild____ Moderate _____ Severe _____ Duration____ |
| Pain medication?  | Yes __ No __ | When __________ | Relief__________ |
| Fever?            | Yes __ No __ | When ______     | How long___________ |
|                   |              | Highest temperature ______ |

#### Antibiotic prescribed? | Yes __ No __
If so, antibiotic prescription completed?
| Yes __ No __ | If no, why not__________ |

#### Current contraception? | Yes __ No __
If yes, what type __________
If so, satisfied with method? | Yes __ No __

### Psychosocial examination

| Emotional status ____________________________________________ |
|__________________________________________________________|
|__________________________________________________________|
|__________________________________________________________|

| How does the woman say she feels at this point? ____________________________ |
|__________________________________________________________|
|__________________________________________________________|
|__________________________________________________________|
Physical examination (if applicable)

Uterus: size ___ weeks ___ tenderness ___
Cervix: motion tenderness? Yes ___ No ___
Abdomen: soft/not tender? Yes ___ No ___
Adnexa: tenderness? Yes ___ No ___
Mass? Yes ___ No ___
Speculum exam done? Yes ___ No ___
Pulse ____________ Temperature ____________ Blood pressure ____________
Hgb/Hct ____________ Other lab results ________________________________
Comments: ____________________________________________________________________________________
Plan: ________________________________________________________________________________________

Re-evacuation procedure (if applicable)

Re-evacuation procedure notes: __________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Follow-up

Medication ordered: ____________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Referrals (if applicable)

Reason and referring facility: __________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

(Adapted from Hern, 1984 and Paul, 1999)
Medication Abortion

Key Topics in This Module:

- Eligibility requirements and contraindications
- Side effects and potential complications
- Essential information for women
- Regimens using mifepristone plus misoprostol and misoprostol alone
- Pain-management approaches and medication regimens
- Post-procedure care and follow-up visit

1.0 Introduction

Mifepristone and misoprostol are increasingly used worldwide for medication abortion. Other medications, including Methotrexate, and various prostaglandins are also sometimes used.\(^1\) This module will focus primarily on the first of the following two regimens:

1. Mifepristone and misoprostol used in combination through 63 days (nine weeks) since the last menstrual period (LMP). This regimen has been widely studied and safely used by women in many countries.

2. Misoprostol alone. This regimen is less effective than the combination of mifepristone plus misoprostol, but may be useful where mifepristone is not available. Studies to identify ideal regimens for using misoprostol alone are ongoing.

Mifepristone was first approved for clinical use in 1988 and is becoming available in a growing number of countries each year. Developed in France and originally known as RU-486, 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.

Misoprostol, a prostaglandin analogue, is administered at varying intervals up to 72 hours following mifepristone to stimulate uterine contractions and cause expulsion of the pregnancy. Misoprostol is inexpensive, stable at room temperature and available in many countries for the prevention and treatment of gastric ulcers. It is readily absorbed when used either orally or vaginally. Studies investigating the use and effectiveness of sublingual and buccal routes are being conducted and appear promising.

Studies to date indicate that the combination of mifepristone plus misoprostol is more effective in achieving complete abortion than either drug used alone. Research

\(^1\) Methotrexate plus misoprostol has been used in some countries for early medical abortion and the treatment of ectopic pregnancy. Methotrexate is a cytotoxic drug used to treat cancer, rheumatoid arthritis and other conditions. Because of the risk of teratogenicity in pregnancies that are continued following failed attempts to abort with methotrexate, a 1997 WHO Toxicology Panel recommended against its use for abortion.
Medication-abortion protocols using mifepristone plus misoprostol for pregnancies up to and including 63 days (nine weeks) since the LMP report success rates of up to 98% (Von Hertzen et al., 2003). Studies investigating the use of misoprostol alone for the same length of pregnancy have used varying regimens and are difficult to compare, but indicate that there is potential for some regimens to result in complete abortion in 85% - 90% of cases (RHTP and Gynuity, 2003).

2.0 Preparation
Before administering any medications:
- Provide counseling to the woman and obtain informed consent
- Perform a clinical assessment, including medical history and physical examination
- Confirm the woman’s access to emergency care, if needed
- Discuss her contraceptive needs

2.1 Counseling and Informed Consent
Detailed counseling should take place during the first visit and include the following elements:

Describe the basic information about medication abortion
All women choosing medication abortion should understand the entire process prior to taking any medications. The health-care worker should ask the woman if she has a companion at the clinic who she would like to also hear the medication-abortion information. If she does, invite her companion to join the session. Review and explain the Medication Abortion with Mifepristone and Misoprostol - Questions and Answers sheet (Appendix A). A woman who is unable to read may still find it useful to take a copy of this sheet; she may choose to have someone read the sheet to her if she has questions and wants to review the information during the extended abortion process. It is important to take adequate time to answer any questions or clarify any misunderstandings the woman may have regarding the procedure.

Women should be informed that:
- There is a small risk that the medication abortion will not work, meaning the pregnancy may continue after taking the medications. It is important to make clear that, once the woman begins taking the medication, she should complete all the necessary steps of the process. Should the woman stop the abortion process before it is complete, there will be a slightly increased risk of birth defects in the current pregnancy resulting from the abortion medications (RHTP and Gynuity, 2003). If the abortion is not completed with the medications, it is recommended that the woman undergo completion with vacuum aspiration.
- Medication abortion involves a longer duration of bleeding and cramping than abortion using vacuum aspiration.
- The benefits of medication abortion include the avoidance of anesthesia and an invasive medical procedure. Some women also feel that it is more private and natural.

Discuss the side effects of medication abortion
It is important to review with the woman what she may experience, including what she should expect to go through during the administration of the misoprostol.
• Bleeding and cramping, which are expected parts of the medication-abortion process, are usually heavier than what is experienced during a menstrual period; essentially the woman will experience symptoms resembling an early miscarriage. When discussing cramping, providers should refrain from describing cramping pains as similar to labor pains. Instead, pain can be compared to heavy or severe menstrual cramps.

• Bleeding often lasts for nine to 16 days.

• Diarrhea is an occasional side effect; some women also experience nausea and vomiting.

• There is a small risk of severe or prolonged bleeding that might require treatment with vacuum aspiration.

**Obtain informed consent**

Confirm the woman’s decision to undergo medication abortion and obtain her informed consent. Also, reiterate that if the woman decides not to have a medication abortion prior to taking the medications, she will still receive competent care of her choice without any repercussions. (See the Counseling module for more information.)

### 2.2 Clinical Assessment: Medical History and Physical Examination

Clinicians who prescribe medications for medication abortion must be well trained and possess strong skills in bimanual pelvic examination. They must also be proficient in diagnosing and dating an early pregnancy, ruling out any contraindications to medication abortion, and assessing signs and symptoms that could indicate an ectopic pregnancy. (See the Clinical Assessment module for more information.)

#### 2.2.1 Diagnose and Accurately Date the Pregnancy

Confirm that the pregnancy is 63 days (nine weeks) since the LMP or less. The regimens described here are only for use up to and including 63 days (nine weeks) since the LMP. The use of ultrasound to date pregnancy can be helpful, but is not an absolute requirement. In some countries or facilities, ultrasound is routinely used to diagnose and date pregnancies prior to medication abortion.

#### 2.2.2 Contraindications to Medication Abortion

- Ectopic pregnancy, either confirmed or suspected, or undiagnosed adnexal mass
- Allergy to mifepristone, misoprostol or another prostaglandin
- Current use of long-term systemic corticosteroid
- Chronic adrenal failure
- Hemorrhagic disorder
- Current anticoagulant therapy
- Intrauterine device in place (remove before giving mifepristone)
- Inherited porphyria

*Adapted from Mifeprex™ (mifepristone) package insert. Danco Laboratories LLC, 2000*

#### 2.2.3 Diagnosing Ectopic Pregnancy

Women seeking medication abortion often present in early pregnancy when the possibility exists for diagnosis and treatment of an ectopic pregnancy prior to

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**Counseling Tools**

Each facility can develop tools to assist in the management of counseling and services. One such tool is an information sheet to be taken home by the woman, which states that she is undergoing a medication abortion and outlines the medications received and emergency care available. If the woman seeks medical care at another facility after the abortion, the sheet can be taken with her to inform the new provider about what care and which medications she has received. (See Appendix B: Sample Information Sheet for Mifepristone and Misoprostol Medication Abortion.)
Medication Abortion

rupture. Therefore, thoroughly and accurately confirming of the length of pregnancy and ruling out ectopic pregnancy is essential to providing safe medication abortion. Mifepristone or misoprostol are not effective in ending ectopic pregnancy. Furthermore, an ectopic pregnancy can go undetected after a medication abortion because, unlike abortion using vacuum aspiration, the provider will not necessarily observe the expelled tissue to confirm termination of the pregnancy. The use of ultrasound, if available, can help confirm an intrauterine pregnancy.

