Government of the People's Republic of Bangladesh

Woman-Centered Menstrual Regulation and Postabortion Care Services

Reference Manual

Ministry of Health and Family Welfare
Directorate General of Health Services
Directorate General of Family Planning
Directorate General of Nursing and Midwifery

Published on

First Edition January 2013
Second Edition March 2016
Third Edition June 2021

Published by

Ipas Bangladesh
Bangladesh Country Office
House # 438
Road # 30, DOHS, Mohakhali
Dhaka-1206, Bangladesh

Cover Design and Photography

MMMA Zakaria

Printed by

Dot Net Limited
51-51/A, Purana Paltan
Level # 3, Dhaka-1000
Cell : 01711-624248

ISBN 978-984-90494-1-8

Woman-Centered MR and Postabortion Care Services

Acknowledgments - Third edition, 2021

Technical Reviewers:

Dr. Sharmin Sultana, Senior Advisor, Training and Health Systems,Ipas Bangladesh

Dr. Mohd. Abul Khair, Senior Advisor -Health Systems, Ipas Bangladesh

Dr. Hamida Khatun, Advisor, Health Systems,Ipas Bangladesh

Dr. Sadia Afroze, Clinical Trainer, RHSTEP

Dr. Rejuana Rahman, Clinical Trainer, RHSTEP

Dr. Zulekha Akhter, Quality Assuarance Officer, RHSTEP

Prof. Alison Edelman, Senior Clinical Advisor, QoC, Ipas

Shadie Tofigh, Senior Technical Advisor, QoC, Ipas

Curriculum Review Committee members, 2021

Dr. Tahmina Sultana, Director (PHC & ITHC), DGHS

Dr. Md. Yunus, Director, Chief Monitoring, Coordination & Covid unit

Prof. Md. Nazmul Islam, Director (Disease Control), LD (CDC), DGHS

Dr. Farid Hossain Miah, Director Hospital, DGHS

Md. Abdul Aziz, Chief BHE, DGHS

Dr. Mahmuda Begum, Deputy Director, PHC, DGHS

Dr. Md. Harun-or-Rashid, Deputy Director (Audit), DGHS

Dr. Md. Shamsur Rahman, Deputy Director (Planning & Research), DGHS

Dr. Md. Dulal Hossain, Assistant Director (PHC), DGHS

Dr. Fatema Karim, Medical Officer, CSIC

Acknowledgments – Second edition, 2016

Technical reviewers:

(Not according to seniority)
Prof. Alison Edelman, Senior Clinical Consultant, Ipas

Prof. Shahanara Chowdhury, Head of Department of Obstetrics and Gynaecology, Chittagong Medical College and Hospital

Prof. Iffat Ara, Organizing Secretary, Obstetrical & Gynaecological Society of Bangladesh

Dr. Sharmin Sultana, Senior Advisor, Training & Health Systems, Ipas Bangladesh

Dr. Shamila Nahar, Senior Advisor, Training & Health Systems, Ipas Bangladesh

Dr. Hamida Khatun, Advisor, Training & Health Systems, Ipas Bangladesh

Sara Dunbar, Asia Regional Health System Advisor, Ipas Chapel Hill, North Carolina, USA

Lea Jones, Asia Regional Advisor, Youth Program, Ipas Chapel Hill, North Carolina,USA

Acknowledgments – First edition, 2013

Dr. Seerat Nasir, Ipas Bangladesh

Dr. Sharmin Sultana, Ipas Bangladesh

Dr. Kamal Kanti Biswas, Ipas Bangladesh

Dr. Shamila Nahar, Ipas Bangladesh

Arabinda Biswas, Ipas Bangladesh

Rezwana Chowdhury, Ipas Bangladesh

We give special thanks to the colleagues who reviewed the first edition: 2013

(Not according to seniority)

Prof. Dr. Md. Ismail Khan Head of the Department of Pharmacology& Vice Principal, Dhaka Medical College and Dean, Faculty of Medicine Dhaka University	**Dr. Jahirul Karim** Former Training Specialist, IST, DGHS
Prof. Dr. Redwanur Rahman Head of the Department of Medicine Shaheed Suhrawardy Medical College & Hospital	**Dr. Yasmin Rahman** Senior Consultant, Model Family Planning Clinic Dhaka Medical College &Hospital
Dr. Md. Abul Monsur Khan Former Director - Planning & Research, DGHS	**Dr. Amir Hossain Rahat** Former Deputy Program Manager IST (Local Training), DGHS
Dr. Md. Abdul Hoque Former Deputy Director (PHC) & Program Manager (MNH), DGHS	**Dr. Azizul Alim** Deputy Program Manager EOC-PHC, DGHS
Dr. Paresh Chandra Sarkar Assistant Professor & Head of the Dept. of Anesthesiology Sir Salimullah Medical College & Mitford Hospital	**Dr. Md. Muniruzzaman Siddique** Director, Mohammadpur Fertility Services & Training Center
Dr. Tapash Ranjan Das Former Deputy Director, MCH Services, DGFP	**Dr. Chinmoy Kanti das** Former Assistant Coordinator Training & Research Maternal and Child Health Training Institute
Dr. Farid Uddin Ahmed Assistant Director, MCH Services, DGFP	**Dr. Gias Uddin** Former Deputy Director, MCH Services, DGFP
Dr. Ishrat Jahan Former Program Manager (ARH), DGFP	**Prof. Ferdousi Islam** Head of the Department of Obstetrics and Gynaecology, Dhaka Medical College & Hospital
Dr. Md. Jaynal Haque Assistant Director, MCH Services, DGFP	**Prof. Iffat Ara** Organizing Secretary, OGSB
Dr. Rezaul Karim Former Assistant Director, MCH Services, DGFP	**Ms. Taslima Begum** Former Director, Directorate of Nursing Services
Dr. Fahmida Sultana Deputy Director, MCH Services, DGFP	**Ms. Shuriya Begum** Registrar Bangladesh Nursing Council
Dr. Md. Shamsul Karim Former Assistant Director, MCH Services, DGFP	**Dr. Mobarak Hossain Khan** General Manager, Marie Stopes Bangladesh
Prof. Kohinoor Begum Past President, OGSB	**Dr. Altaf Hossain** Director, BAPSA
Prof. Latifa Shamsuddin Past President, OGSB	**Dr. Nilufar Begum** Training Coordinator, BAPSA
Prof. Nasima Begum Past General Secretary, OGSB	**Dr. Nasrin Khairunnessa** Former Program Coordinator, RHSTEP-Ipas Project

We give thanks to the colleagues who reviewed the second edition: 2016

(Not according to seniority)

Prof. Iffat Ara Organizing Secretary, OGSB	**Prof. Rowshan Ara Begum** President, OGSB
Prof. Shahanara Chowdhury Head of Department of Obstetrics and Gynaecology Chittagong Medical College and Hospital	**Dr. Md. Atiar Rahman** Assistant Director, PHC, DGHS
Prof. Ferdousi Islam Head of the Department of Obstetrics and Gynaecology Dhaka Medical College and Hospital	**Dr. Md. Ali Zulkawsar** Assistant Director, MCH Services, DGFP
Dr. Pabitra Kumar Sikder Deputy Director (PHC) &Program Manager (MNH), DGHS	**Ms. Shuriya Begum** Registrar, Bangladesh Nursing Council
Dr. Md. Shahzahan Assistant Director, Private Clinics & Medical Board (MBPC) DGHS	**Dr. A. F. Shahabuddin Khan** Deputy Project Manager, IST, DGHS
Dr. Rawshan Ara Project Manager (NCMT), IST, DGHS	**Dr. Nilufar Begum** Training Coordinator, (BAPSA)
Dr. Md. Billal Hossain Deputy Program Manager, IST (Local Training), DGHS	**Dr. Anjuman Ara** Project Manager, RHSTEP-Ipas Project
Dr. Rashidun Nessa Director Planning& Line Director (PMR), DGHS	**Dr.Ferdausee Haque** Deputy Director,Medical Education, DGHS
Dr. Rouseli Haq Deputy Director, Medical Education, DGHS	**A.B. Siddique** Training Specialist, In-service Training (IST) DGHS
Dr. Md. Abdul Ghani Deputy Director & Program Manager (Admin & Finance), IST DGHS	

Reference Manual

Ipas Bangladesh supports the Directorate General of Health Services and Directorate General of Family Planning in the drive to improve maternal health in Bangladesh in order to reduce maternal mortality and morbidity. The main purpose of the Ipas Bangladesh program is to ensure the provision of high quality comprehensive menstrual regulation and Postabortion Care services that are accessible to all women in Bangladesh regardless of their socio-economic status. For more information on Ipas Bangladesh program nd publications, please contact:

House # 438, Road # 30
New DOHS, Mohakhali,
Dhaka-1206, Bangladesh
www.ipas.org

Printed in Bangladesh

This manual was adapted from:
Ipas. (2013). Woman-Centered, Comprehensive Postabortion Care: Reference Manual (Second Ed.) K. L. Turner & A. Huber (Eds.), Chapel Hill, NC: Ipas.
Ipas. (2013). Woman-Centered, Comprehensive abortion Care: Reference Manual (Second Ed.) K. L. Turner & A. Huber (Eds.), Chapel Hill, NC: Ipas.
Ipas. (2020). *Clinical Updates in Reproductive Health.* L. Castleman & N. Kapp (Eds.). Chapel Hill, NC: Ipas.

Director General
Directorate General of Health Services
Ministry of Health and Family Welfare
Peoples Republic of Bangladesh

MESSAGE

During the last few years, the government of Bangladesh has intensified its effort to improve the effectiveness of the public health sector. There has been a special emphasis with comprehensive approaches to provide all components of Reproductive Health (RH) through public health systems. However, we still need to intensify our efforts to increase access, availability, and quality of reproductive health services, especially at the peripheral levels to achieve our SDG commitments of ending preventable maternal deaths.

Seven percent of all maternal deaths of the country occurs due to complications of unsafe abortions which can be prevented by providing quality Menstrual Regulation (MR) and Postabortion Care (PAC) services. MR services are approved and available in Bangladesh in the union and above level public health facilities, but due to unavailability of trained providers and social stigma around 1.2 million women in Bangladesh seek services outside health facility and put their health at risk every year by having an unsafe abortion.

It is essential to reduce the incidence of unwanted pregnancies and unsafe abortions in Bangladesh by ensuring access to quality MR, PAC and family planning services. To meet this goal, training of the service providers – doctors, midwifes, nurses, FWVs, paramedics and SACMOs on comprehensive MR, PAC and FP services is a prerequisite. For a successful training, a standard Reference Manual is very important.

I would like to share my appreciation to all the relevant officials of DGHS, DGFP and DGNM for the joint initiative to update the "Reference Manual for Woman-Centered Menstrual Regulation and Postabortion Care Services". This manual provides guidance to health care personnel on improving the quality of care available to women and adolescent seeking MR and PAC services. I would also like to acknowledge the valuable contributions of academicians, scientists, obstetricians, public health experts and officials from DGHS, DGFP, DGNM, OGSB and development partners who worked hard for updating this manual. I also express my heartiest thanks to Ipas Bangladesh for providing technical support in developing this manual.

I believe that this Reference Manual will be utilized at its optimum to serve the women and will contribute to achieve SDG 3 by reducing maternal mortality and morbidity and by ensuring universal access to sexual and reproductive health care services.

Prof. Dr. Abul Bashar Mohammad Khurshid Alam

Director General (Grade-1)
Directorate General of Family Planning
Ministry of Health and Family Welfare
Peoples Republic of Bangladesh

MESSAGE

Bangladesh has made significant progress in sexual and reproductive health over the last decades. Bangladesh is committed to achieve the sustainable development goals (SDGs). We are particularly working to achieve SDG 3 by the year 2030 that includes reduce the maternal mortality ratio to less than 70 per 100,000 live births (SDG target 3.1) and ensure universal access to sexual and reproductive health care services including family planning (SDG target 3.7). Providing quality Family Planning, Menstrual Regulation (MR) and Postabortion Care (PAC) services are the critical elements for preventing maternal mortality and morbidity.

Unsafe abortion is one of the major causes of maternal mortality which can be prevented by ensuring availability and access of quality MR, PAC and Family Planning services. Menstrual Regulation (MR) services was introduced in Bangladesh in 1974 and have been part of the national family planning program since 1979. However, even after several decades of introduction of the MR services in the national program estimated 27% of women seeking MR services are turned away from service facilities (2014). These women usually end up seeking care from untrained providers, undergo unsafe abortion in unhygienic conditions and suffer from complications which sometimes lead to death or disability.

The risk of unwanted pregnancy and unsafe abortion can be reduced only if women have access to information and services of family planning, menstrual regulation and postabortion care. To make MR and PAC services available in health facilities, presence of trained provider is a precondition. Availability of Reference Manual on MR and PAC services is crucial to ensure standard training for providers as per national guidelines.

I would like to share my appreciation to all the relevant officials of DGHS, DGFP and DGNM for the joint initiative to update the “Reference Manual for Woman-Centered Menstrual Regulation and Postabortion Care Services”. This manual provides guidance to health care personnel on improving the quality of MR and PAC services. I would also like to express my heartiest thanks for the valuable contributions of all relevant academicians, clinicians, public health experts and officials from DGHS, DGFP, DGNM, OGSB and development partners who worked hard for updating this manual. I also express my deepest thanks to Ipas Bangladesh for providing technical support in developing this manual.

I wish the successful implementation of this Reference Manual across the country to serve the women. I hope this manual will contribute to help Bangladesh on its way towards to achieve SDG 3 by reducing maternal mortality and morbidity and by ensuring universal access to sexual and reproductive health care services.