Serious concern about a possible ectopic pregnancy might indicate the need for a vacuum-aspiration procedure—which allows for examination of the products of conception (POC) and confirmation of intrauterine pregnancy—rather than a medication abortion. If ectopic pregnancy is suspected when the woman has already taken mifepristone, administer the misoprostol at the clinic and have her wait until vaginal bleeding begins. Then carefully check for expelled POC. If there is no evidence of POC by the time the woman leaves the clinic, follow local protocols for ruling out ectopic pregnancy. (See the Clinical Assessment module for more information.)

2.3 Access to Emergency Care

The provider must ensure that the woman has access to emergency care in the rare case of serious complications. Also, as mentioned above, it must be clearly ascertained that the woman is willing to complete the procedure using a back-up method, preferably vacuum aspiration, in the case of a continuing or failed medication abortion. (See the Complications module for more information.)

2.4 Contraceptive Needs

The provider or counselor should discuss the woman’s fertility goals and plans for postabortion contraception, if desired. It is important to ensure that the woman’s method of choice is available for her to begin as soon as indications allow. (See the Contraceptive Services module for more information.)

3.0 Mifepristone Plus Misoprostol Regimens

A range of regimens using mifepristone and misoprostol for medication abortion are in use around the world. The following instructions on routes, dosage and timing are based on regimens used in clinical trials and evidence-based practice.

Thorough counseling and instructions are an important part of the medication-abortion process. All steps outlined in Section 2.0 of this module should be completed before the mifepristone is administered.

The provider should proceed with administering the mifepristone only when the woman has received the following information:

• What she should expect to feel after taking the mifepristone
• When to return or when to self-administer the misoprostol, depending on protocol
• A list of warning signs and instructions about what to monitor as potential problems
• Who to contact in case of questions or an emergency
• Which pain-management drugs to take
• How to handle the pregnancy tissue if it is passed when the woman is not at the clinic

Offer contraceptive methods
• That she will likely see blood clots, but it is unlikely that she will view anything resembling a fetus

3.1 Administration of Mifepristone
For women who are 63 days (nine weeks) since the LMP or less, the provider should administer 200mg mifepristone orally.²

The majority of women will not notice any change in how they feel after taking the mifepristone. Some women will have bleeding that begins prior to the administration of the second agent, misoprostol, and a small number of women will abort after taking the mifepristone and prior to taking misoprostol. Bleeding after mifepristone does not mean, however, that the abortion is complete; the majority of women will still need to take the misoprostol.

3.2 Administration of Misoprostol
Evidence to date supports a range of options for the route, dosage and timing of misoprostol administration. Institutional policy regarding route and the location for administration will determine which procedure and instructions are to be followed. Client safety and convenience should play a key role in determining policy.

Various dosages of misoprostol are used in actual clinical practice and in studies. After seven weeks since the LMP, oral doses are often associated with lower rates of complete abortion than vaginal doses; therefore, vaginal misoprostol should be used in pregnancies after seven weeks since the LMP. Up to 90% of women will expel the pregnancy within six hours of vaginal administration of misoprostol following mifepristone (WHO, 2003).

3.2.1 Protocol for Administration of Misoprostol
Day 1 is defined as the day that mifepristone is administered.

Vaginal use
For gestations up to 56 days (eight weeks) since the LMP: On Day 2, 3 or 4, insert four 200mcg tablets (800mcg total) of misoprostol into the vagina, one after the other.

For gestations 56 to 63 days (eight to nine weeks) since the LMP: On Day 2 or 3, insert four 200mcg tablets (800mcg total) of misoprostol into the vagina, one after the other.

Oral use
For gestations up to 49 days (seven weeks) since the LMP: On Day 2 or 3 take two 200 mcg (400mcg total) tablets of misoprostol by mouth, one after the other.

For gestations 49 to 63 days (seven to nine weeks) since the LMP: Use vaginal misoprostol, following the protocol described above. Oral misoprostol is not recommended because it has lower efficacy at this length of pregnancy.

(The preceding section is based primarily on the following studies: Schaff et al., 2000; Schaff et al., 1997; Ashok et al., 1998; and Creinin et al., 1999.)

3.2.2 Home Administration of Misoprostol
Researchers have demonstrated that allowing women to take the misoprostol—

² Where Rh-immunoglobulin is routinely provided to Rh-negative women, it should be administered either at the time of administration of mifepristone or prior to the administration of misoprostol.

Recent Research
In earlier years, 800mg of oral mifepristone was administered for first-trimester abortion. More recent research studies have shown that 200mg of mifepristone, given orally, is as effective and significantly less expensive than the higher dose (WHO, 2003).

Clinical Updates
The timing, dosage and route of administration of medication abortion are rapidly evolving. For example, a recent clinical study showed that the timing of misoprostol administration is effective when taken six to eight hours after mifepristone, which is earlier than described in this module (Creinin, 2004). The regimens here, however, are the most widely used at the time of publication. For the latest updates of accepted clinical practice, consult the medication abortion section of the Ipas website (www.ipas.org).

Instructions for Vaginal Insertion of Misoprostol
• Empty the bladder
• Wash hands
• Insert all the misoprostol tablets, one immediately after the other
• Push the tablets as far into the vagina as possible
• It is not a problem if the tablets do not completely dissolve
either vaginally or orally—at home is safe, effective and acceptable to women (Elul et al., 2001; Guengant et al., 1999; Ngoc et al., 1999). Clinics that offer home use of misoprostol should also give women the option of returning to the clinic for the misoprostol if they prefer. Successful home administration of misoprostol requires that women have clear instructions about when to take or insert the misoprostol tablets, what to expect after taking the misoprostol, and how to contact the clinic with any questions or concerns. It is also helpful to talk with each woman about her specific situation, helping her make a plan for pain management—for example, use of a hot-water bottle, ibuprofen, paracetamol or a narcotic—and for having her partner or another support person with her when she takes the misoprostol.

Preparing for misoprostol use at home
If the woman will be taking the misoprostol at home, the provider must give the woman either a prescription or the misoprostol pills to take home with her. The provider should review instructions for using the misoprostol, including what to expect, how to manage pain and under what circumstances to contact the clinic.

Considerations for Home Administration of Misoprostol
• Women will need to have time and an appropriate place for experiencing the cramping and bleeding that will occur.
• A support person, child-care arrangements and time off from work are among the logistical issues that may need to be considered and organized prior to taking the misoprostol.
• There must be a level of privacy and confidentiality that is satisfactory to the woman.
• Pain medication must be readily available in case it is needed, as well as contact information and instructions for what to do in the rare case of an emergency.

Finally, a follow-up visit should be scheduled.
It is advised that providers give all women aborting at home a packet containing the following items when they leave the clinic:
• Written information on the medication-abortion protocols, side effects and warning signs, and a reminder for the next appointment (see Appendix B: Sample Information Sheet for Mifepristone and Misoprostol Medication Abortion for an example)
• Detailed information on the home use of misoprostol
• Information on who to contact in case of questions or complications
• Other optional items: sanitary pads, cotton wool, contraceptive information, emergency contraception

3.2.3 Clinic Administration of Misoprostol
Preparing for misoprostol use in a clinic setting
If the misoprostol will be administered at the clinic, the woman should schedule a time to return after taking the mifepristone. The time will vary according to clinic protocols and the length of pregnancy (see above). At the return visit, the provider should:
• Review the woman’s progress since taking the mifepristone and ascertain if she has already aborted.

• If she has not already aborted, offer her the choice of taking the misoprostol orally, if she is eligible, or vaginally, inserted either by herself or by the provider.

### Considerations for Clinic Administration of Misoprostol

- The policies of the clinic, health system or government regulatory bodies will determine if women are discharged immediately following administration of misoprostol or if they remain at the clinic for four to six hours or until they abort.

- In cases where women will stay at the clinic for four to six hours, it is necessary to provide a comfortable space with appropriate privacy, a place to rest, and a clean, functioning toilet or latrine facility. A bedpan may be used to collect the POC.

- Staff who are trained to support and monitor women staying at the clinic must be available.

- Support persons can be available to women staying at the clinic to answer their questions, provide them with comfort and help reduce any anxiety they might have.