Shahan Ara Banu, ndc

Director General
Additional Secretary
Directorate General of Nursing and Midwifery
Ministry of Health and Family Welfare
Peoples Republic of Bangladesh

MESSAGE

Unsafe abortion is one of the common causes of maternal mortality and providing abortion services from a trained provider can save women lives. One of the common causes of maternal mortality is unsafe abortions and providing abortion services from a trained provider can save women lives. To ensure the quality Menstrual Regulation (MR) and Postabortion Care (PAC) services, policy and programmatic actions are needed to increase the availability of and access to MR and PAC services. Treatment for postabortion complications is also important to be addressed. If the strategies will include additional number of training for midlevel providers in the facility level the accessibility of MR & PAC services will be increased also. Dissemination of information about the MR program at the community level and the availability of trained providers in the facilities will increase the accessibility of MR & PAC services.

This Reference Manual will be a helpful tool for the service providers to provide safe and quality MR and PAC services. This will help to the reduction of maternal mortality and morbidity due to unsafe abortion in Bangladesh.

I appreciate the role of Ipas Bangladesh in the development and updating of the Reference Manual for Safe MR and Postabortion Care. My gratefulness is also to all honorable technical team members who were engaged in development and updating of this Reference Manual, which included obstetricians, clinicians, public health experts and officials from DGHS, DGFP, DGNM and other development partners. I am thankful to OGSB for their enormous contribution. I am confident that this Reference Manual will be well taken by the users and contribute significantly to access comprehensive abortion care.

I do believe that the “Reference Manual on Woman-Centered Menstrual Regulation and Postabortion Care” will increase the capacity of service providers in providing quality MR & PAC services, which will increase access of women and girls to safe menstrual regulation services and post abortion care.

Siddika Akter

Director (PHC & ITHC)
Directorate General of Health Services
Ministry of Health and Family Welfare
Peoples Republic of Bangladesh

MESSAGE

Bangladesh is committed to achieve the sustainable development goals (SDGs) and with that objective Directorate General of Health Services (DGHS) is working hard for reducing maternal mortality ratio to less than 70 per 100,000 live births (SDG target 3.1) and ensure universal access to sexual and reproductive health care services including family planning (SDG target 3.7). In Bangladesh 7 % of all maternal deaths are due to complication of unsafe abortion. Providing quality Family Planning, Menstrual Regulation (MR) and Postabortion Care (PAC) services are the critical elements for preventing maternal mortality and morbidity by averting unsafe abortion.

The 'Reference Manual for Woman-Centered Menstrual Regulation and Postabortion Care Services' has been developed to equip the trainers and the service providers with the updated evidence, knowledge and skills of provision of quality MR and PAC services. This is an important milestone for ensuring quality MR and PAC services in the country.

I am thankful to all my colleagues of the Directorate General of Health Services, Directorate General of Family Planning, Directorate General of Nursing & Midwifery, Clinicians and experts of Obstetrical & Gynecological Society of Bangladesh (OGSB) and other stakeholders for their enormous support and meaningful contribution.

I would like to appreciate and acknowledge the contribution of Ipas Bangladesh who came forward to develop and update this time-demanding manual with an objective to reduce maternal mortality and morbidity by averting unsafe abortion.

I earnestly hope that the relevant trainers and health service providers will utilize this resource to update their knowledge and skill and thus contribute to ensure availability and access of high-quality MR and PAC services at all levels of health care services.

Dr. Tahmina Sultana

Director (MCH) & Line Director (MC-RAH)
Directorate General of Family Planning
Ministry of Health and Family Welfare
Peoples Republic of Bangladesh

MESSAGE

Bangladesh has made noteworthy progress in reproductive health sectors and Ministry of Health and Family Welfare has undertaken many initiatives for measures to reduce maternal mortality. The total fertility rate (TFR) decreased and contraceptive prevalence rate (CPR) increased significantly but still there is concern on the progress for SDG 3 to achieve maternal mortality ratio to less than 70 per 100,000 live births by the year 2030. In Bangladesh, unsafe abortions which is one of the preventable causes still contribute seven percent of maternal death. By ensuring availability and access of quality MR, PAC and Family Planning services this can be prevented.

The Directorate General of family Planning is the forefront of the implementation of Sexual and reproductive health services. DGFP envisages this Reference Manual as a suitable and need based document for the relevant providers in delivering high quality services quality MR and PAC services available in health facilities.

“Reference Manual for Woman-Centered Menstrual Regulation and Postabortion Care Services” is a dynamic document and has been updated recently considering professional recommendations and best practices. This Reference Manual should be disseminated widely among all concerned for effective implementation of the comprehensive MR and Postabortion Care services.

I would like to express our sincere gratitude to all experts from the Obstetrical & Gynecological Society of Bangladesh (OGSB), DGHS, DGFP and other relevant stakeholders who contributed their valuable effort to update this Reference Manual. My special thanks to Ipas for providing all their technical support during the whole development process and printing of the manual.

We hope that this manual will not only serve for the current intervention areas, also would be used as national technical standard for MR and PAC services in both public and private sector health care settings.

Dr. Mohammed Sharif

Line Director (MNCA&H)
Directorate General of Health Services
Ministry of Health and Family Welfare
Peoples Republic of Bangladesh

MESSAGE

Maternal health is one of the most important indicators to achieve the SDG goal which includes reduction of maternal mortality to reach to below 70 per 1,00,000 live births. Recognizing the fact that unsafe abortion is one of the major concerns in Bangladesh which contributes 7 % of all maternal deaths due to complications of unsafe abortion services in the public and private sector health facilities. Providing quality menstrual regulation (MR), postabortion care (PAC) and family planning services are the important elements for preventing maternal mortality and morbidity by preventing unsafe abortion.

This "Reference Manual for Woman-Centered Menstrual Regulation and Postabortion Care Services" will improve service provider skills and ensure women-centered comprehensive MR, PAC &Family Planning services. This will serve as a major steppingstone on the path in achieving universal access to quality MR and PAC to all women irrespective of their socio-economic condition or geographical locations.

I would like to express my sincere gratitude to the members of the Directorate General of Health Services, Directorate General of Family Planning, Obstetrical & Gynecological Society of Bangladesh (OGSB) and other stakeholders who contributed significantly during the entire process of updating this Reference Manual. I must also acknowledge Ipas Bangladesh to come forward to develop and update this time-demanding manual on Women- Centered MR and Postabortion care services.

I hope this manual will meet the need of the health care providers, contribute to reduce the current trend of maternal mortality and morbidity by ensuring quality MR and PAC services at the facility level.

Dr. Md. Shamsul Haque

OGSB

President
Obstetrical & Gynecological Society of Bangladesh

MESSAGE

Menstrual Regulation and Postabortion Care are very important component of Sexual and Reproductive Health Services. Availability and accessibility of the services across facilities save women's life preventing them from going unsafe abortion.

The Reference Manual for Menstrual Regulation and Postabortion Care Services will be a guidance for service providers practicing standard methods to provide quality menstrual regulation and post abortion care services. I believe this Reference Manual also help services providers to give up obsolete practice like D&C and improve quality of services. All the methods described here offer women safe, effective options for first-trimester uterine evacuation.

I wish to thank Ipas Bangladesh for their contribution to develop this Reference Manual for comprehensive MR and PAC services. I also appreciate the contributions rendered by the members of the technical group of Ipas headquarters, OGSB, development partners, and the health and family planning experts of DGHS and DGFP for updating this manual.

I admitted the efforts of the MoHFW for developing this valuable resource and anticipate that the application of this "Reference Manual for Menstrual Regulation and Postabortion Care services" will bring significant changes in the field of maternal and women's health.

Ferdousi Begum

Prof. Ferdousi Begum

Ipas Partners for Reproductive Justice
BANGLADESH

Country Director
Ipas Bangladesh

ACKNOWLEDGEMENT

I would like to share my gratitude and thanks to all the relevant officials of DGHS, DGFP and DGNM for the joint initiative with Ipas to develop and update the "Reference Manual for Woman-Centered MR and Postabortion Care Services". We are proud to be the part of this novel initiative that will provide guidance to health care personnel on improving the quality of MR and PAC services as per the country policy and guidelines.

This manual will be used by service providers at government and non-government institutes. While retaining the clinical perspective, this manual is more comprehensive and women centric. This will help the service providers to consider factors like the woman's personal circumstances and situation and provide respectful, confidential and high-quality services. This manual is not intended to serve as a self-guided learning tool. It is designed to be used as a participants' manual during trainer-facilitated courses that include simulated practice under the supervision of an experienced trainer.

We express our most profound gratitude and thanks to the Director General of DGHS and Director General of DGFP, Director (PHC) & Line Director (MN-CAH) of DGHS. Director (MCH Services) & Line Director (MC-RAH of DGFP, Present & Immediate-past President of OGSB who also served as Chairperson of the Technical Committee for Ipas Bangladesh & the General Secretary of OGSB for their visionary inputs to the development of the manual. Without necessary directives from them, completion of this should never be possible. We are grateful to Editorial Board Members and Reviewers of the Reference Manual for their technical inputs which helped improving the quality of the manual.

Finally, I would like to express our heartfelt thanks and gratitude to all concerned who contributed, even with their best wishes. I would also like to acknowledge the valuable contributions of academicians, scientists, obstetricians, public health experts and officials from DGHS, DGFP, DGNM, OGSB and development partners who worked hard for updating this manual. I also express my heartiest thanks and appreciation to Ipas Bangladesh and Ipas NC teams for undertaking this initiative and their support to incorporate state-of-the-art knowledge and technology in the manual.

We hope that this Reference Manual will improve the quality of comprehensive MR and PAC services, contribute to reduction of maternal mortality and morbidity and help to achieve the SDGs. We also hope that this Woman-Centered MR and Postabortion Care Services Reference Manual would be useful in further strengthening MR and PAC services for women at all levels of service delivery.

Dr. Sayed Md. Akhter Rubayet

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
BAPSA	Association for Prevention of Septic Abortion, Bangladesh
BMMS	Bangladesh Maternal Mortality Survey
CDC	Communicable Disease Control
D & C	Dilatation and Curettage
D & E	Dilatation and Evacuation
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DMPA	Depot Medroxy progesterone acetate
ECP	Emergency Contraceptive Pill
FP	Family Planning
FIGO	International Federation of Gynecology and Obstetrics
FWV	Family Welfare Visitor
HIV	Human Immunodeficiency Virus
HLD	High Level Disinfection
IM	Intramuscular
IP	Infection Prevention
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
IV	Intravenous
LMP	Last menstrual period
MCWC	Mother and Child Welfare Centre
MoHFW	Ministry of Health and Family Welfare

Abbreviations

MMR	Maternal Mortality Ratio
MR	Menstrual Regulation
MRM	Menstrual Regulation with Medication
MVA	Manual Vacuum Aspiration
NGO	Non-Governmental Organization
NSAID	Non-Steroidal Anti- Inflammatory Drug
NTC	National Technical Committee
PAC	Postabortion Care
PAFP	Postabortion Family Planning
PID	Pelvic Inflammatory Disease
PPFP	Postpartum Family Planning
Rh	Rhesus (blood group)
RHSTEP	Reproductive Health Services, Training & Education Programme
RTI	Reproductive Tract infection
SAE	Serious Adverse Event
STI	Sexually Transmitted Infection
UE	Uterine Evacuation
UHC	Upazila ealth Complex
USG	Ultrasonography
VA	Vacuum Aspiration
VCAT	Values Clarification for Attitude Transformation
VAW	Violence Against Women
WHO	World Health Organization

About the Reference Manual

This reference manual is part of the Woman-Centered, Comprehensive MR, PAC curriculum which includes a trainer's manual and two reference manuals (Bangla & English). Woman-Centered, Comprehensive MR, PAC Services: Reference Manual reflects comprehensive Menstrual Regulation (MR),Postabortion Care (PAC) service delivery model, which encompasses MR as well as treatment for incomplete abortion and complications of unsafely induced abortion and postabortion contraception. Those planning to conduct courses should obtain the Woman-Centered, Comprehensive Menstrual Regulation(MR) and Poatabortion Care: Trainer's Manual, which includes trainer instructions, activity materials and competency-based evaluation and other training tools and is written to address the needs of all adult-learning styles. This curriculum is useful for a broad audience, including sexual and reproductive health clinicians, trainers, program managers, health educators, social workers and other health-care workers. The curriculum brings a women's rights perspective to MR,PAC -care training and service delivery.

The primary purpose of this reference manual is to provide guidance to health care personnel on improving the quality of MR and PAC services.

This manual provides guidance to health-care personnel on improving the quality of care available to women seeking uterine evacuation services. It introduces the MVA plus® aspirator and EasyGrip® cannulae and explains the manual vacuum aspiration (MVA) uterine evacuation procedure in detail. It also explains uterine evacuation methods that use the pills misoprostol and mifepristone (often called medical MR). All the methods described here offer women safe, effective options for first-trimester uterine evacuation. The scope of this curriculum is first-trimester uterine evacuation. This manual provides in-depth clinical information on uterine evacuation with both MVA and Medication. It is recommended that the techniques introduced in this manual be followed as clinical protocols for MR and PAC related services at health-care centers and systems. In addition to clinical information, the Chapters address broader service delivery and access issues such as women's sexual and reproductive rights, including the rights of young women, client-provider communication, provider and community partnerships, quality of care, and monitoring to improve services.

This manual 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 courses that include simulated practice

and clinical practice with clients under the supervision of an experienced clinical trainer; 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 MR, PAC and Postabortion contraceptive care.

Ipas's training strategies place equal emphasis on improving the technical quality of MR, PAC and on the overall quality of care that women receive. This comprehensive approach requires learners to reflect on values, attitudes and myths associated with MR, PAC and to focus services on the needs and desires of each woman receiving care.

Ipas's woman-centered training strategy addresses the clinical and non-clinical aspects of care to ensure overall quality of MR,PAC services. This approach requires learners to follow evidence based clinical recommendations and also to reflect on values, attitudes and myths associated with MR, PAC to ensure that services meet each woman's needs and circumstances, including those of young women. To ensure the training delivery is effective, Ipas 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.

This 3rd edition of Ipas's Woman-Centered, Comprehensive MR,PAC Care: Reference Manual and Trainer's Manual is consistent with the World Health Organization's Safe abortion: Technical and Policy Guidance for Health Systems, Second Edition (2012), Clinical Practice Handbook for Safe abortion (2014), Medical Management of abortion (2018)

For more information on Ipas Bangladesh program and publications, please contact:

Ipas Bangladesh
House # 438, Road # 30
New DOHS, Mohakhali,
Dhaka-1206, Bangladesh
www.ipas.org

Table of Contents

Table of Contents

Table of Contents

Table of Contents

Table of Contents

Table of Contents

Overview and Background

Overview and Background

Key topics in this Chapter:

- Key Elements of Woman-Centered MR and Postabortion Care
- MR Policy, Abortion Law
- Reproductive Rights

1.0 Introduction

Woman-centered Menstrual Regulation (MR) and Postabortion Care (PAC) is a comprehensive approach to provide MR and Postabortion Care 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. It includes Menstrual Regulation (MR), Postabortion Care services, treatment of incomplete, missed or unsafe abortion; MVA procedure, MRM procedure, compassionate counselling, contraceptive services, related sexual and reproductive health services provide on site or via referrals to accessible facilities and community linkage.

Within the law and policy of her country or region, a woman has an individual right to MR or abortion; however, the conditions that enable or hinder her access to safe services 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 MR and PAC 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.

No woman should risk her life in order to exercise her reproductive choices. Woman-centered MR and PAC includes:

- safe, affordable and timely services that are tailored to women's medical and personal needs
- respectful and confidential care
- the right to information, privacy and a range of choices

This Chapter provides the foundation for the curriculum. It is recommended as a prerequisite for health-care providers offering first-trimester MR, PAC services and provides an introduction to the following concepts:

- Comprehensive Menstrual Regulation (MR) and Postabortion Care (PAC) services
- Client Rights
- Provider Ethics

1.1 Global Abortion Scenario

Globally each year around 210 million women become pregnant; of those, 75 million pregnancies end in stillbirth, or spontaneous or induced abortion. Worldwide, 25 million unsafe abortions (45% of all abortions) occurred every year between 2010 and 2014, according to a new study by WHO and the Guttmacher Institute published in The Lancet. The majority of unsafe abortions, or 97% occurred in developing countries in Africa, Asia and Latin America. WHO ranks unsafe abortion as one of the major causes of maternal mortality, as it claimed 13 percent of all maternal deaths. WHO estimates that 47,000 women died due to unsafe abortion in 2008 *(WHO, 2011).* Unsafe abortion disproportionately affects adolescent girls and young women. In 2008, forty-one percent of unsafe abortions were among young women aged 15-24 years (Shah & Åhman, 2012) and of all abortion-related deaths approximately one-third are among women younger than 25 years (IHME 2014). Other than claiming this large number of women's lives per year, unsafe abortion also leads to high morbidity, including life-long disability, making unsafe abortions a prime public health concern.

Maternal Mortality Rate (MMR) is defined as the number of maternal deaths per 100,000 live births (WHO, 2015). The global MMR is 211 (UNICEF, 2017); and MMR in Bangladesh has improved over the years (196 in 2016 BMMS as compared to 399 in 2000), it is as low as 3 in developed countries. Thus, there is a large scope for decreasing maternal mortality. Reducing the number of deaths by unsafe abortions is one of the easier strategies through which this can be achieved.

Unsafe abortions are usually performed by providers lacking qualifications and skills to perform induced abortion or in unhygienic conditions and may also be self-induced. Unsafe abortions are preventable but they continue to pose undue risks to a woman's health, leading to morbidity and/or mortality.

1.2 MR and Abortion in Bangladesh

A recent study determined the annual MR rate in Bangladesh to be 10 per 1,000 women aged 15-44 (Hossain et al., 2017). The study also estimated the total number of MR procedures to be 430,000 annually based on facility data.The rate of MR is moderate in comparison to levels worldwide, but the proportion of unsafe abortion is high in Bangladesh, with an annual rate of 29 per 1,000 women. In 2014 alone there were approximately 11,94,000 unsafe abortions, resulting in 257,000 women presenting for treatment of complications for a rate six per 1000 women aged 15-49. Due to the stigma around out-of-wedlock pregnancies and low levels of MR knowledge, the risk of unsafe abortion is high for young women, especially unmarried adolescents. A study found that the likelihood of an abortion was 35 times higher among unmarried adolescents than that of married adolescents (Ahmed, 2005).

1.3 Abortion Law and Menstrual Regulation Policy in Bangladesh

Abortion law in Bangladesh is based on the Penal Code of 1860. The Penal Code (sections 312-316) permits abortion only for the purpose of saving a woman's life. In 1972 the law was waived temporarily for women who were raped during the liberation war of Bangladesh. Regardless of the restrictive nature of the abortion law, "Menstrual Regulation" (MR) services have been included in 1979 the Government's family planning program. **MR is an "interim method of establishing non-pregnancy for a woman at risk of pregnancy, whether or not she actually is pregnant"** ***(Bangladesh Institute of Law and International Affairs, 1979)***. MR services do not conflict with the current abortion laws, as it is provided as a backup of family planning methods by the Government, not as a means for abortion.

Abortion law in Bangladesh

Abortion law in Bangladesh is based on the Penal Code of 1860. The Penal Code (sections 312-316) permits abortion only for the purpose of saving a woman's life

"A person who performs an illegal abortion (an abortion not performed for the good faith purpose of saving the life of the woman or by using menstrual regulation) before the woman is quick with child is subject to up to three years' imprisonment or a fine or both penalties. If the abortion is performed after quickening has occurred, the person is subject to up to seven years' imprisonment and a fine. A woman who performs an abortion on herself is subject to the above penalties. If an abortion is performed without the womans consent at any point during the pregnancy, the person performing it is subject to up to 10 years' imprisonment and to a fine. If the abortion is performed with the woman's consent and results in her death, the penalty is up to 10 years' imprisonment and payment of a fine. If the woman has not consented and death results, the penalty may be increased."

In 1974 the government encouraged the introduction of menstrual regulation (MR) services in a few isolated family planning clinics and the Pathfinder fund international initiated an MR training and services program for doctors and FWVs in seven medical colleges and two government district hospitals in 1978. In a government circular in 1979, MR was included in the national family planning program and doctors and paramedics were encouraged to provide MR in all public sector health facilities up to Upazila Health Complexes. Currently MR services are available in most of the government hospitals, and other health and FP facilities down to the primary level (Union Health & Family Welfare Centers), and limited number of NGO and private clinics. As a part of their in-service Obs/Gyn training, internship trainees receive two-week MR training at all government medical college hospitals.

1.4 Who Can Perform MR?

Menstrual Regulation, however, can be performed on an out-patient basis and may be performed by a trained Doctor, Nurse, Family Welfare Visitor (FWV), Midwife, Paramedic, Sub-Assistant Community Medical Officer (SACMO), Mid level provider .

In practice, many providers of menstrual regulation have received only informal training. Trained doctors can perform MR up to 12 weeks & mid level service provider can perform up to 10 weeks of missed period.

1.5 MRM in Bangladesh

Menstrual Regulation with Medication (MRM) is approved in Bangladesh by National Technical Committee of DGFP up to 63 days (9 weeks) of amenorrhea in 2014. In 2021 National Technical Committee of DGFP approved MRM up to 70 days (10 weeks). MRM will be applicable by Mifepristone and Misoprostol for women who have a history of amenorrhea for 10 weeks.

2.0 Key Elements of Woman-Centered MR and Postabortion Care

Woman-centered, comprehensive MR and PAC includes a range of medical and related health services and is comprises of three key elements:

1. Choice
2. Access
3. Quality

Framework for woman-centered care

2.1 Choice

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 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 MR, choice means a woman's right to determine :

- If and when to become pregnant
- Whether to continue or terminate a pregnancy
- Which available MR procedures, contraceptives, providers and facilities to use

Woman's choices must be informed by complete and accurate information. They must also have the opportunity to ask questions and express concerns to providers. She must have the right to have complete and accurate information on the procedure, service providers and facility, personalized pain management, and referral facilities. Finally, to be woman- centered in the care they are providing, health workers must recognize and respond to a woman's right to all available choices within the circumstances of her environment.

Many women needing MR care are in vulnerable situations that make it difficult for them to exercise autonomous decision-making. They may be at the mercy of family members or others who coerce them into having an MR or continuing a pregnancy. In some settings, health care providers may agree to provide an MR 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 MR and 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
- Are easily reached local communities
- Have many service delivery points

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.

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.
- 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 display respectful, caring, empathetic attitude

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:

- References for male children and needs
- Excessive influence of in-laws
- Societal expectations for women to produce children, sometimes starting from an early age.
- Stigmatization of women's sexuality, abortion and reproductive health - seeking behaviors
- Cultural norms that cause women, particularly young women, to feel embarrassed to seek reproductive health care, especially from a male provider.
- Forms or processes that unintentionally exclude some women, such as young women or women who partner with women.

Long-term sustainability of services is also critical to access to high-quality care. MR services should be instituted in a way that can be maintained by the health system. MR services should be available to all women through a wide range of settings such as government centers include primary health centers, district hospital, Medical College Hospital, governmental and nongovernmental teaching hospitals, nursing homes and private clinics, and through NGOs and INGOs. To sustain MR and PAC services, 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
- Effective management, monitoring and evaluation of services.
- Community and service-provider linkages.

2.3 Quality

Some fundamental aspects of high-quality care are:

- Care that is tailored to social circumstances and individual needs.
- Information and counseling that supports fully informed choices, including for young women who may need more information or time to make an informed choice
- Internationally recommended medical technologies, particularly manual vacuum aspiration (MVA) and medical methods
- Appropriate clinical standards and protocols for infection prevention, pain management, and managing complications
- Contraceptive services and a range of contraceptive method choices at the time of abortion-related services to help women prevent unwanted pregnancies and ensure healthy spacing of children
- Reproductive and other health services at the time of abortion-related services, such as screening, diagnosis and treatment of sexually transmitted infections (STIs) including HIV and screening and counseling for sexual violence
- Providers ensure that the unique needs of young women are addressed
- Confidentiality, privacy, respect and positive interactions between women and staff of the health facility, regardless of age or marital status
- Systems are in place for monitoring adverse events
- Systems are in place for quality improvement including involvement from community members

3.0 Postabortion Care (PAC)

Postabortion Care (PAC) is a series of interventions designed to manage a woman presenting after spontaneous or induced abortion (with or without complication). It is an important component of comprehensive reproductive health services, saving women's lives and reducing morbidity and mortality.

Woman-centered Postabortion Care (PAC) is a comprehensive approach which takes into account a woman's individual physical and emotional health needs and circumstances and ability to access care. It includes treatment of incomplete, missed or unsafe abortion; compassionate counseling; contraceptive services; related sexual and reproductive health services provided onsite or via referrals to accessible facilities; and community-service provider partnerships.

Spontaneous abortion: Loss of pregnancy before fetal viability (sometimes called early pregnancy loss or miscarriage)
Induced abortion: Termination of pregnancy before fetal viability; can be either safe or unsafe
Incomplete abortion: A spontaneous or induced abortion in which some pregnancy tissue passes out of the uterus but some remains
Missed abortion: A spontaneous abortion in which the pregnancy ends, but the tissue remains in the uterus

Postabortion complications constitute the most common gynaecological admissions in developing countries and contribute significantly to maternal morbidity and mortality (Sing, 2006). Preventing unsafe abortions saves women's lives and reduces the cost of emergency services needed for abortion complications.

It is anticipated that Postabortion Care (PAC) services in conjunction with high-quality MR services, available at all levels of the health care system, would result in a significant reduction in maternal morbidity and mortality.

The information presented in this Chapter includes the elements of Postabortion Care and global agreements to reduce unsafe abortion.

3.1 Key Elements of Postabortion Care (PAC)

Comprehensive Postabortion Care, which includes both curative and preventive care, has five key elements. These five key elements are:

- **Treatment** of incomplete and unsafe abortion and abortion-related complications that are potentially life-threatening;
- **Counseling** to identify and respond to women's emotional and physical health needs and other concerns;
- **Contraceptive and family-planning services** to help women prevent an unwanted pregnancy or practice birth spacing;
- **Reproductive and other health services** that are preferably provided on-site or via referrals to other accessible facilities in providers' networks;
- **Community and service-provider partnerships** to prevent unwanted pregnancies and unsafe abortion, mobilize resources to help women receive appropriate and timely care for complications from abortion, social support to

access services and ensure health services reflect and meet community expectations and needs.