### Accommodation and Care

The woman may wait at the clinic for approximately four to six hours, depending on when her abortion is complete and on clinic protocol. Most women expel the pregnancy during this time. Clinics may have individual rooms with a bed and restroom or, more commonly, a room that has several cots and a toilet nearby. Women do not need to be restricted to their beds. They may be more comfortable with the freedom to move around the room, clinic, courtyard or other areas, as appropriate. Staff members should consider providing hot-water bottles to relieve discomfort from cramping, as well as pain medications such as ibuprofen or paracetamol and/or a narcotic before women begin to feel pain.

When several women are receiving misoprostol on a given day, they can rest in the same waiting area. During this time, a clinician or counselor should be available to answer questions and to address any medical concerns, such as nausea, vomiting, diarrhea or cramping. There should be enough toilet facilities to accommodate the maximum number of women receiving misoprostol at a given time. Facilities should also consider allowing each woman to have her partner or a support person with her during this time.

Protocols may include an examination of the woman, prior to her leaving the facility. In some cases the pregnancy tissue is lodged at the cervix and may be removed. It is important to inform the woman whether she has aborted, if this can be determined.

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 pertinent to aborting at home.
- Provide her with pain medication to take home.
- Schedule a follow-up visit to the clinic within 14 days to confirm pregnancy termination.
- Provide a contraceptive method, if desired by the woman.

In some settings, the woman may prefer to leave the clinic immediately after the misoprostol is given; however, she must be aware that she may start to abort while in transit from the health facility to her home.

4.0 Misoprostol-Alone Regimens

The broad availability of misoprostol around the world has led to its use as a single agent for medication abortion. The use of misoprostol alone for medication abortion has been demonstrated to be less effective than the combination of mifepristone plus misoprostol (WHO, 2003). However, a misoprostol-only regimen may be a useful option where mifepristone is not available.

Clinical research continues to examine the ideal regimen for using misoprostol alone for early induced abortion. A group of epidemiological, clinical and programmatic experts developed a consensus statement on indications for use based on currently available data and clinical expertise. (See Appendix C: Abortion Induction With Misoprostol (Cytotec®) in Pregnancies up to 9 Weeks Since the LMP.) The recommended regimen for misoprostol alone in pregnancies up to 63 days (nine weeks) since the LMP is 800mcg vaginally, taken two separate times 24 hours apart, for a total dose of 1600mcg.

Depending on local protocols and if the woman has ready access to emergency care, she may take the misoprostol home with her and proceed with the abortion there if she wishes. Prior to this, thorough counseling should be conducted and written instructions reviewed with the provider in the clinic. (See the question and answer sheet in Appendix D: Early Medication Abortion with Misoprostol.) A copy of the instructions should be given to the woman to take home along with the misoprostol. (See Section 3.2.3 in this module.)

The woman should return to the clinic for a follow-up visit within 14 days of taking the misoprostol to confirm completion of the abortion. Because misoprostol is associated with a slightly increased risk of birth defects when given in early pregnancy compared to pregnancies that have not been exposed to the drug, vacuum aspiration, preferably, should be performed to complete the abortion for women with a failed or otherwise unsuccessful misoprostol-induced abortion. (Refer to Section 4.0 of the Complications module for information on women with persistent gestational sac after medication abortion.)

In many countries, women may self-medicate with misoprostol and then present to a health facility for treatment of a failed abortion or an abortion that is in process. Many women may choose not to report self-inducing an abortion using misoprostol, but providers should consider it as a possibility and recognize related symptoms.

5.0 Pain Management

Pain during a medication abortion usually begins after the administration of misoprostol, often within one to three hours, and diminishes after the abortion is complete. As the uterus contracts and its contents are expelled through the
cervix, women generally feel some degree of cramping. The amount of cramping
pain experienced varies greatly, with some women noting only mild cramping and
others experiencing severe pain.

Thorough counseling and the review of complete information prior to the
provision of medication abortifacients help women prepare for any subsequent
cramping and pain. Reassurance and support during the abortion process,
conducted either by staff in the clinic or a support person at home, can also be
helpful.

The woman should also be provided with pain medication or a prescription at the
time the mifepristone—or misoprostol in the case of misoprostol-only
regimens—is administered. Women should begin taking pain medication when
cramping begins rather than waiting for it to become severe, when the pain cycle
is more difficult to interrupt.

Both non-narcotic and narcotic analgesics are used for pain management during
medication abortion. Pain-management medications for medication abortion
include paracetamol (acetaminophen) and ibuprofen. Paracetamol with codeine
or codeine alone may be provided, if needed. Nonsteroidal anti-inflammatory
drugs (NSAIDs) do not interfere with misoprostol (Creinin et. al., 1997).

The application of low heat to the abdomen or lower back—using a hot-water
bottle, warm cloths, or a hot bath or shower—may also help relieve the pain of
cramping.

6.0 Side Effects
The drugs used in medication abortion may produce a range of side effects that
are almost always relatively minor and short-term and usually do not require
treatment. (See Section 7.0 for information on complications.) Women need to
know which side effects they are likely to experience, and providers must be
familiar with the normal range of side effects in order to differentiate them from
more serious complications.

Vaginal bleeding and cramping are expected, normal components of medication
abortion. Other side effects of mifepristone and misoprostol include:

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

6.1 Vaginal Bleeding
Vaginal bleeding, often accompanied by the passage of clots, is usually of greater
quantity than a menstrual period. Bleeding sometimes begins following ingestion
of mifepristone, but most often starts one to three hours after misoprostol is
administered. Although the amount and duration of bleeding varies, bleeding is
generally heaviest during the actual abortion, often lasting one to four hours.
Women tend to bleed or spot longer after medication abortion than after abortion
using vacuum aspiration. Studies indicate an average duration of bleeding with
medication abortion of nine to 16 days, though a minority of women may have
some bleeding for extended periods of time (Davis et al., 2000).

Excessive bleeding is an uncommon risk of medication abortion, and is most
often successfully treated with vacuum aspiration. If vacuum aspiration is
unavailable, providers should treat using sharp curettage. Excessive bleeding
requiring transfusion is rare. A US-based study found that out of 80,000 women who received mifepristone and misoprostol for medication abortion, only 13 received blood transfusions (Hausknecht, 2003).

Providers need to have clearly defined procedures for evaluating and treating potentially abnormal bleeding. They should assess the quantity of bleeding using common measurement criteria relevant to the resources and practices of local women.

For example, where women use sanitary pads, saturating less than two thick pads per hour after taking misoprostol, with a decreasing flow over time, is normal. Saturating more than two to three pads per hour for two consecutive hours should alert the provider to monitor the woman’s progress closely. Severe hemorrhage and prolonged heavy bleeding require immediate attention.

6.2 Cramping

Of those women whose medication-abortion experience has been studied, the majority report cramping pain. The degree of pain a woman reports depends on both individual and cultural factors. Providers should inform women prior to taking medication abortifacients that cramping pain is expected as part of the abortion process, and provide them with pain medication.

Clinical judgment must be called upon to differentiate between the “expected” pain of medication abortion and pain that signifies potential pathology. Pain that is persistent should be evaluated, as should pain in combination with other symptoms of possible ectopic pregnancy. Women should be advised to contact the clinic if they experience pain associated with bleeding that is heavier than expected or persistent fever.

6.3 Gastrointestinal Side Effects

Nausea, vomiting and diarrhea are regularly reported following the use of misoprostol; for some women, these symptoms also result following the ingestion of mifepristone. Such side effects are most frequently reported in cases that involve higher doses of misoprostol and later lengths of pregnancy.

Gastrointestinal side effects are usually mild and self-limiting. It is unclear if anti-emetic and antidiarrheal medications are helpful, but they may be prescribed when needed. Vaginal administration of misoprostol is associated with fewer gastrointestinal side effects than oral administration.

6.4 Fever, Warmth and Chills

Many women experience short-lived fever, a feeling of warmth, chills or shivering during medication abortion as a side effect of the medications, perhaps in combination with endogenous hormonal changes. Treatment is generally not required, but women should know that they may experience these symptoms. Although postabortion infection rarely accompanies medication abortion, persistent fever could indicate infection and must be evaluated.

6.5 Headache and Dizziness

Approximately one-fifth of women studied reported headache or dizziness associated with the medication abortion (Honkanen, 2004). Headache is treatable with analgesics and mild dizziness of a short duration is managed by hydration, rest and by exercising caution when changing position. However, women
experiencing dizziness in combination with heavy bleeding should be promptly evaluated for hypovolemia.

The side effects described above are commonly considered to be associated with misoprostol, though many may also result from mifepristone ingestion. Research to date indicates that the types of side effects experienced by women using the optimal dosage of misoprostol for a misoprostol-only first-trimester abortion are similar to those described for combination mifepristone-misoprostol regimens.