(Adapted from Postabortion Care Consortium, 2002)

3.2 Why Postabortion Care (PAC) is Important

- PAC is a life-saving intervention for women and is a signal function for emergency obstetric care. Protecting a woman's right to accessing and recieving quality Postabortion Care is essential health care. Women's health can be protected by educating women on the danger signs and where to access PAC services, providing appropriate referrals and information on other reproductive health services (eg. Contraception)
- PAC reduces women's suffering**.** Unsafe abortion and miscarriage have physical and emotional consequences for women which can be minimized by making provision of compassionate, high-quality medical care.
- Providing contraceptive counseling and services can help them to prevent unwanted pregnancies and reduce their need for abortion services and subsequent emergency Postabortion Care.
- PAC offers opportunities to meet the multiple health needs of women. For some women, the first contact with the formal health care system occurs during emergency treatment of abortion-related complications. Thus, PAC offers an opportunity to inform women about available contraceptive methods for those wanting to prevent pregnancy, as well as other types of reproductive health care services.
- PAC reduces health care costs**.** Significant health care costs in terms of personnel, supplies, anesthesia, blood transfusions, antibiotics, hospital beds and operating rooms can be curtailed by high quality Postabortion Care services.

4.0 Upholding Women's Rights in a MR and Postabortion-Care Setting

The International Planned Parenthood Federation (IPPF) has produced a formal statement declaring the sexual and reproductive rights of all people 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 IPPF Charter for Reproductive Rights:

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

4.1 Values, Attitudes, Empathy and Respect

Health-care workers must separate their personal beliefs and values from their professional practices and treat all women equally, regardless of age or marital status. All health-care workers need to treat their clients with *empathy,* the ability to understand another person's feelings and point of view and to communicate this understanding. (See the *Counseling* Chapter for more information on these concepts.)

Health-care workers' attitudes toward women have a strong influence. Positive encounters with empathetic, respectful health-care workers heighten women's satisfaction with their care, increase their adherence to medical-care instructions and make them more inclined to trust health-care workers and seek appropriate medical care in the future *(Hall et al., 1988). Positive encounters also are a foundation for good relationships between providrs and the community they serve, which can create a supportive environment for their work.*

Comprehensive MR and PAC service providers should strive to:

- Identify their values and attitudes regarding sexuality and reproductive health and be aware that their values about young women's sexuality may require special attention.
- Separate their values from those of their clients.
- Recognize how their attitudes can negatively or positively affect client interactions and quality of care.
- Ensure that they are able to provide compassionate and empathetic care

Facility 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* Chapter for more information.)

4.2 Interaction and Communication

Positive interaction and Communication between health-care workers and clients are essential to high-quality medical care. It is important not to make assumptions about women seeking these 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. Because MR is a highly stigmatized area of health-care, providers need to take extra measures to ensure they are not contributing to further stigmatization through their actions and words.

To initiate positive interactions, providers can:

- Speak respectfully
- Listen attentively
- Ask thoughtful questions
- Give accurate information and answers using simple language the woman understands.
- Show empathy and kindness to each woman in their care.

Simple considerations—such as apologizing for a long wait or allowing the woman to remain clothed until the physical assessment is about to begin—can improve the overall quality of a woman's visit.

4.3 Privacy and Confidentiality

It is essential that MR and PAC related counseling and care are private and confidential.

- Managers should post confidentiality policies in client-care areas.
- Staff should explain the privacy policies to each woman.
- Administrators should establish and enforce strict confidentiality policies and procedures that apply to all health-care workers.
- Access to client information should be established before talking to or examining the woman.

4.4 Voluntary, Informed Consent

Health-care workers should explain the woman's condition and options to her in non-technical language and obtain her voluntary, informed consent prior to initiating care. Health-care workers should not proceed with medical services until the woman has given her informed consent and signed a written consent form. Young women are capable of making the decision for MR. In some settings, it is appropriate and common to provide witnessed verbal consent in lieu of written consent. Obtaining informed consent should not delay emergency procedures needed to save a woman's life.

5.0 Barriers to safe MR/abortion services

The restrictions in gestational age prevent women seeking services for over >12 weeks pregnancy. Lack of skilled providers and standard service provision sites, and social, religious and cultural stigma against MR/abortion, also can force women to resort to unsafe abortions.

6.0 Summary

- The overview and background Chapter serves as the recommended prerequisite Chapter for this entire curriculum.
- All women, including young women, who seek MR and PAC have the right to high-quality health care.
- Choice, Access and Quality are three key elements of woman-centered MR and PAC.
- Key components of comprehensive MR and PAC include options counseling, use of appropriate technology, privacy, infection prevention, pain managementand post-MR or postabortion contraception.
- 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.
- Woman-centered, comprehensive abortion care includes: Menstrual Regulation and induced abortion to the full extent of the Policy and law; treatment of incomplete, missed or unsafe abortion; compassionate counseling; contraceptive services; related sexual and reproductive health services provided on site or via referrals to accessible facilities and community-service provider partnerships.
- Postabortion Care (PAC) is composed of five elements designed to manage incomplete abortion and ensuing complication or issues:
    - — Treatment
    - — Counseling
    - — Contraceptive services
    - — Reproductive and other health services
    - — Community and service-provider partnerships

Community Linkages

Community Linkages

Key topics in this Chapter:

- Importance of creating links with communities
- Community assessments
- Community based intervention

1.0 Introduction

As with the other essential health services, it is the obligation of health and family planning systems to make Menstrual Regulation (MR) and Postabortion Care (PAC) services available at the most local level possible—in the communities where women live & work. 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 and family planning 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, comprehensive MR and PAC services. Community linkages can help service providers to 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 including young women.

This Chapter will give us an overview on understanding the community, it's importance and the ways to create linkages at societal level. This section will also highlight the roles of family welfare visitors (FWVs) and community level health workers (e.g., family welfare assistants, health assistants, family planning inspectors, health Inspectors, assistant health inspectors) in creating awareness at the community level on accessing safe MR services, availability of safe MR services and preclusion of unsafe abortion. Community linkages also include linking with other stakeholders in the community to increase access to safe MR care.

2.0 Community

Community can be defined as a group of people who share something in common. We can define a community by the shared attributes of the people in it and/or by the strength of the connections among them. Community can also be defined as a bunch of people who are alike in some way, who feel some sense of belonging or interpersonal connection.

Community is homogeneous, and socially and geographically immobile and

characterized by values such as the centrality of kinship ties, solidarity as a community and attachment to the locality.

The term community can be defined in various ways. The term is commonly or town 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.

3.0 Understanding SBC, Community Empowerment and Mobilization

Social and Behavior Change (SBC): a systematic application of interactive, theory-based, and research-driven processes and strategies to effect change at individual, community, and social levels. SBC examines challenges from multiple sides by analyzing personal, societal, and environmental factors in order to find an effective way to achieve sustainable change. SBC also employs strategies that influence the physical, socio-economic, and cultural environment working at the multiple and interrelated levels within the socio-ecological model to facilitate healthy norms and choices and remove barriers to them.

Community-based Participatory Research (CBPR): is a partnership approach to research that equitably involves, e.g., community members, organizational representatives, and researchers in all aspects of the research process and wherein all partners contribute expertise and share decision making and ownership. The aim of CBPR is to increase knowledge and understanding of a given phenomenon and integrate the knowledge gained with interventions and policy and social change to improve the health and quality of life of community members

Community empowerment: is active participation or engagement of communities. It implies community ownership and action that explicitly aims at social and political change. It recognizes that if some people are going to be empowered, then others will be sharing their existing power and giving some of it up.

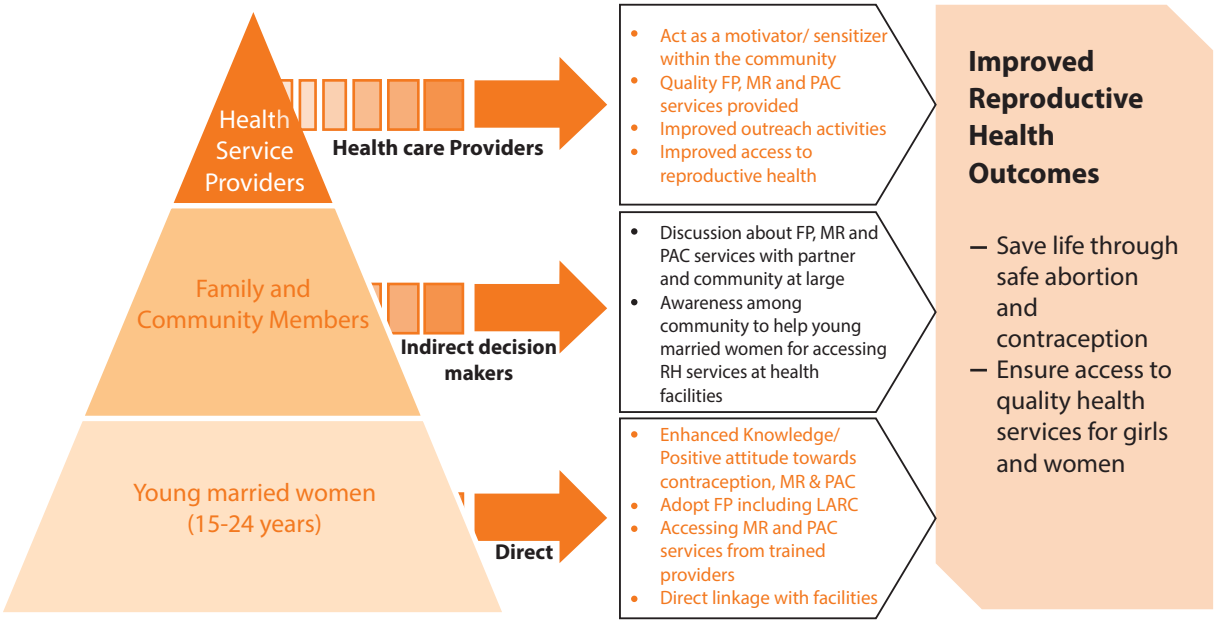
Community mobilization: is a sub-strategy of social mobilization. Social mobilization includes building coalitions on certain issues and usually takes place at a national level among civil society organizations, donors, and government.
Community mobilization can do the same at a community level with similar techniques. Coalitions can be formed among community leaders, spiritual and traditional leaders, women's groups, and other groups in the community. Community mobilization is a newer, but important component of improving access to MR and Postabortion Care services.

4.0 Community Based Interventions

Community-based interventions refer to multicomponent interventions that generally combine individual and social behavior change strategies across multiple settings aiming to prevent dysfunction and to promote well-being among population groups in a defined local community. In most cases, entire communities (e.g., neighborhood, city, county) are used as units of intervention. Furthermore, community programs offer the opportunity to stimulate cultural changes.

Community based interventions is now widely recognized as an important strategy to deliver key maternal and child survival interventions. Interventions delivered at the community level have not only been advocated to improve access and coverage of essential services, but also to reduce the existing disparities and reaching the hard to reach populations.

Schematic representation of multi-layered intervention to improve reproductive health access among young married women



The above diagram explain how the community interventions works! There is substantial evidence that community based interventions have the potential to improve reproductive health outcomes of young women and adolescents. A recent review of literature on community level interventions to improve quality of care for women reproductive health including maternal health indicated that home visits, community mobilization and training of community health workers and traditional birth attendants have the maximum potential to improve reproductive health outcomes1. The determinants of reproductive health behaviors including health care

[1] Lassi ZS, Das JK, Salam RA, Bhutta ZA. Evidence from community level inputs to improve quality of care for

comprehensive package of intervention is expected to improve reproductive health access of young married women.

Women, their partners and families need information about:

- Pregnancy signs and symptoms
- Pregnancy options
- Availability of contraception services, including emergency contraception
- Legal indication for induced abortion
- Access to safe MR services or treatment for MR complecations
- Dangers of unsafe MR
- Importance of seeking MR related care from trained and authorized providers

Women need to be able to exercise their right to reproductive health to the fullest extent of the law, and providers should do what they can to facilitate that. They can do so in the following ways:

Educate women and their partners about human reproduction, contraception and pregnancy options. For example, health-care personnel can organize community meetings and conduct educational sessions or train community based health workers to do so.

Educate community leaders about the need for comprehensive sexual and reproductive health education for young women. Ensure they understand that information does not lead to heightened sexual activity but rather leads to better decision making, more protected sex and fewer unplanned pregnancies and unsafe abortions.

Create a partnership with young women. Young women can help define and design more accessible and appropriate abortion care for their peers, and can help evaluate quality of services, and influence quality improvement efforts.

Train and equip community-health workers to provide contraceptive counseling and method provision so women can get their contraceptive needs met closer to home. Health-facility staff can identify resources and develop a referral system to accommodate women who need specialized services.

Alert the community to negative public-health trends. For example, if many women are coming in to health facilities with complications from unsafe abortion, providers

maternal and newborn health: interventions and findings. Reprod Health. 2014;11 Suppl 2:S2.

could meet with community leaders to encourage local education on safe services and assistance for women who need care. Similarly, if many young women who are engaging in sex with much older or married male partners are contracting sexually transmitted infections (STIs), providers can alert community and youth leaders about those concerns. Providers must always take care to maintain women's confidentiality.

Increase awareness and support for abortion and care providers. Providers can conduct values clarification workshops in the community to increase knowledge and support and reduce stigma for women who have abortions and providers who offer care. Health managers can make announcements, postings and media messages to ensure that the public is aware of their facility's services and commitment to uphold their confidentiality policies. Public campaigns can encourage women who want to terminate their pregnancy to seek safe services.

Educate pharmacists and other drug sellers and women about medical abortion with mifepristone and/or misoprostol. Providers can offer information to those who use or dispense medications about safe doses of mifepristone and misoprostol and establish a referral network for pharmacists dispensing the drugs.

Identify community, regional or national resources. Find the available resources that can meet specific client needs and develop a referral system to accommodate women who need specialized services.

5.0 Programmatic Strategies

Health-care providers should use the information gathered in the community-assessment phase to design programmatic activities that will link MR 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.