7.0 Complications
Medication abortion results in few serious complications. Those that do occasionally occur are failed abortion, hemorrhage and infection.

Women who experience complications of medication abortion need clear, honest explanations of the situation, and should be included in decisionmaking 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. (See the Complications module for more information.)

8.0 Instructions Prior to Leaving the Clinic and Care Afterwards

8.1 What to Inform the Woman About Before She Leaves the Clinic
Most well-informed and appropriately counseled women who leave the clinic following, or in the midst of, the medication-abortion process will have a successful, problem-free experience.

Prior to leaving the facility, the woman should know when to return for a routine but important follow-up visit. She must also receive instructions about when and where to seek medical help in case of an emergency. For example, the Sample Medication Abortion Information Sheet for Mifepristone and Misoprostol that was reviewed prior to mifepristone administration, and which the woman should take with her when she leaves, describes the normal medication-abortion experience and highlights warning signs that indicate the need to seek medical help. Ideally, if a woman has concerns or problems, she should contact the clinic that administered the medication abortifacients, where staff members are familiar with the protocols being followed and any expected side effects associated with the procedure.

Postabortion antibiotics are not necessary or recommended for women who have a medication abortion because instruments have not been inserted into the uterus. Antibiotics should be reserved for cases where the woman exhibits signs and symptoms of potential infection.

8.2 Care After Leaving the Clinic
Where telephone systems are in place, many concerns and possible problems can be managed by providing information over the phone. Optimally, a 24-hour on-call telephone contact should be available, so women can call whenever they have problems or concerns. However, in many locations, a return to the health facility may be the only way for the woman to access information and for the provider to assess her progress.

Although persistent side effects and serious complications are rare, clinic staff

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**Warning Signs After Medication Abortion**

Women should contact their health-care provider immediately if they experience:

- Excessive bleeding: soaking more than two to three thick pads per hour for two consecutive hours*
- Persistent fever of 38°C (100.4°F) or higher, or fever beginning more than eight hours after taking the misoprostol
- No bleeding within 24 hours after taking the misoprostol

*Note that the description of excessive bleeding must be culturally appropriate

(Adapted from Stewart et al., 2001)
must be able to provide timely treatment or make appropriate referrals. If ultrasound is not routinely used in clinics that offer medication abortion, a referral system for ultrasound services should be established, if at all possible, to evaluate any questionable or troublesome cases that may occur.

As discussed above, an alternative method, preferably vacuum aspiration, must be available on-site or through referral as back-up for failed medication abortions.

8.3 Postabortion Contraception
Contraceptive information and methods should be available to women who want them. Women must be informed that they can become pregnant as early as 10 days following the completion of their medication abortion. In general, all contraceptive methods can be considered for use after a first-trimester medication abortion and must be initiated immediately after an uncomplicated abortion, with the exception of fertility awareness-based methods also known as “natural family planning.” (See Contraceptive Services module for more information.)

9.0 Follow-Up Visit
Women should return for a follow-up visit within two weeks after taking the abortion medications. During this visit, the provider should:

1. Inquire about the woman’s experience with the medication-abortion process.

2. Assess the completeness of the abortion by:
   - Taking a history of the abortion process, amount and duration of bleeding, cramping and passage of clots (see Uterine Evacuation Procedure with Ipas MVA Plus® Appendix H: Sample Follow-Up Visit Medical Form)
   - Conducting a physical examination
   - Performing an ultrasound or checking for decreasing ßhCG levels through serial quantitative tests, if it is unclear whether the abortion is complete

3. Perform vacuum aspiration, preferably, to complete the process in the case of a continuing pregnancy.

4. Provide treatment if there is a persistent gestational sac (incomplete abortion), either by:
   - Expectant management, in which more time is given for the uterus to expel the pregnancy; in such cases another follow-up visit is usually scheduled within one to two weeks
   - A repeat dose of vaginal misoprostol
   - Vacuum aspiration, preferably, or sharp curettage

5. Inform the woman of what to expect following completion or continued treatment.

6. Review any laboratory tests results with the woman.

7. Provide a contraceptive method, if desired by the woman.

10.0 Summary
• Studies to date indicate that the combination of mifepristone plus misoprostol is more effective in stimulating complete abortion than either drug used alone.
• Although misoprostol used alone for medication abortion has not yet been demonstrated to be equally effective as the combination of mifepristone and misoprostol, it may be a useful option where mifepristone is not available.

• Vaginal administration of misoprostol is recommended for pregnancies after seven weeks rather than oral administration due to higher efficacy.

• Abortion completion, preferably with vacuum aspiration, is recommended for continuing pregnancies, as there may be a risk of birth defects after the administration of medication abortifacients.

• Counseling during the first medication-abortion visit includes the discussion of: basic information about medication abortion; side effects and complications; and the importance of completing the medication-abortion process once it has begun.

• Preparation prior to administering mifepristone includes: counseling and obtaining informed consent; performing a client assessment, including medical history and physical examination; confirming the woman's access to emergency care; and discussing her contraceptive needs.

• Before every physical examination or the administration of medication, it is important to make sure the woman knows what to expect and feels encouraged to express her concerns, questions and feelings.

• Thoroughly and accurately confirming the length of pregnancy and ruling out ectopic pregnancy is key to safe, effective medication abortion.

• Appropriate facilities and staff support should be available to women who remain in the clinic during the medication-abortion process.

• Heavy vaginal bleeding and cramping are expected and normal components of medication abortion. Other side effects include nausea, diarrhea, vomiting, fever, warmth or chills, headache and dizziness.

• Both non-narcotic and narcotic analgesics can be used to treat pain associated with medication abortion.

• Although serious complications from medication abortion are rare, complications that can occur are continuing pregnancy, hemorrhage, infection and undiagnosed ectopic pregnancy.

• Before leaving the clinic, the woman should know the expected side effects of the medication she has taken or will take at home; the warning signs for potential complications; and when and where to seek medical help.

**Additional Resources**


Bibliography


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Medication Abortion Appendix A: Medication Abortion with Mifepristone and Misoprostol - Questions and Answers

What is medication abortion?
Medication abortion is a safe way to end a pregnancy by taking certain medications. Medication abortion works to end a pregnancy up to 63 days/9 weeks from the first day of your last menstrual period. The abortion is usually done using two medications: mifepristone and misoprostol (Cytotec®). Medication abortion is an alternative method to vacuum aspiration and dilatation and curettage.

How safe is medication abortion?
Medication abortion is very safe. Mifepristone and misoprostol have been used for medication abortion for more than 15 years by millions of women around the world. Complications are rare, but may include prolonged or heavy bleeding, which is experienced by about one out of every 100 women, incomplete abortion or ongoing pregnancy. There have been no reports of long-term risks. Medication abortion will not affect your future fertility, your menstrual cycles or your sexual activity.

Who can use misoprostol and mifepristone?
The appropriateness of misoprostol and mifepristone depends on each woman’s individual clinical history and physical exam. The medications should not be used if you have a pregnancy outside the uterus (an ectopic pregnancy), an intrauterine device (IUD) in place or certain medical conditions, such as severe anemia, cardiac disease, bleeding disorder or allergy to the medications.

How does medication abortion work?
A woman takes the two different medications at different times. The first is the pill mifepristone which stops the pregnancy from growing. The second pills taken are misoprostol which cause the uterus to contract and expel the pregnancy.

Step One
After the clinician has taken your medical history and performed an examination, and you’ve given informed consent, you will take the mifepristone.

Step Two
Within a few days after taking the mifepristone, you will take the misoprostol tablets. The timing for this step depends on how far along the pregnancy is. The clinic staff will tell you when to start the misoprostol. Most women have cramping and heavy bleeding resembling a very heavy menstrual period after taking the misoprostol. Generally, this will last for four to six hours; the cramping may last longer for some women.

Step Three
You will return to the clinic for a follow-up visit to make sure the abortion is complete. It is very important to return for this visit.

How effective is medication abortion?
Mifepristone and misoprostol used together for medication abortion is about 92–98% effective in ending a pregnancy. In other words, 98 out of every 100 women who take these medications will have a complete abortion and two will not. If the medication fails and there is an ongoing pregnancy, it is recommended
that vacuum aspiration be performed. Misoprostol is associated with a slightly increased risk of birth defects when given in early pregnancy compared to pregnancies that have not been exposed to misoprostol. For this reason, you should not begin a medication abortion unless you are sure you want to end your pregnancy.