6.0 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 MR; where they can obtain safe 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 and field workers 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/MR that may exist.
- Health-care workers can collaborate with community leaders to organize community meetings and sensitization discussions on women's rights to reproductive health information, informed consent and choices in care when receiving health services. 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.
- Counselors and field workers can work with youth leaders to disseminate accurate messages on sexual and reproductive health, where to access quality services, and to provide support and encouragement to young people to seek care and support when experiencing any physical, sexual, and emotional abuse.

Ways to increase public awareness of safe MR services:

- Advertise
- Develop and disseminate community-specific flyers and mass-media messages; consider adolescents, specially working in the industries (e.g. Garment Industries) who have least access to the reproductive health services
- Attend community activities
- Facilitate community discussions
- Encourage satisfied clients to talk to others

Key messages to share:

- Prevention of unwanted pregnancy is key to reducing unsafe abortion
- What are the legal indications for MR and abortion in the country or locally
- Women must avoid untrained providers and unsafe abortions
- Earlier terminations of pregnancy are safer than later ones
- If, after an MR a woman has any problems or complications, she should not delay in returning to the health facility

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 abortion, 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 MR 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.

7.0 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.
- 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 safe MR.
- Early referral for complications of unsafe abortion 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 safe MR and Postabortion 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.

Values Clarification and Attitude Transformation

Values Clarification and Attitude Transformation

Key topics in this Chapter:

- What is values clarification
- Values clarification for attitude transformation theoretical framework

1.0 Introduction

Communities are influenced by values, beliefs and biases that are often contrary to women's needs and rights. Multi-pronged strategies and tools, including values clarification, are needed to increase factually correct knowledge, attitudes and practices that are supportive of safe abortion care. The World Health Organization recommends inclusion of values clarification in abortion training programmes for service providers *(WHO, 2012).*

This Chapter, *Values Clarification for Attitude Transformation (VCAT),* is a recommended prerequisite for health-care providers offering MR, PAC and other reproductive health services, and provides an introduction to the concepts of MR, abortion care, client rights and provider ethics for any facility staff member who has contact with women seeking services.

This Chapter will explore, question, clarify and affirm the values and beliefs of service providers about MR and related sexual and reproductive health, such that their awareness and comfort with the provision of comprehensive MR and abortion care is increased.

2.0 What are Values?

Values are what we hold dear and think is important. They influence how we conduct ourselves and live. They serve as our internal road map. Values are closely related to and are affected by our beliefs, ideals and knowledge, and they can affect our attitudes and behaviors. Values play a key role in the decisions we make, what we spend our time and energy on and how we act. Values tend to have persistence and assume a pattern in our lives. There are many definitions of values, including:

Values are enduring beliefs that a specific mode of conduct is personally or socially preferable to an opposite or converse mode of conduct *(Rokeach, 1973).*

Values are the dominating force in life because of the central role they play in directing a person's activity and influencing their perception of reality *(Allport, 1961).*

3.0 What is Values Clarification?

Given the central role that values play in our lives, it is important to understand how values form and how they affect our decision making and behavior. John Dewey

discussed the experience of valuing as the interdependent processes of reasoning, emoting and behaving, "Valuing occurs when the head and heart ... unite in the direction of action" *(Dewey, 1939).*In order for our choices and actions to be the result of informed, reasoned thoughts and feelings, values clarification (VC) was developed. VC is both a theory and an intervention. According to Milton Rokeach, values clarification is the process of examining one's basic values and moral reasoning *(Rokeach, 1973).* VC is done to understand oneself - to discover what is important and meaningful (Steele, 1979).

In the arena of sexual and reproductive health, VC interventions have increasingly been used to address such issues as stigma against people with HIV, providers'willingness to perform MR procedures andabortion procedures and pharmacists' willingness to fill emergency contraception prescriptions.

4.0 Values Clarification for Attitude Transformation

Traditional approaches to values clarification do not suggest any universal set of preferred values. However, given the national standards and guidelines in Bangladesh and the responsibilities that health-care providers have as part of their jobs, it is important to move participants toward support, acceptance and advocacy for comprehensive MR services, Postabortion Care and related sexual and reproductive health care, and the rights for women of all ages irrespective of their age, ethnicity, religion, marital status, sexual orientation, or any other defining characteristic. The MR VCAT approach recognizes that values affecting attitudes and beliefs about MR and related issues can change over time in response to new experiences and a deeper understanding of the issues and context.

An MR VCAT intervention is a process conducted in a safe environment in which individuals engage in honest, open-minded and critical reflection and evaluation of new or reframed information and situations. The content is designed to be accessible and personally relevant. The MR VCAT activities in this Chapter are designed to:

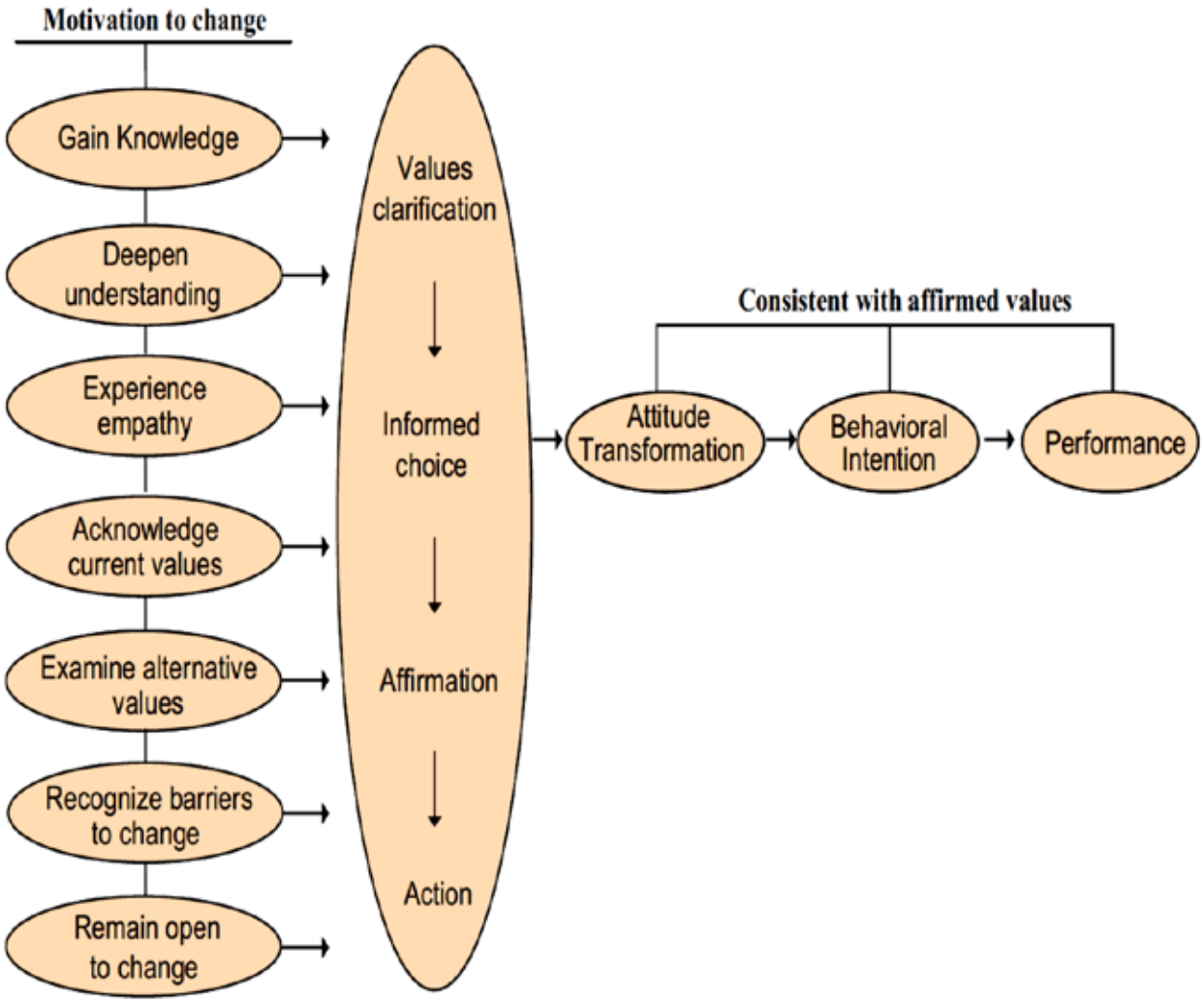
- Provoke participants to challenge deeply held assumptions and myths about MR and related issues;
- Help participants discover or potentially transform their values on MR;
- Assist participants to express their intentions to act in a manner consistent with their affirmed values.

The VCAT process can enhance MR programmes in many ways, including:

- Broadening stakeholder support for the provision of safe MR services and safe abortion to the full extent of the law
- Establishing agreements on service delivery standards, guidelines and clinical

protocols that are favorable to women's health needs and rights

- Creating an enabling environment for service provision with facility administrators and staff prior to initiating services
- Screening health care providers before investing in intensive and costly clinical training



5.0 Values Clarification for Abortion Attitude Transformation Theoretical Framework

The Values Clarification for Abortion Attitude Transformation theoretical framework above is the visual representation of the VCAT process, which is informed by and includes critical elements of Ajzen's Theory of Planned Behavior (TPB) *(Ajzen, 1985; 1988; 1991);* values theory *(Rokeach, 1973; 1979);* and the three main stages of the values clarification process — choosing, affirmingand acting *(Raths, 1966; Rokeach, 1973).*

The theoretical framework and VCAT process take place within existing cultural and social structures and ideologies. Cultural and societal norms are extremely influential in shaping people's attitudes and values. Also, this framework places the process of valuesclarification within a larger context of abortion attitude transformation, behavioral intention and, ultimately, behavior or performance.

As mentioned above, the goal of a traditional values clarification intervention is for participants to clarify their values, whatever those may be. However, this framework is designed to advance an agenda: to move participants along a progressive continuum of support for abortion and reproductive rights; from obstruction to tolerance to acceptance to support and then, ultimately, to advocacy for and/or provision of woman-centered, comprehensive abortion services to the full extent of the law.

Starting to the left of the framework, we begin with the motivation to change — people must be open to examining and potentially changing their attitudes, values and behaviors, or VCAT cannot be expected to have any impact. This carries implications for participant selection: only those participants who are open to change have the potential to clarify their values and transform their attitudes.

To effectively engage in the values clarification process one must: gain new knowledge; deepen understanding of existing or new knowledge; experience empathy for people affected by or who provide abortion; acknowledge current values on abortion; examine alternative values; recognize barriers to change and remain open to change. Ipas modified the three main stages of values clarification to making an informed value choice, affirming that choice and acting on the chosen value, which reflects the process and cognitions an individual would go through when thoughtfully choosing among competing alternatives, affirming those choices and deciding on a particular course of action.

Although it has not yet been empirically tested, we hypothesize that attitude transformation is a logical outcome of values clarification. After undergoing the VCAT process, participants' attitudes would be expected to be consistent with their affirmed values.

6.0 Values Clarification for Young Women

Young women face unique vulnerabilities and barriers to safe MR or abortion even in settings where safe abortion is legal. Social, economic, logistical, policy, and health system barriers to care exist for young women, including: stigma and negative attitudes, fear of negative repercussions, lack of access to comprehensive sexuality education, limited financial resources, transportation, involvement laws and concerns over privacy and confidentiality. These barriers explain why young women resort to unsafe abortions, tend to obtain abortion care later in the pregnancy than adults and are also more likely to delay seeking help for abortion-related complications than adults. These barriers in addition to the sociocultural factors that

contribute to young women's unintended pregnanciesemphasizes thenecessity for special attention and care towards young women when receiving services.

VCAT activities are important for discussing the issue of young women, unwanted pregnancy, unsafe abortion and safe MR. Even when data is presented on the multitude of barriers and high numbers of young women who resort to an unsafe abortion, doubt and hesitation may still exist around why providing quality care to young women is important. Many people have mixed feelings about MR in general, and some may feel even more conflicted about a girl's or a young woman's need or choice of MR and contraceptive services. The VCAT activities are designed to help participants reflect on their values and levels of comfort around various issues such as:

- Acceptability of young women's sexuality;
- Social stigma related to sexual activity among young unmarried women;
- Relationship between acceptability of pregnancy, age, and marital status;
- Chronological age versus emotional and sexual maturity;
- A young woman's right to choose abortion versus requirement for consent;
- Social and cultural norms that contribute to unintended pregnancies;
- Issues of autonomy versus protection (how legislation supposedly designed to protect young women may do just the opposite).

By going through the VCAT process, providers will be able to progress along the continuum of support for young women and their reproductive rights to eventually advocate for and/or provide quality safe abortion care for young women.

7.0 Summary

- Values play a key role in the decisions we make, what we spend our time and energy on and how we act.
- The process of values clarification involves three main steps: choosing, prizing and acting
- The VCAT process can enhance MR programmes by broadening stakeholder support for the provision of safe MR services and safe abortion to the full extent of the law; establishing agreements on service delivery standards, guidelines and clinical protocols that are favorable to women's health needs and rights; creating an enabling environment for service provision with facility administrators and staff prior to initiating services; screening health care providers before investing in intensive and costly clinical training
- VCAT activities are important for discussing the issue of young women, unwanted pregnancy, unsafe abortion and safe MR.

Counseling

Counseling

Key topics in this Chapter:

- What is counseling
- Characteristics and techniques of effective counseling and communication
- Privacy, confidentiality and informed decision-making
- Counselors' values, attitudes and beliefs
- Special populations of women

1.0 Introduction

A woman's experience during Menstrual Regulation (MR)/PAC care is both physical and emotional. When providers deliver emotional support in addition to medical care, the woman is better able to understand her medical condition, the various options available to her, possible outcomes and related health concerns. Counseling, when done privately and confidentially, is a highly successful way for providers to offer emotional care to women receiving MR/PAC services.