**Are there side effects from medication abortion?**
Cramping and bleeding from the vagina are a normal part of the medication-abortion process. Some women also experience nausea, vomiting, diarrhea, temporary fever and chills. Your clinician will make sure you have medicines, such as pain relievers, to help you manage side effects.

**How long does it take?**
Most women abort within four hours of taking the misoprostol. In a few cases, women may not start bleeding for up to 24 hours. The beginning and duration of bleeding and cramping is different for every woman, so it is difficult to predict exactly what your experience will be.

The heaviest bleeding generally occurs during the actual abortion (after taking misoprostol). Most often this entails more bleeding than during a heavy menstrual period, and it is almost always accompanied by cramps. There will also be the passing of blood clots. Bleeding and cramping decrease after the pregnancy is passed. Some bleeding, similar to the amount experienced during a menstrual period, will continue for about nine to 16 days after taking the medications.

**When can I begin a contraceptive method?**
Fertility can return within 10 days of an abortion, and you should have a regular menstrual period four to eight weeks after the abortion. You should discuss contraception with your health-care provider during your first visit for the medication abortion. Different contraceptive methods are begun at different times, and your clinician will give you information specific to the method you select.

**When should I come back for the follow-up visit?**
Your clinician will schedule a time within two weeks when you will return for a follow-up visit. You should contact the clinic in the interim if you have any problems or concerns about your medication abortion. It is very important to talk with your health-care provider if you experience any of these signs:

- Excessive bleeding (for example, soaking more than two thick pads per hour for two hours in a row)
- Persistent fever of 38°C (100.4°F) or higher, or a fever that begins more than eight hours after taking the misoprostol
- No bleeding within 24 hours of taking misoprostol
- Intermittent abdominal pain after the initial bleeding period

These warning signs may indicate a medical problem that can be successfully treated, so you should let the clinician know if you experience any of them.

(Adapted from Planned Parenthood Federation of America, 2002, Stewart et al., 2001)
Medication Abortion Appendix B: Sample Information Sheet for Mifepristone and Misoprostol Medication Abortion

Today, __________________ (date), you took one pill called mifepristone to end your pregnancy. You took 200 milligrams of mifepristone at ________am/pm. You will probably feel no different after taking this pill. You may have some bleeding from your vagina.

The second medication you will receive is called misoprostol. Each misoprostol tablet is 200 micrograms. Either at the clinic or at home, you will take ____ tablets all at one time either vaginally or orally for a total of ____ micrograms.

If you are taking the misoprostol vaginally, either you or a clinician will place all four tablets in your vagina, one after the other, as far into your vagina as possible.

If you are taking misoprostol orally, your provider will give you the appropriate number of pills to swallow.

Usually within 30 minutes to four hours, you will experience strong cramping and heavy bleeding as the pregnancy is passed.

What to expect next:

- You will experience bleeding and cramping during the abortion process, which is usually finished within four hours or sooner. Do not worry—this is a normal part of the medication-abortion process.
- You will be given pain medication to alleviate the cramps along with instructions about what and how much pain medication to take. You can also try methods you would use to reduce pain from menstrual cramps, like a hot-water bottle.
- You may experience nausea, diarrhea or vomiting during the abortion process. This is uncomfortable, but it is not dangerous. Again, it does not signal a problem. These symptoms will pass with time.
- You also may experience headache and dizziness after taking the misoprostol. The pain medications you have been given should help the headache. Drink lots of water or juice—not caffeine or alcohol, which will likely make you feel worse—and move around slowly and carefully if you are dizzy.
- Some women develop a fever for a few hours, sometimes with shivering. This is a side effect of the misoprostol and it will pass within a few hours. It is not dangerous.
- You may experience a surge or gush of watery blood from your vagina once the misoprostol begins working. This is normal. You may want to sit on the toilet or a latrine if you feel an urge coming on. Afterward, be careful to move slowly, especially when standing up from a sitting position. You may feel dizzy and should be careful not to fall.
- You may also pass blood clots of various sizes during the abortion process. This is normal; however, if you pass large clots for more than two hours, let your health-care provider know.
- If you take the misoprostol at the clinic, you may stay at the health facility for about four hours. If your abortion is complete before that time, you may leave earlier. If the abortion has not yet happened by the time you leave the clinic, you should expect it to take place at home.

Possible warning signs:

- After leaving the clinic, if you are worried that you are experiencing a problem, immediately contact the health-care facility where you received the medications. Here is the contact information:
  
  Telephone Number: _______________ Address: _________________________________________________

- You must talk with your health-care provider if you experience any of these warning signs:

  - Excessive bleeding (for example, soaking more than two thick pads per hour for two hours in a row)
  - Persistent fever of 38°C (100.4°F) or higher, or a fever that begins more than eight hours after taking the misoprostol
  - No bleeding within 24 hours after taking misoprostol
  - Intermittent abdominal pain after the initial bleeding period
Follow-up visit:
You are scheduled to return to the clinic on ________________. The clinician will make sure your abortion is complete. This is a very important visit. Once you begin a medication abortion, you must make sure it is completed because the medications may cause birth defects in the current pregnancy if the pregnancy continues.

(Adapted from the Access Project’s Mifepristone medical abortion: Patient information sheet)
Medication Abortion Appendix C: Abortion Induction with Misoprostol (Cytotec®) in Pregnancies up to nine Weeks LMP

Consensus Statement on Instructions for Use: Abortion Induction with Misoprostol (Cytotec®) in Pregnancies up to nine Weeks LMP

From an expert meeting on misoprostol sponsored by the Reproductive Health Technologies Project and Gynuity Health Projects, held on 28 July, 2003, in Washington, DC.

Background
Misoprostol is a prostaglandin analog widely marketed as Cytotec®. Cytotec® is registered for use to prevent gastric ulcers resulting from chronic administration of nonsteroidal anti-inflammatory drugs (NSAIDs). As Cytotec® also induces uterine contractions, it is often used off-label for pregnancy termination. Studies have demonstrated that misoprostol can be used to terminate pregnancies of any gestation. This information is presented for the guidance of trained medical professionals.

Indication and Usage
Effective regimens, their course, and success and complication rates depend on the length of gestation. The following information applies to pregnancies estimated to be 9 completed weeks (63 days) LMP or less. Use of misoprostol for pregnancy termination of gestations up to nine weeks LMP has a success rate of 85-90%. It is important to know the duration of the pregnancy, for example as estimated by the last normal menstrual period, in order to determine if it is appropriate for the woman to use this method.

Contraindications
- Confirmed or suspected ectopic pregnancy or undiagnosed adnexal mass
- IUD in place (remove IUD before administering misoprostol)
- History of allergy to misoprostol or other prostaglandin

Precautions
1. Teratogenic effects in live births following failed abortion with misoprostol
According to animal model evidence, only one study involving rats has shown a teratogenic effect of misoprostol.

Sixty-nine cases of live births exhibiting anomalies after misoprostol exposure in utero have been reported. A review of these case reports reveals that the majority of the reported anomalies can be classified as pertaining to the central nervous system and the upper and lower limbs. The most frequent anomalies identified among all cases are equinovarus (clubfoot), followed by anomalies of cranial nerves VII, VI, V, and XII, and agenesis or absence of the fingers.

Three case-control studies conducted in human populations have consistently shown a higher prevalence of anomalies among misoprostol-exposed infants. However, the absolute risk of teratogenicity with misoprostol exposure appears low, on the order of 10 per 1000 exposed fetuses. In population–based registries, the observed incidence of anomalies does not appear to be high, even when misoprostol exposure is relatively frequent in the population.

2. Nursing mothers
Misoprostol is rapidly metabolized throughout the body. It is not known if the
active metabolite (misoprostol acid or misoprostol) is excreted in human milk, although almost all substances found in maternal serum are excreted in breast milk. Discarding breast milk for 24 hours after misoprostol administration may be prudent to avoid the potential occurrence of diarrhea among breastfed infants.

3. Gestational age beyond nine completed weeks LMP
There is insufficient evidence to recommend a regimen of misoprostol for abortions beyond nine completed weeks LMP. The regimen described here is inappropriate beyond the first trimester; the doses in this label are too high for use later in gestation (see Notes).

Effects and Side Effects
Prolonged or serious effects and side effects are rare.

1. Bleeding
Bleeding often starts within the first day, generally within an hour after taking misoprostol. Bleeding typically lasts 7 to 10 days with additional days of spotting that can last until the next menstrual period. Return to menses usually occurs 4 to 6 weeks after misoprostol administration. It is important to understand that bleeding alone does not indicate a successful abortion.

The woman should be instructed to contact the provider if any of the following occur: (1) if she soaks more than two maxi sanitary pads an hour for more than two consecutive hours, (2) if she stops bleeding and subsequently experiences a sudden onset of bleeding two weeks or longer after taking misoprostol, (3) if she has bled continuously for several weeks or begins to feel dizzy or light-headed, or (4) if no or scant bleeding has occurred by 7 days after misoprostol administration.

2. Cramping
Cramping usually starts within the first day and may begin as early as 30 minutes after misoprostol administration. The pain may be much stronger than that experienced during a regular period. Nonsteroidal anti-inflammatory drugs (NSAIDs) or other analgesia can be used for pain relief without affecting success of the method.

3. Fever and/or chills
Chills are common side effects of misoprostol but are transient. Fever is less common and does not necessarily indicate infection. If fever or chills persist beyond 24 hours after taking misoprostol, the woman may have an infection and should seek medical attention. An antipyretic can be used for relief of fever, if needed.

4. Nausea and vomiting
Nausea and vomiting may occur and will resolve 2 to 6 hours after taking misoprostol. An antiemetic can be used if needed.

5. Diarrhea
Diarrhea may also occur following administration of misoprostol and should disappear within a day.
Dosage and Administration
The recommended regimen for abortion induction with misoprostol in
pregnancies up to nine weeks LMP is 800mcg vaginal misoprostol, repeated after
24 hours (2 x 800 mcg).

Evidence indicates that wetting the tablets with a few drops of water after
vaginal insertion is likely to increase success with the method.

Notes:
• Misoprostol probably also works well when placed between the cheek and gum
  (buccally) or under the tongue (sublingually).
• Currently, there is insufficient evidence to recommend a specific regimen of
  misoprostol for late first trimester induction. As gestation increases and the
  uterus becomes more sensitive to misoprostol, the dose necessary to effect
  expulsion will decrease. However, with increasing gestation, both the time
  required to expel the pregnancy and the expected blood loss will be increased.

For a reference list of literature supporting this document or for more
information, refer to www.gynuity.org or www.rhtp.org.

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What is medication abortion?
Medication abortion is a safe way to end a pregnancy by taking certain medications. Medication abortion works to end a pregnancy up to 63 days (nine weeks) from the first day of your last menstrual period. The abortion is usually done with two medications: one called mifepristone (also known as RU-486) and one called misoprostol (the brand name is Cytotec®). In many countries, however, mifepristone is not available so misoprostol is commonly used alone for medication abortion. It is an alternative to methods commonly referred to as surgical abortion, which include vacuum aspiration, also known as suction abortion, and dilatation and curettage. Misoprostol used alone is not as effective, however, as the combination of mifepristone and misoprostol when used together or as vacuum aspiration.

How effective is misoprostol?
Depending on the duration of pregnancy, dosage and method of taking the pill, misoprostol is about 85–90% effective when used alone through 63 days (nine weeks) of pregnancy. For the 10–15% of cases in which the medication does not work, vacuum aspiration, preferably, must be used to complete the process in order to end the pregnancy.

How safe is medication abortion?
Medication abortion is very safe. Medication abortion has been used for more than 10 years by millions of women around the world. Complications are rare, but may include prolonged or heavy bleeding, failure to expel all of the pregnancy, or ongoing pregnancy. There have been no reports of long-term risks. Medication abortion will not affect your future fertility, your menstrual cycles or your sexual activity.

Why might a woman choose medication abortion?
Although vacuum aspiration is highly effective and safe, women may choose medication abortion because they may feel it offers privacy and resembles a natural process. It is a noninvasive procedure, free from the risk of injury to the uterus or cervix from the use of instruments, that requires only simple pain medications to ensure the woman’s comfort. Additionally, many women may simply not have the option to choose between types of abortion procedures or to choose the mifepristone with misoprostol combined regimen for medication abortion; thus, using misoprostol alone may be their only option.

How does misoprostol work?
Misoprostol causes the uterus to contract and the cervix to soften. The uterine contractions generally cause the detachment and expulsion of the pregnancy within a few hours or, in some cases, days after taking misoprostol.

How is misoprostol used?
To use misoprostol as described here, you must have an intrauterine pregnancy of less than nine completed weeks. It is suggested that your health-care provider reviews your medical history to be sure that you are eligible for medication abortion with misoprostol and explains the procedure. Your health-care provider will advise you to insert the misoprostol tablets vaginally or take them by mouth.
The tablets may be administered in the clinic or at home. Pain medicine will be prescribed to you. You must attend a follow-up visit within two weeks after using the medication for the provider to confirm that the abortion is complete and that there are no complications.

**Who can use misoprostol?**
The appropriateness of misoprostol depends on your clinical history and physical exam. Misoprostol should not be used if you have a pregnancy outside the uterus (an ectopic pregnancy), you have an intrauterine device (IUD) in place or you have certain medical conditions, such as severe anemia, cardiac disease, bleeding disorder, or allergy—such as itching or a rash—to misoprostol.

**What should I expect after taking the misoprostol tablets?**
Misoprostol produces cramps and vaginal bleeding, similar to but often heavier than a heavy menstrual period. Most women will experience cramping and vaginal bleeding anytime from one to four hours after taking the misoprostol tablets. The cramping can range from mild to very intense and can last for several hours as the pregnancy tissue is being expelled. Bleeding usually starts after the cramping and can range from light, with a few small clots, to very heavy, with several large clots. Bleeding or spotting may continue off and on for one to two weeks and may last as long as three to four weeks. Side effects include nausea, vomiting, diarrhea, headache, fever and chills. These effects, however, are usually mild and of short duration.

**How do I know if the abortion is complete?**
There is no simple answer because the abortion process is different for each woman. Cramping and bleeding, passage of clots and tissue, a lack of pregnancy symptoms and a negative pregnancy test 20–30 days after taking misoprostol usually indicate that the pregnancy has ended. These signs, however, do not always mean that the abortion is complete. A follow-up examination is strongly recommended to determine that the abortion is complete. Sometimes a provider will use ultrasound to confirm completion, but this is not required.

**Are there any warning signs of complications when having a medication abortion? What should I do if I experience them?**
You should call your health-care provider if you experience any of the following conditions: extremely heavy bleeding (two or more sanitary pads soaked per hour for two hours in a row); persistent severe pain that doesn’t respond to prescribed pain medications; an allergic reaction to the medication, such as itching, rash, or difficulty breathing; or a prolonged (more than a day) temperature above 38.5°C (100.4°F). Your health-care provider will answer any questions you may have and tell you how to manage any problems. Although these complications are rare, you may need to visit the health-care clinic to resolve them.

**What happens if the misoprostol is not effective?**
If the medication fails and there is an ongoing pregnancy, it is recommended that vacuum aspiration be performed because there is a slightly increased risk of birth defects associated with early pregnancies that have been exposed to misoprostol compared to those that have not. For this reason, you should not begin a medication abortion unless you are sure you want to end your pregnancy.

Occasionally, an ultrasound exam during your follow-up visit will show that, while the pregnancy is not continuing, the tissue was not completely expelled. In
this case, your health-care provider will recommend either waiting another one to two weeks for the pregnancy to be expelled, taking another dose of misoprostol, or completing the abortion through vacuum aspiration.

**Can I become pregnant again after I have a medication abortion?**
Yes. You can become pregnant again as soon as 10 days after undergoing medication abortion. If you don’t want to become pregnant again soon, contraception should be initiated promptly. Fertility awareness methods, also known as “natural family planning,” should not be used without a back-up method until you have had three normal menstrual cycles since the abortion.

**When will I get my period?**
Medication abortion begins a new menstrual cycle. You should have a regular period four to eight weeks after your pregnancy ends.

**When can I have sex again?**
You can have sex again when you feel comfortable doing so, but if you want to avoid pregnancy right away, you must use effective contraception.

Misoprostol should only be used under medical supervision to avoid possible risks and complications.

If you have any questions or concerns, discuss them with your health-care provider.
Complications

Key Topics in This Module:

- Signs and symptoms of abortion complications
- Steps to diagnose, manage or refer complications
- Key principles of after-care

1.0 Introduction

When performed by a trained provider, abortion procedures rarely result in immediate or long-term complications. In many cases, complications can be avoided by accurately estimating the duration of the pregnancy. It is important, however, to be prepared to diagnose complications and provide treatment quickly and safely—or make appropriate referrals—if and when they do occur. Complications can occur during the abortion procedure, in the recovery period or later, or at a combination of these times, and facilities must have an established protocol that addresses them. In most cases, complications associated with abortion can be managed successfully if appropriate treatment is initiated promptly. Serious complications are rare, and can usually be treated effectively by a trained clinician providing general emergency medical and surgical care. If such emergency facilities are not available on site, complications should be managed through the timely transfer of the woman to an acute-care facility.