All women receiving MR/PAC care have the right to high-quality counseling, regardless of their medical or psychological circumstances. Effective counseling, an integral part of high-quality MR/PAC care, provides an opportunity to assess the woman's ability to cope and can help 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.

Who can be a Counselor?

- A designated staff counselor with an appropriate background and experience
- Current staff members, after receiving appropriate training (if no full-time counseling positions designated)
- Clinicians who provide medical care, (but should possess counseling knowledge and skills and a caring, nonjudgmental attitude)

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 health-care encounter *(Baker, 1999).*

This chapter covers essential information on how providers can interact and communicate with clients in a respectful, effective manner. Topics covered include: privacy, confidentiality and informed decision-making; counselor values, attitudes and empathy; methods for effective communication; and common feelings experienced by women receiving MR/PAC care. This chapter 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.

Welcome client

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 Counselling Approch

An effective counselor does more than describe the various methods available for MR/PAC services and also 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. Counseling requires an open exchange of information that can only occur in an atmosphere of mutual respect. The GATHER technique for counseling is used widely:

Obtain voluntary informed consent

GATHER (Hutchinson, 2012)
G = Greet clients
A = Ask and assess need
T = Tell about services
H = Help
E = Explain
R = Return for follow up

3.1 Voluntary Informed Consent

Voluntary informed consent refers to the process by which a woman is given full information about her options—for pregnancy decisions, MR 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. (See Appendix 14 for Informed Consent Form).

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.

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

Elements of Informed Consent

- Determine if the woman is capable of listening to and understanding the information offered.
- Explain the procedure(s) available to her, including benefits, risks and alternatives, in clear, non-technical language.
- Always ask her in private if she wishes to include others, and include her partner or family members only if she desires their presence; otherwise, speak to her privately.
- Encourage the woman to ask questions and discuss her condition.
- Ensure that the woman understands the information you have provided; if she does not, explain the procedure and her options again.
- Ask the woman—or her representative if she is unable to comprehend medical explanations—to give consent for care.
- If customary according to local protocols, have the woman or her representative sign the appropriate consent form.

informed consent. Such circumstances include situations where the woman:

- is under pressure from her partner or family members to have an MR
- has difficulty communicating due to language barriers
- is hard of hearing or deaf
- is cognitively disabled or mentally ill
- is very young/is a minor
- has experienced a traumatic event (for example, has been subjected to violence or has had an unsafe MR/abortion)
- When providers are working with adolescent and young women, the Principle of Capability and Evolving Capacities should be used to determine ability to give informed consent. (See Appendix 18 D: Additional Special Populations)

4.0 Counseling in the MR/PAC Setting

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

Information on MR/PAC procedures

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

- What will be done during and after the procedure;
- Eligibility, effectiveness, regimens and protocol;
- What she is likely to experience (e.g. menstrual-like cramps, pain and bleeding);
- How long the procedure will take;
- What pain management can be made available to her;
- Risks and complications associated with the method;
- Warning signs and time to seek help;
- When she will be able to resume her normal activities, including sexual intercourse;
- Ensuring access to emergency care;

- Contraceptive needs;
- Follow-up care; and
- Referrals to additional services, if necessary.

If a choice of MR/PAC methods is available, providers should be trained to give women clear information about which methods are appropriate, based on the uterine size and the woman's medical condition and potential risk factors.

Provision of contraceptive information and services is an essential part of MR/PAC care as it helps the woman avoid unintended pregnancies in the future. Every woman should be informed that ovulation can return as early as about 1-2 weeks after MR/PAC, putting her at risk of pregnancy unless an effective contraceptive method is used. She should be given accurate information to assist her in choosing the most appropriate contraceptive method to meet her needs. The final selection of a method, however, must be the woman's alone.

A woman's acceptance of a contraceptive method must never be a requirement for providing her an MR/PAC.

The circumstances of MR 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 understand 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.

5.0 Privacy, Confidentiality and Informed Decision-Making

Women have the right to privacy and confidentiality in the MR/PAC setting. Ideally, all MR/PAC-related counseling should take place in a setting where no one else can see or overhearand 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.

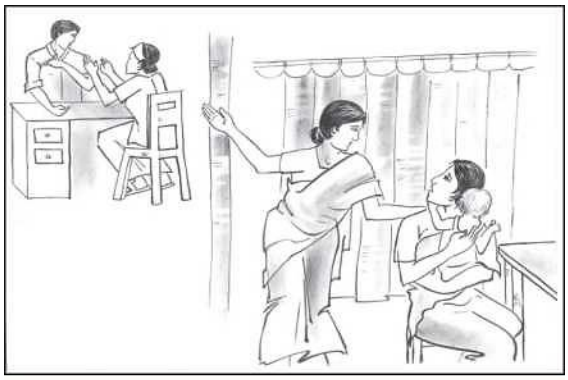
Provide Privacy

In a counseling setting, informed decision making refers to the process by which a woman makes decisions of her own free will after she understands complete and accurate information. The counselor should inform the woman that any med 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 Values and Empathy

Counselors should extend compassion and respect to every woman, regardless of her circumstances. Counselors should examine their attitudes and assess their potential biases against women who, for example:

- Do not want to be pregnant but do not use contraception
- Undergo multiple abortions
- Present later in pregnancy
- Have multiple children or no children
- Carry pregnancies to term even though the pregnancies were not intended or desired



Ask if she would like her partner to be present

- Terminate a pregnancy due to fetal malformation
- Have multiple sexual partners
- Have been sexually assaulted
- Are unmarried
- 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

Health-care providers' attitudes and beliefs affect their interactions and counseling with women and carry considerable influence. Providers may unconsciously hold beliefs about who should control the abortion experience or about a woman's right to determine what happens in her body, and these may be linked to beliefs about gender, age, sexuality and other factors. Unlike vacuum aspiration and depending on the protocol, medical methods can put the abortion more in the control of the woman rather than the clinician, In many approved protocols, she can initiate and manage the abortion at home or other place outside a health-care facility where it is most convenient and comfortable for her to manage the abortion process. Providers' discomfort with women managing the abortion themselves, whether conscious or unconscious, may negatively affect provision of medical abortion and even cause them to resist offering MA services.

A woman-centered approach to care means that providers should:

- Identify their personal beliefs and values about abortion and related factors such as gender, age, sexuality and control of the procedure
- Separate their beliefs and values from those of their clients and focus on their client's needs
- Show respect to all women, regardless of their age, marital status, sexual and reproductive behaviors and decisions
- Treat women with empathy , understanding their feelings and perspectives and communication this understanding

Values clarification can help providers identify their beliefs and values, explore the consequences of their actions, learn how to separate their values from those of their clients and offer care in a way that shows respect for a woman's rights and decisions.

Clinic managers and clinical mentors can help establish and maintain an environment of sensitivity and respect for women's needs through a variety of methods, including values clarification and other training, clinical coaching, supportive supervision, feedback from coworkers, anonymous evaluations and client surveys. (Please see additional resources, informed consent, information and Counseling.)

7.0 Effective Communication

A woman seeking MR 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 clients' 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.

Effective Verbal and Nonverbal Communication

Counselors who practice effective communication:

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

Counselors who do not practice effective communication:

- Make assumptions about the woman and her needs
- Focus on their own priorities rather than the woman's needs
- Indicate their lack of interest through nonverbal cues

- Ask only closed-ended questions
- Do not listen carefully
- Interrupt or speak over the woman
- May misunderstand the woman's words
- Do not pay attention to or misinterpret the woman's nonverbal cues
- Do not check back to make sure that the woman has understood their questions
- Allow interruptions such as telephone calls or people coming into the counseling space
- Show distraction while the conversation is taking place

8.0 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.

Communicate effectively

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.

8.1 Active Listening

Active listening 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. Some elements of active listening are:

- Showing attentiveness by interjecting phrases such as "I see" or "I understand"
- 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 are not being taken seriously.

8.2 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 as much as possible 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 MR?" The implied judgment is that a woman who has had an MR 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.

8.3 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 counselor can use nonverbal communication to show concern for a woman by:

- Facing her or sitting beside her and removing any physical barriers between

them such as a desk or counter

- Leaning slightly forward and making appropriate eye contact for the context
- Nodding and using a reassuring tone of voice
- Avoid turning and looking away, repeatedly looking at a watch or clock or using a harsh tone of voice.

Counselors should remember that nonverbal cues vary from culture to culture, as well as according to age and gender within a given culture.

9.0 Women's Feelings and Decisions

Cultural values and norms affect a person's feelings about fertility, pregnancy, miscarriage, MR 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.

9.1 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 MR may largely depend upon 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 MR.

9.2 Information and Options

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

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
- terminate the pregnancy

Counselors can discuss with the woman the benefits, risks and alternatives of these options and, if needed, make appropriate referrals. Counselors should emphasize the confidentiality of care and the voluntary nature of the woman's decision. If the woman makes a firm, informeddecision of her own free will to terminate the pregnancy, the counselor should then proceed by gathering certain information, such as the length of pregnancy, and offering information about:

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

9.3 Method Choice

If both vacuum aspiration and medication for MR 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 or treatment
- what she is likely to experience—for example, menstrual-like cramps or pain
- how long the procedure or treatment 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 for MR, the counselor should explain that in the unlikely event the uterus is not evacuated successfully, the provider will need to complete the MR 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.

Comparison of Vacuum Aspiration and Medication MR for Counseling Purposes in Bangladesh

	Vacuum Aspiration	Mifepristone & Misoprostol
What is it?	A uterine evacuation procedure that uses electric or manual suction instruments inserted into the uterus	Medications that taken together cause the uterine lining to detach and uterine contractions to expel the pregnancy, usually avoiding an invasive procedure.
How does it work?	Uterine contents are evacuated from the uterus through a cannula into a handheld manual vacuum aspirator or electric pump	Mifepristone prevents progesterone from supporting the pregnancy. Misoprostol causes uterine contractions that expel the pregnancy.
When can it be used in an outpatient setting in Bangladesh?	Up through 10-12 weeks* since the LMP	Up to 70 days (10 weeks) since the LMP.
Where can it be used?	Procedure is done in a clinic	Some of the process may occur at home.
How effective is it?	98% to 100% effective	95% to 98% effective
What are the side effects and complications?	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 MR.	Side effects include nausea, vomiting, diarrhea, abdominal cramping or pain, fever or chills, vaginal bleeding, dizziness and, rarely, anemia. Occasionally, medication MR can fail requiring completion, preferably using vacuum aspiration. There is a possible, but rare, need for blood transfusion.
How is it typically used?	Procedure time is usually 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. POC is examined and procedure completion is immediately confirmed, necessitating only one clinic visit.	Mifepristone is given orally at a clinic visit. 1-2 days later, the woman takes misoprostol, either vaginally, sublingually or buccally. A follow-up visit is scheduled to confirm the treatment is successful.
What happens if the procedure or treatment fails?	Re-evacuation is performed.	Vacuum aspiration is performed, when MA is not available.

(Adapted from Talluri - Rao and Baird, 2003; Stewart et al., 2001; Kulier et al., 2004; Paul et al., 2002)

** Bangladesh MR Policy allows Doctors to provide MR services for LMP up to 12 weeks, while FWVsand Nurses can provide MR services for LMP upto 10 weeks.*

10.0 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.

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.

A referral is needed when:

- The problem or issue discussed with the woman is beyond the counselor's skill or knowledge
- The counselor has a conflict of interest or personal values that make it difficult to be impartial, nonjudgmental or maintain confidentiality.
- The woman's needs and questions are beyond the capacity of the health-care facility and its counselers and providers
- 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 accessible to the woman, both geographically and financially

It is also a good idea for counselors to routinely ask each woman if it is safe for her to receive written referral information. For some women, it may be dangerous to receive information that may be found by someone else. In such situations, the counselor can work with the woman to find an alternative way to provide her with the information.

11.0 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

12.0 Special considerations

Some clients may have special needs that they are not comfortable mentioning to a counselor. Therefore, it is important that counselors ask questions to elicit information about each woman's situation and decision. 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, such as:

- Women with multiple abortions
- Women who have experienced violence
- Women living with HIV
- Young women
- Women who do sex work or exchange sex for goods or money
- Women with cognitive and developmental disabilities and mental illness
- Refugees and displaced persons
- Women who partner with women
- women who present later in pregnancy

(Please see Appendix 18 D: Special considerations.)

13.0 Summary

- Counseling is a supportive, confidential interaction between a provider and client, in which information is provided by both, in order for the client to make the best decision about her care.
- 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.

Clinical Assessment

Clinical Assessment

Key topics in this Chapter:

- Complete clinical assessment
- Conditions such as ectopic pregnancy and reproductive-tract infections
- Special client Considerations

1.0 Introduction

Before performing a uterine evacuation 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 assist the woman in making an informed choice about her preferred method of uterine evacuation.

The assessment should be conducted in private & respectfully.

The Components of a complete clinical assessment are:

- Client history
- Psychosocial assessment
- Physical examination, including pelvic exam
- Laboratory investigations (optional)

2.0 Client History

A client history is important to determine the woman's gestational age and eligibility for medical MR/PAC or vacuum aspiration, and to provider information that will help the provider meet her other reproductive and sexual health needs. The provider needs to ask the woman about her requirement and record the medical history, including:

- First day of Last Menstrual Period (LMP)
- Signs and symptoms of pregnancy
- Whether she had a pregnancy test or ultrasound and the results of the tests
- Whether she has had any bleeding or spotting during the pregnancy
- Known drug allergies
- Recent medications taken including misoprostol or herbal medicines
- Obstetric and gynecological history, such as number of previous pregnancies,

live births, miscarriages or abortions, history of ectopic pregnancy, menstrual history, fibroids, infections or any recent MR related/Postabortion Care.