This module presents information on the most common complications that can occur during or after a first-trimester induced abortion, as well as their accompanying signs and symptoms.

Women may also present with pregnancy-related or gynecologic complications—such as molar pregnancy, ectopic pregnancy or uterine abnormalities—that require specific clinical consideration and management. However, such complicating conditions are often discovered during the clinical-assessment phase of client care and can be addressed before the procedure is performed. (For more information on ectopic pregnancy and other complicating conditions, refer to the Clinical Assessment and Medication Abortion modules.)

2.0 Complications of Vacuum Aspiration

Vacuum aspiration is an extremely safe procedure with only rare complications. Those complications that do occasionally occur are: retained products of conception (POC); infection; continuing pregnancy; uterine atony; cervical, uterine, and abdominal injuries; medication-related complications; hematometra; and vasovagal reaction.

2.1 Retained POC and Infection

Retained POC are decidua and fetal tissue that have remained in the uterus after a spontaneous or induced abortion. Large amounts of retained POC can result in heavy bleeding and infection if untreated. If only small amounts of tissue are retained, it is

Complications of Unsafe Abortion

Severe complications, such as shock and sepsis, occur more frequently in environments where unsafe abortions are common and where contraceptive services and safe abortion care are lacking. Retained products of conception (POC) often contribute to these complications, causing bleeding, infection and pain. Uterine evacuation is usually required for women presenting with retained POC. In cases of shock and other life-threatening conditions, complete clinical assessment and voluntary informed consent may be deferred until immediate actions have been taken to save the woman’s life. Once the woman is stabilized, the provider should make a complete clinical assessment and obtain her voluntary informed consent for continuing treatment. This type of situation, often referred to as postabortion care (PAC), is described in more detail in the Ipas curriculum Woman-Centered Postabortion Care: Reference Manual. When treating a woman with PAC complications, refer to the Management of Complications module in that manual.
possible that they may pass spontaneously without requiring further intervention. Close monitoring until the retained products are expelled may be sufficient. Otherwise, treatment involves evacuation of the uterus, preferably using vacuum aspiration. Note that some women with retained POC may be asymptomatic.

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

**Signs and Symptoms**

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

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

### 2.2 Continuing Pregnancy

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

**Signs and Symptoms**

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

### 2.3 Uterine Atony

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

- Copious vaginal bleeding
- Large, soft, boggy uterus

2.4 Cervical, Uterine and Abdominal Injuries

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

Signs and Symptoms

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

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

2.5 Medication-Related Complications

Although medications are widely used in a safe and effective manner for abortion care, there are potential complications associated with their use. Complications can be caused by overdosage, intravascular injections or a hypersensitivity reaction. General anesthesia during vacuum aspiration has been shown in some settings to produce increased risk of complications as compared to local anesthesia (Thonneau et al., 1998). Treatment for anesthesia- and other medicine-related complications may include using reversal agents, treating respiratory and cardiac depression and stabilizing convulsions.

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

2.6 Hematometra

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

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

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

3.0 Complications of Medication Abortion

Medication abortion results in few serious complications. Those that do occasionally occur are persistent gestational sac, continuing pregnancy, hemorrhage, infection and undiagnosed ectopic pregnancy.

3.1 Persistent Gestational Sac

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

3.2 Continuing Pregnancy

The continuation of a pregnancy is uncommon in women using mifepristone and misoprostol up to 63 days (9 weeks) since the last menstrual period (LMP). Continuing pregnancy is more likely in women who use misoprostol alone. In this case, the abortion must be completed, preferably using vacuum aspiration.
3.3 Hemorrhage
Providers must have clearly documented procedures for assessing and managing abnormally heavy bleeding. Acute hemorrhage associated with medication abortion—assuming there is no physical trauma to the pelvic organs—is likely to require vacuum aspiration along with fluid replacement and, in some instances, transfusion.

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

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

4.0 Rarer Complications
Safe abortion does not cause future infertility, preterm delivery, breast cancer or severe psychological reactions (RCOG, 2004; National Cancer Institute, 2003; ACOG Committee, 2003; Adler, 1990).

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

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

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

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

Full provisions for treatment of all potential complications of induced abortion are not necessary for a health-care site to provide abortion services; however, providers of abortion services must be able to identify complications and to make any necessary referrals in a timely manner. Referral plans and protocols should be established at all health facilities. A written referral plan must be carefully constructed and should safely and smoothly navigate the woman through the appropriate levels of care, from the primary level up to the highest-level site that can treat her appropriately. Prompt communication and rapid transfer is essential within the facility and between facilities. (See Appendix F: Sample Clinical Referral Forms in the MVA for Uterine Evaluation module.)

Urgent referral and transport of the woman may be necessary at any time, and clinic staff should be prepared to make any needed arrangements 24 hours a day. Because a woman’s life can be saved if she is immediately transported to an emergency-care facility for treatment of serious complications, it is essential to consider all available means and community resources for transportation. These may include police cars, agency vehicles, health-care workers’ cars, residents’ cars and taxis. If applicable, providers should make all possible efforts to control excessive bleeding prior to transport.

Providers should also be prepared to stabilize a woman for transport by:
- Managing her airway and breathing
- Providing intravenous fluid replacement
- Controlling pain
- Ideally, controlling bleeding

6.0 After-Care

During after-care following abortion complications, the woman must be:
- Physically monitored and emotionally supported, with a focus on her individual medical needs determined by the nature of her complications
- Advised about her condition, including use of medications and contraceptive methods, and any follow-up care needed
- Counseled about any long-term changes resulting from the complications and their treatment—for example, post-hysterectomy or bowel-perforation repair
- Told what to expect and what to be concerned about, as well as what to do and not do in emergency situations
- Given written or illustrated materials about her condition

(For more information, see the Counseling and Contraceptive Services modules.)

7.0 Summary

- Abortion procedures rarely result in immediate or long-term complications when performed by well-trained providers.
- Members of the health-care staff must recognize and be able to treat—or make the appropriate referral for—any complications that might occur during the abortion, in the recovery period or later.
- Retained POC can occur after a vacuum-aspiration or medication abortion and
can be resolved by evacuation of the uterus, preferably with vacuum aspiration.

- Retained POC is often indicated by vaginal bleeding, pain and inadequate amounts of tissue according to the duration of pregnancy. If left untreated, retained POC can lead to infection.

- Continuing pregnancy, or failed abortion, requires uterine aspiration to terminate the pregnancy.

- Uterine atony is a condition that can occur when the uterus cannot contract to stop bleeding; it can usually be treated through uterine massage and the use of uterotonic.

- Uterine injury including perforations and cervical lacerations, as well as intra-abdominal injury, are rare in safe induced-abortion settings with vacuum aspiration, but do occasionally occur.

- Medication-related complications can occur from overdosage, incorrect injection or hypersensitivity.

- Vasovagal reaction occurs rarely during vacuum aspiration and will usually resolve itself.

- Complications of medication abortion are rare, but include heavy bleeding, retained POC, and continuing pregnancy.

- It may be necessary to refer women to another facility if life-threatening complications or pre-existing conditions require additional resources.

- Women with abortion complications must be closely monitored, informed about necessary follow-up care and counseled on any medical and emotional consequences.

**Additional Resources**


**Bibliography**


Woman-Centered Abortion Care: Glossary

0.5% chlorine solution: A chlorine-type (sodium hypochlorite) bleach solution that is used as a disinfectant for clinical equipment and instruments and for cleaning the environment; it inactivates some, but not all, microorganisms.

Acute hematometra: An accumulation of blood in the uterine cavity that occasionally occurs after a uterine evacuation procedure.

Aseptic technique: A general term used in health-care settings to describe the combination of efforts made to prevent entry of microorganisms into any area of the body where they are likely to cause infection. The goal of aseptic technique is to reduce to eliminate or reduce to a safe level the number of microorganisms on both living surfaces (skin and tissue) and non-living objects (surgical instruments, equipment and the clinic environment).

Asymptomatic: Without symptoms; for example, an infection without symptoms.

Back-up method of contraception: Any method of contraception that is used concurrently with another method of contraception in case the first method should fail.

Barrier methods: Methods of contraception that prevent pregnancy by physically impeding the sperm from passing beyond the cervix. Some of these methods can also provide protection against certain sexually transmitted infections (STIs). Typical barrier methods include condoms, diaphragms and dental dams.