- Sexual history, such as number of partners or recent new partners
- HIV status and presence of sexualy transmitted infection (STI)
- Previous medical and surgical history
- Physical or cognitive disabilities or mental illness
- Known health conditions
- History of contraceptive use
- Tobacco or drug use

Pre-Existing Conditions

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

Pre-Existing Conditions	Comments
Hypertension	• 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.
Seizure disorder	• The woman should take her usual dose of anti- seizure medication on the day of the MR/PAC • Benzodiazepine sedative may be administered before performing a uterine evacuation. • Several anti-epileptic drugs interfere with some form of combined hormonal contraception
Anemia	• If hematocrit or hemoglobin very low, be prepared to treat appropriately
Asthma	• The woman should be stable and not having an acute asthmatic attack prior to uterine evacuation procedure.
Suspected ectopic pregnancy	• Evaluate, treat or refer according to local protocol.
Cervical stenosis	• Consider performing vacuum aspiration under ultrasound guidance, using an agent such as misoprostol to prepare the cervix to procedure, or waiting until the woman is 8 weeks.
Alcohol or drug abuse	• Be prepared for low pain threshold. • Consider use of narcotic analgesic and parenteral sedatives.

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

Prior Self-Administration of Misoprostol

Self-administration of misoprostol to terminate pregnancy is seen frequently in some settings. No specialized treatment is needed, 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 continues.

Although women may have no side effects from misoprostol, nausea and diarrhea can occur; these effects maybe more common or more severe with higher doses. The effects of misoprostol varywith the length of amenorrhea.

Information on the unsupervised use of the 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.

2.1 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. Some women may show signs of nervousness or other distress. Particularly in young women or those who are having an MR for the first time, special care should be taken to ease any fear they may have about the procedure.

Providers should use a gentle, nonjudgmental tone and display a sense of concern and confidentiality. 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* Chapter for more information.)

It is also important to note any cognitive disabilities or mental illness. Providers should encourage the woman to discuss the circumstances that led to her seeking care:

- Is there anything she feels the provider needs to know?
- Does she have a stable family environment and support system?
- Is she subject to violence?

3.0 Physical Examination

Clinicians who provide abortion or Postabortion Care should have strong skills in pelvic examination and be competent in diagnosing and dating early pregnancy. Three commonly used approaches to pregnancy dating are:

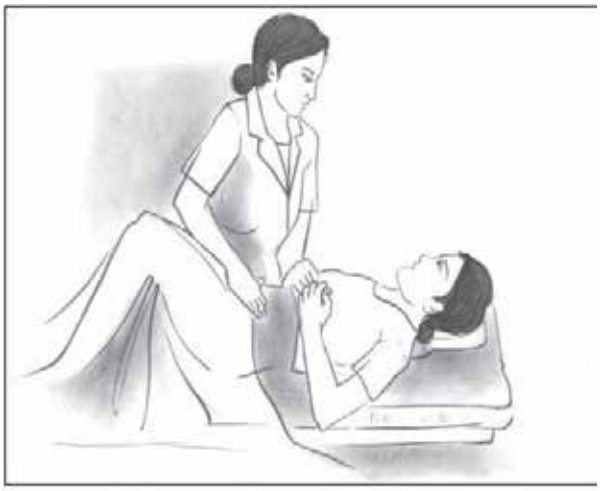
- Determining the date of the last menstrual period (LMP)
- Performing a pelvic exam to assess uterine size
- Uising ultrasound

Gestational age can be accurately estimated based on LMP and pelvic examination.

3.1 General Health

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

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



Positioning the woman

For a woman who comes for Postabortion Care note the following:

- Skin pallor
- Skin should feel warm and dry
- Level of consciousness, fainting or anxiety
- Signs of general health, including any weakness or lethargy
- Listen to her heart for:
  — irregularities of beat
- Listen to her lungs for:
  — signs of respiratory distress
  — wheezing or rales
  — shallow breathing

Examine her abdomen for:

- — distention
- — decreased bowel sounds
- — rigidity or hardness
- — rebound tenderness
- — masses or other abnormalities

Examine her extremities for:

- — cyanosis (blueness)
- — possible signs of violence, such as bruises or burns
- — shoulder pain, which could be referred pain of internal injuries

3.2 Pelvic Examination

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 MVA Plus*®Chapter.)

Verbal reassurance

Explain to the woman what to expect and what she might feel before beginning the pelvic exam. Ask her if she would like to have a support person with her. If this is her first pelvic exam, she may be anxious, and it particularly important to reassure her.

The pelvic examination includes a speculum and bimanual examination, 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. Always make sure the woman's privacy is protected and let the women know what to expect. This is especially important if this is the women's first pelvic examination, which is most likely in young or nulliparous women.

Positioning the woman

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

Lithotomy position

Speculum examination

The speculum examination 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 vagina carefully.
- Check for bleeding. If present, check the amount and source of the bleeding.
- Check for an open cervical os or products of conception in the os or vagina.
- Note if any 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 bacteriological culture, if possible.
  - Even if lab tests are not possible to confirm the type of infection, antibiotics should be administered at this time, before evacuating the uterus, according to National Guidelines for Management of Sexually Transmitted Infection, NASP, DGHS, MoH&FW, GOB of Bangladesh, 2006.
- Remove any visible products of conception (POC) gently, retaining the tissue removed for later examination.
- Check for any tears, burns or perforations visible in the vagina or cervix.
  - Presence of fat, bowel or omentum indicates uterine perforation.
  - Repair immediately — laparoscopy or laparotomy may be necessary
  - Women who may be immunocompromised, including women with HIV, may need more aggressive treatment of possible infection.

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

Assessing the uterus in early pregnancy can be challenging and requires training and supervised practice. There are different training techniques to teach clinicians how to accurately assess uterine size. Regardless of the technique used, MRM service delivery programs should ensure that clinicians are properly trained in pregnancy dating. Provider assessment of uterine size has been shown to be sufficient for providing MRM to women with gestations of less than 10 weeks. The technique of assessing uterine size is the same in all women, including young women.

Potential Adverse Effects of Underestimating Length of Amenorrhea:

Vacuum aspiration

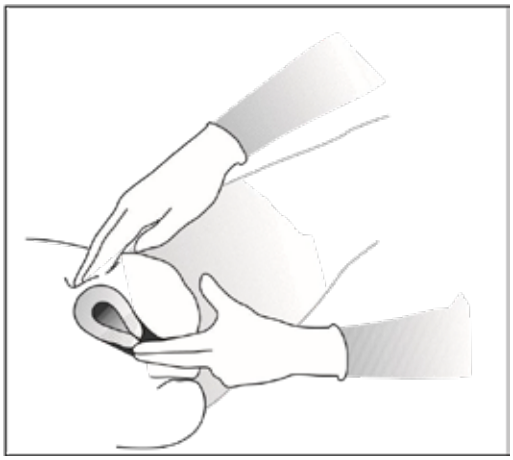
- longer procedure time, more bleeding
- greater risk of cervical trauma
- increased risk of uterine perforation and intra-abdominal injury
- increased anesthesia risk if more powerful pain medications are required
- surgical care compromised if transfer is required
- rapport with woman compromised;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

Medications for Menstrual Regulation

- May not result in complications.Reduction in effectiveness of MRM regimens as LMP increases is gradual.
- If underestimation is clinically significant, it can result in an increased chance of incomplete uterine evacuation.

Bimanual examination

- The provider should perform a bimanual examination to assess the size, consistency and position of the uterus and adnexa.
- Signs of pregnancy, including softening of the cervix and softening and enlargement of the uterus, are detectable during the bimanual exam as early as six to eight weeks since the LMP.
- Women with signs of a pelvic infection will have cervical, uterine or lower abdominal tenderness on bimanual exam.
- After 6 weeks LMP, the uterus increases in size by approximately 1 centimeter per week and takes on a roundish shape.
- To assess the uterus and adnexa, the clinician places two fingers into the vagina and then palpates the abdomen with the other hand. The size of the uterus is then compared with the history of amenorrhea.
- The technique of assessing uterine size is the same in all women, including young women.



Perform Bimanual examination

Dorsal or Frog-leg 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.

If the uterus is **smaller** than expected, providers should consider one of thefollowing conditions:

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

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

- Inaccurate menstrual dating
- Multiple pregnancies
- Uterine anomalies such as fibroids or bicornuate uterus
- Gestational trophoblastic neoplasm/molar pregnancy (although the uterus can sometimes be smaller also)
- Normal variation between women at a given length of pregnancy

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

For more information on the use of history and bimanual exam to confirm completion of menstrual regulation with medication

Table: Guide to uterine size determination*

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

*Adapted from *"Comprehensive Abortion Care: Participants Handbook 2011, Ipas Nepal"*

3.3 Laboratory Test

In most cases, providers only need the information obtained from a woman's history and physical examination to determine eligibility for MR.
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 2012 *Technical and Policy Guidelines for Safe Abortion,* 2nd edition, "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 MR. The need for routine Rhesus (Rh) iso-immunizationhas not beenproven by clinical studies (WHO, 2012). Where Rh immunoglobin is routinely provided to Rh-negative women, this protocol should also be applied for women undergoing MR. It should be administered at the time of the procedure when performing vacuum aspiration and, in the case of medication MR, at the time of the administration of the medications.

Other reproductive health services may be offered to women where available, but are not required to perform an MR safely and should not be a precondition for provision of MR care. *(See the Additional Resources section of this Chapter for more information.)*

4.0 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 MR *(WHO, 2012).* Where it is available, it can be used along with quantitative BHCG measurements to help detect unruptured 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 minutes, possibly indicative of internal bleeding; internal bleeding is not necessarily accompanied by vaginal bleeding
- No uterine contents present 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 to preserve their future fertility.

Table 3-1; Ectopic pregnancy	
Risk factors for ectopic pregnancy	Risk of ectopic in the current pregnancy
Previous ectopic pregnancy	10-15%
History of tubal surgery including	25-50%
Presence of intrauterine device	25-50%

5.0 Reproductive-Tract Infections

The administration of antibiotics to women at the time of an MR/PAC 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, 2012).*

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 at the time of her uterine evacuation procedure. These women will also need a course of antibiotics after the procedure to ensure that the infection has been eradicated.

Use caution in vacuum aspiration to avoid perforation or failed MR with:

- Retroverted uterus (uterus tilted backwards)
- Anteverted uterus (uterus tilted forward)
- Laterally displaced uterus (uterus tilted to one side)

6.0 Special Populations to Consider During Clinical Assessment

Providers should be particularly sensitive when physically examining adolescents or women who have experienced violence. Adolescents may have never had a pelvic exam and may be particularly apprehensive. Providers should not begin the examination without receiving her consent even if an adult has legally consented on her behalf. When the examination does begin, ask permission before touching her with a hand or speculum. Women who have experienced violence may be afraid or uncomfortable about being touched in their genital area.

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 Chapter for more information*.)

7.0 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 MR 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 uterine size and LMP is a critical factor in both selecting an MR method and preventing complications.
- The physical examination involves assessing the women's general health and performinga pelvic exam.
- Although laboratory tests are not required for the provision of routine MR, 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 MR/PAC 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 MR with vacuum aspiration to help reduce women's risk of post-procedure infections but should not serve as a barrier to receiving services if not available.

Uterine Evacuation Methods

Uterine Evacuation Methods

Key topics in this Chapter:

- Recommended methods for MR, PAC in the first trimester
- Possible risks, side effects, costs and benefits of these methods
- Recommended method for MR and Postabortion Care

1.0 Introduction

Uterine evacuation is the removal if the contents of the uterus. There are two recommended methods for MR/PAC in the first trimester:

- Vacuum aspiration
- Medical methods (mifepristone combined with misoprostol or misoprostol only)

Vacuum aspiration evacuates the contents of the uterus using suction provided by a handheld, portable aspirator (manual vacuum aspiration). Vacuum aspiration is an important alternative to and occasional back-up for, medical abortion.

Medical MR (MRM) uses medications to empty the uterus. The World Health organization (WHO) states that "medical methods of abortion have been proved to be safe and effective, "When used for induced abortion, misoprostol only has a lower efficacy than the combined regimen. The medications, mifepristone and misoprostol are increasingly used worldwide for medical abortion. (Other medications, namely methortrexate, and other prostaglandins, such as gemeprost, are sometimes used) This manual focuses on regimens using mifepristone combined with misoprostol or misoprostol only for MR/PAC.

Recommended methods for first trimester incomplete abortion are:

- Vacuum aspiration (manual)
- Misoprostol

In the case of incomplete abortion, vacuum aspiration is used to suction retained pregnancy tissue from the uterus. Misoprostol evacuates retained pregnancy tissue by contracting the uterus and expelling its contents. Expectant management for incomplete abortion allows uterine contractions to naturally expel the contents of the uterus, while monitoring to ensure that all contents are fully expelled.

Uterine evacuation with vacuum aspiration or with misoprostol to remove retained pregnancy tissue is often a life-saving component of Postabortion Care. Health-care workers who will be treating women with abortion-related complications, as well as those who will be providing MR services, should be clinically competent in performing or facilitating uterine evacuation.