Cognitive disabilities: Cognitive disabilities include mental retardation and other developmental disabilities such as autism, severe and persistent mental illness, traumatic brain injury (TBI), stroke and Alzheimer’s disease. Cognitive disability entails sub-average intellectual performance and limitations in adaptive behavior and can originate at any time.

Complete clinical assessment: Information taken by the health-care provider(s) which includes physical examination of the client, review of the client’s medical and surgical history, psychosocial assessment, and laboratory and radiological testing.

Contraceptive counseling: Talking and listening to a woman about her needs and desires regarding pregnancy to help her determine whether she needs a contraceptive method and, if so, choose the most suitable method for her situation. Also known as family-planning counseling.

Contraceptive services: The provision of contraceptives, appropriate to one’s needs and lifestyle, by medical personnel. Also known as family-planning services.

Contraindication: Any factor in a client’s condition that renders a particular course of treatment undesirable or improper.

Deinfibulation: A medical procedure whereby a woman who has been infibulated has the opening to her vagina restored.
Emotional support: Gentle, caring assistance to allay one’s fears or negative feelings. Emotional support can be physical, such as holding a person’s hand, or verbal, such as using reassuring or encouraging words.

Endospores: Bacteria with a hard outer coating which are difficult to destroy.

Environmental cleanliness: Hygienic physical surroundings. Everything in a clinical setting, including patients, instruments and equipment, should be kept clean and dry; workers will be touching clinic surfaces and clients, which can spread infection.

Family-planning services: Another term for contraceptive services. Contraceptives and family planning help men and women control their own fertility by preventing or spacing pregnancies.

Female genital cutting (FGC): A term used to refer to any practice that includes the removal or the alteration of the female genitalia for cultural and other non-therapeutic reasons. Also known as female genital mutilation, female circumcision and, in some forms, infibulation.

Fertility goals: The number of children one would like to have and the spacing of those children.

GATHER technique: Used widely in family-planning counseling, this acronym stands for Greet, Ask, Tell, Help, Explain and Refer.

Gender: Widely shared ideas and expectations regarding appropriate identities, appearances, behaviors and roles of women and men. These ideas and expectations often vary from culture to culture and are largely shaped by societal values.

High-level disinfection (HLD): A process that inactivates most, but not all, disease-causing microorganisms on inanimate objects. High-level disinfection through boiling or the use of some chemicals inactivates all microorganisms except some bacterial endospores.

Human chorionic gonadotropin (hCG): A hormone produced early in pregnancy by the placenta; its detection in urine is the basis for one kind of pregnancy test.

Human right: Any basic right or freedom to which all human beings are entitled and in whose exercise a government may not interfere.

Hydatidiform mole: An abnormality during pregnancy in which chorionic villi grow in grapelike clusters around the embryo; usually associated with the degeneration of the embryo.

Indicator: A quantitative measure for monitoring any aspect of a process or outcome.

Infertility: For females, the diminished ability or the inability to conceive or bear children; for males, the diminished ability or the inability to impregnate a female.

Infibulation: Also known as pharaonic circumcision, the procedure consists of clitoridectomy (partial or complete removal of clitoris), excision (partial or complete removal of labia minora), and cutting of the labia majora to create raw surfaces, which are then stitched or held together to form a cover over the vagina when they heal. A small hole is left to allow urine and menstrual blood to
escape. In some less conventional forms of infibulation, less tissue is removed and a larger opening remains.

**Instrument processing:** The removal of microorganisms from instruments to make them safe for use on clients.

**Intrauterine device (IUD):** A contraceptive device consisting of a plastic or metal loop, ring or spiral that is inserted through the vagina into the uterus to prevent implantation of a fertilized egg.

**Intrauterine system (IUS):** A contraceptive method consisting of an intracervical or intrauterine device (IUD) that also releases hormones.

**Laparotomy:** An operation to open the abdomen.

**Lytotomy position:** The posture assumed by the client lying supine with the hips and the knees flexed and the thighs abducted and rotated externally; also called dorsosacral position.

**Male contraceptive methods:** Methods that men can use to prevent impregnating a woman; condoms are the most commonly used male contraceptives.

**Microorganism:** An organism of microscopic or submicroscopic size, especially a bacterium or protozoan.

**Modern methods of contraception:** Contraceptive methods that are scientifically developed and proven to be sound and effective.

**Monitoring:** The routine tracking of health-care services in order to provide feedback for ongoing quality improvement.

**Multiparous:** Delivering two or more offspring at one birth.

**Nonconsensual sex:** A sexual act where one of the partners has not given his or her consent to participate.

**No-touch technique:** Aseptic technique used during a medical procedure that involves keeping processed instruments that will enter the body from touching any contaminated surface. In uterine evacuation, it means avoiding the vaginal walls when handling the intrauterine instruments used for the procedure.

**Pain management:** Using drugs, psychological support and other means to decrease a client’s reaction to pain. Studies have shown that clients who are scared or nervous are more likely to experience greater levels of pain during an abortion procedure than those whose fears or concerns have been allayed.

**Parity:** The classification of a woman by the number of live-born children as well as the number of stillbirths she has delivered at more than 20 weeks of gestation.

**Pathogen:** An agent that causes disease, especially a living microorganism such as a bacterium or fungus.

**Peer counseling:** Counseling performed by those who are considered equal, in some respect, to the person who is being counseled.

**Perineal area:** The portion of the body in the pelvis occupied by urogenital passages and the rectum, bounded in front by the pubic arch, in the back by the
coccyx, and laterally by part of the hipbone; between the posterior vulva junction and the anus in females.

**Personal protective barriers:** Gowns, gloves and face protection used to keep the exchange of germs and pathogens to a minimum.

**Postabortion care (PAC):** A series of medical and related interventions designed to manage incomplete abortion and its ensuing complications.

**Psychosocial assessment:** Part of the complete clinical assessment, the psychosocial assessment explores, through an interview with the client, relevant aspects of her work, family life, social history and future plans, as well as her feelings about any of those issues, usually in the context of her current condition.

**Quality of care:** The degree of conformity with accepted principles and practices (standards), the degree of fitness for the woman’s needs, and the degree of attainment for achievable outcomes (results), consonant with the appropriate allocation or use of resources.

**Secondary infertility:** This term is used when a woman who has previously been able to conceive is not able to conceive again, regardless of whether she carried the first pregnancy to term.

**Sexual health:** The health of one’s physical reproductive system, as well as the ability to express sexuality in psychologically healthy ways.

**Sharps-disposal containers:** Containers that are specially designed to hold used sharps until they can be permanently discarded.

**Sharps:** Medical slang for needles or similar pointed objects that can penetrate skin.

**Steam sterilize/autoclave:** A chamber for sterilizing with steam under pressure. The original autoclave was essentially a pressure cooker.

**Sterilize:** To make free from live bacteria or other microorganisms.

**Sustainability:** The capacity to meet the needs of the present without compromising the ability to meet future needs.

**Temporary methods of contraception:** Most contraceptive methods are temporary, with the exceptions of male and female sterilization, which are permanent. Temporary methods can range from those that are effective for only a single act of sexual intercourse, such as male or female condoms, to long-lasting but reversible methods, such as intrauterine devices (IUDs).

**Teratogenic:** Able to disturb the growth or development of the fetus or embryo. Teratogens may halt a pregnancy outright or cause a birth defect in the child.

**Tools:** Programs, forms or other items that are utilized in assessing, evaluating or collecting information.

**Universal/standard precautions:** Infection-control measures, such as handwashing and the use of personal protective barriers, that are designed to block transmission of potential infection. Universal/standard precautions apply to blood, all body fluids, secretions and excretions, except sweat (regardless of whether they contain visible blood), non-intact skin, and mucous membranes.
Unsafe abortion: An abortion that is performed either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both.

Utility gloves: Rubber surgical gloves that are worn for infection prevention when processing instruments.

Vagal reaction: Also known as vasovagal syncope, it is a transient reaction marked by pallor, nausea, sweating, bradycardia, and rapid fall in blood pressure that can result in loss of consciousness; it is often evoked by stress associated with fear or pain.

Verbal support: Caring, spoken encouragement to ease one’s fears or negative feelings.

Violence against women: Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Well-woman check-ups: Visits to a medical provider that prevent or screen for future illness or disease, as well as maintaining the woman’s current well-being.

Bibliography


Ipas works globally to increase women’s ability to exercise their sexual and reproductive rights and to reduce abortion-related deaths and injuries. We seek to expand the availability, quality and sustainability of abortion and related reproductive-health services, as well as to improve the enabling environment. Ipas believes that no woman should have to risk her life or health because she lacks safe reproductive-health choices.