- Vacuum aspiration up to 12 weeks LMP, with appropriate provider training, experience and equipment
- Dilation and evacuation (D&E), which uses a combination of vacuum aspiration and forceps
- Mifepristone followed by repeated doses of misoprostol for induced abortion
- Misoprostol only, which can be used safely for induced and Postabortion Care

Young women may use the same methods of uterine evacuation as adult women. Adolescent women seeking medical abortion have similar or lower rates of adverse outcomes to adult women.

Many different types of health-care professional can safely 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 Chapter focuses on uterine evacuation in the first trimester and provides:

- A brief overview of recommended first -trimester uterine-evacuation methods
- Information on clinical safety and effectiveness, cost, acceptability to women
- Specific risks and side effects associated with each method

Sharp curettage is not recommended by WHO. A description of the technique is included because it is still available in many settings.

2.0 Vacuum aspiration

Vacuum aspirations is considered an essential service by many national and international authorities such as the World Health organization (WHO) and the International Federation of Gynecology and Obstetrics (FIGO).

Potential Side Effects of All Uterine Evacuation Procedures:

- *abdominal cramping*
- *mild to moderate nausea, vertigo*
- *vomiting*
- *pain*
- *menstrual-like bleeding*

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.

- Manual vacuum aspiration (MVA) uses a hand-held, portable aspirator

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

The procedure involves dilating the woman's cervix, inserting a cannula through the cervix into the uterine cavity, and attaching the cannula to the vacuum source. The uterine contents are then suctioned out. Depending on the uterine size and amount of tissue, the procedure takes from three to 10 minutes to complete.

Clinical safety and effectiveness

Vacuum aspiration is extremely effective and safe. and is successful in 98% to 100% of cases, for both MR and treatment of incomplete abortion. The method results in few complications, especially when performed up to 12 weeks. Safety and programmatic benefits of vacuum aspiration, compared to sharp curettage, include:

- Reduced blood loss
- Reduced procedure time
- Reduced risk of major and minor complications
- Reduced pain
- Reduced cost

Because many providers perform sharp curettage in an operating theatre with heavy sedation or general anesthesia, anesthetic risks are decreased with vacuum aspiration.

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*
- *haemorrhage*
- *acute hematometra*
- *failed complete evacuation of uterine contents*

Cost

Vacuum aspiration can be very cost-effective when performed on an outpatient basis. Vacuum aspiration can result in savings to the facility that can then be passed on to the woman.

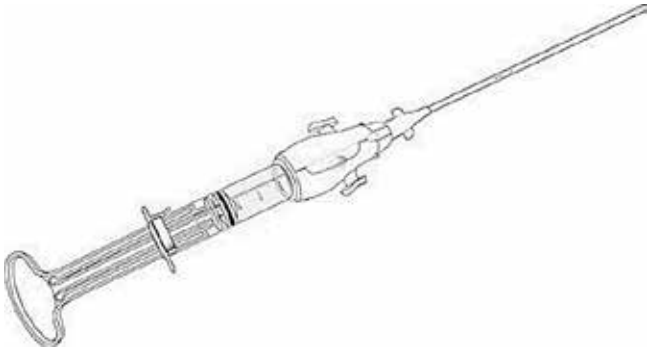
Acceptability to Women

Vacuum aspiration is well-accepted by women, including young 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 (NSAIDs), verbal reassurance (Verbocaine) and, if desired, light sedation allow women to be awake and aware of what is happening to them during the procedure and decrease anxiety. With lower levels of pain medication, MR care can be provided in an outpatient setting, which is generally more acceptable to women than a hospital stay.

2.1 Manual Vacuum Aspiration (MVA)

WHO—in conjunction with the United Nations Population Fund (UNFPA), the United Nations Children Fund (UNICEF), and the World Bank and with endorsement by FIGO and International Confederation of Midwives (ICM), endorses MVA as an essential technology for uterine evacuation.

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

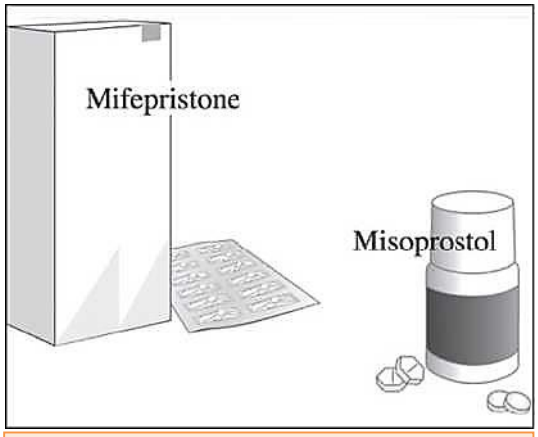


MVA Plus® with EasyGrip® cannula

MVA is safe and effective

- With no difference in complications rates compared to doctors.
- It does not required electricity and can be used in decentralized, rural settings with intermittent electrical supplies.
- It can be provided in a clinic setting on outpatient basis, requiring fewer facility resources and reducing cost of care.
- Where instruments can be reused, the cost per procedure can be relatively low.
- Reduced waiting times and increased local availability of care make this an acceptable method for many women, including young women.
- MVA creates little noise during the procedure, which some women find preferable.

2.2 Medical methods



MRM pills

Medical MR uses mifepristone combined with misoprostol,

- Mifepristone blocks progesterone activity in the uterus, leading to detachment of the pregnancy. It also causes the cervix to soften and the uterus to contract. Mifepristone used alone does not cause an abortion but works in combination with another prostaglandin like misoprostol.
- Misoprostol was developed for gastrointestinal indications but also has the effectof softening the cervix and stimulating uterine contractions. It is an effective abortifacient either alone or in combination with mifepristone. It is used for many obstetric and gynecologic indications including labor induction, medical abortion, treatment of incomplete or missed abortion, prevention and treatment of postpartum hemorrhage and cervical preparation.

These medications stimulate uterine contractions and cause expulsion of the pregnancy. Other medications have been used for abortion, but clinical evidence supports the combined use of mifepristone plus misoprostol as the most effective and safe method. Misoprostol only for induced abortion is an option in settings where mifepristone is not available and is also used for treatment of incomplete abortion.

Mifepristone and misoprostol for uterine evacuation are on WHO's Model List of Essential Medicines, as well as the Interagency List of Essential Medicines for Reproductive Health, compiled by several of the UN agencies and other international NGOs.

Clinical Safety and Effectiveness

- Combined regimens using mifepristone and misoprostol through 10 weeks LMP have been widely studied and safely used by millions of women in many countries. Studies indicate that the combination of mifepristone plus misoprostol is more effective in stimulating complete induced abortion than either drug used along, Research protocols for pregnancies up to and including 10 weeks report success rates of over 95 percent.
- Misoprostol only for induced abortion, using the recommended regimen, is successful in approximately 85 percent of cases.
- Misoprostol for treatment of incomplete abortion, also known as misoprostol for Postabortion Care (MPAC), has average efficacy rates reported in the

literature of 91 - 99 percent, depending on the regimen used and the study.

Misoprostol has been used safely for incomplete abortion in many different countries and has not been associated with any ling-term effects on women's health.

Most women undergoing uterine evacuation with medical methods experience some amount of abdominal cramping and bleeding. Other possible side effects, depending on dosage and route of administration, If a woman decides to continue a pregnancy after unsuccessful medical abortion, her health-care provider should respect her decision.

Cost

The cost of a medical abortion depends on the clinical regimen, the technology and the cost of providing backup in case re-evacuation is needed. Uterine evacuation with medical methods is considered a low-cost treatment.

Acceptability to women

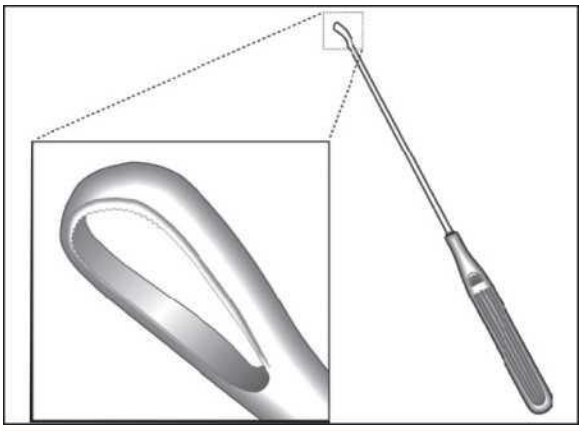
MA is highly acceptable to women in a variety of settings, including where resources are limited. Studies consistently show that 85 to 95 percent of women are satisfied or highly satisfied with the method, and would be willing to use it again or recommend it to a friend if needed. Women should be given a choice of method whenever possible and be provided sufficient information to make an informed decision.

Young women show similar preferences around medical abortion and participation in the decision making-process.

3.0 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.



Metal Curette

According to the WHO, "Dilatation and curettage (D&C) is an obsolete method of surgical abortion and should be replaced by vacuum aspiration and/or medical methods. "The International Federation of Gynecology and Obstetrics (FIGO) also supports the use of vacuum aspiration or medications over sharp curettage for uterine evacuation.

4.0 Considerations for Postabortion Care

- Uterine size may be smaller than the woman's report of her last menstrual period because some of the uterine contents have already been expelled. A woman's eligibility for uterine evacuation method for Postabortion Care should be guided by uterine size rather than LMP.
- Wherever possible, women should be given a choice of uterine evacuation methods based on her eligibility.
- Both vacuum aspiration and misoprostol are clinically- safe and cost-effective and highly acceptable to women and providers.

5.0 Summary

- The two recommended methods of first trimester uterine evacuation are vacuum aspiration and medical methods.
- Mifepristone followed by misoprostol is the most effective method of medical abortion.
- Vacuum aspiration for first-trimester abortion and Postabortion Care is safe and acceptable, including for young women, and is successful in 98 to 100 percent of cases.
- Medical abortion for first-trimester abortion is safe and acceptable, including for young women, and is successful in at least 95 percent of cases using mifepristone plus misoprostol, and 85 percent of cases using misoprostol-only.
- Misoprostol for incomplete abortion is safe and acceptable, including for young women, and is successful in 91-99 percent of cases.
- Providers need to take the following factors into consideration when determining which uterine-evacuation method to use: the woman's personal preferences, clinical condition, gestational age, availability of equipment, supplies and skilled staff; and currently available scientific and medical evidence.
- Sharp curettage is not recommended because it is less safe than other methods. If uterine evacuation is not currently being provided, vacuum aspiration and medical abortion should be introduced first.

MVA Instruments

MVA Instruments

Key topics in this Chapter:

- Instrument features & use
- Processing & care of Instruments

1.0 Introduction

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

Several circumstances require uterine evacuation. According to the World Health Organization (WHO), vacuum aspiration is a preferred method for uterine evacuation (WHO, 2012).

Although single valve aspirators (SVAs) are still available in Bangladesh for providing MR services at the public and private sector health facilities, the government is increasingly supplying MVA Plus® aspirators, which can be used for uterine evacuation up to 12 weeks LMP per national policy, as well as for the management of PAC. Providers will be trained on the use of the MVA Plus®aspirator and EasyGrip® cannulae, which are safe and effective instruments designed to meet women's MR and postabortion-care needs.

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

- Instrument features, care, use and processing: Information on MVA Plus® and 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 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

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

Information in this section is based on the product labeling for the MVA Plus® aspirator and EasyGrip® cannulae. Details on Single Valve Aspirator (SVA) are added as *Annex* at the end of the Chapter.

2.1 Description of MVA Instruments

MVA instruments consist of a manual vacuum source (aspirator) that removes tissues and blood through uterine-evacuation procedures. Cannulae are attached to the aspirator and used to apply suction to aspirate tissue from the uterus.

Description of aspirators

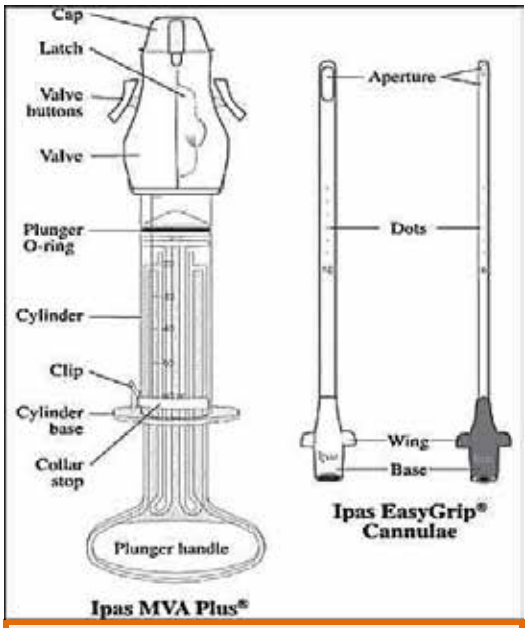
The MVA Plus® aspirator provides a vacuum of 24 to 26 inches (609.6 to 660.4mm) of mercury.

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 MVA Plus® is compatible with EasyGrip® cannulae, flexible Karman cannulae and cannulae from other manufactures.

MVA aspirators are designed for multiple uses.

Although aspirators are clean when shipped, they must be high-level disinfected or sterilized prior to first use and after each procedure to remove contaminants. The MVA Plus® aspirator is made of steam-autoclavable materials and was designed specifically to allow steam contact with all surfaces when disassembled. It can also be processed with sterilization or high-level disinfection.



Instrument parts assembled

Description of cannulae

EasyGrip® cannulae are compatible with the MVA Plus® aspirator. 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 separate adapters are needed withEasyGrip® 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.

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 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. 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 self life for packaged cannulae is three years. Cannulae must be sterile or high-level disinfected (HLD) when reused.

EasyGrip cannulae are reusable after processing where regulations allow. These cannulae require high-level disinfection or sterilization between patients and must be HLD or sterile when inserted into the uterus.

EasyGrip cannulae are made of steam-autoclavable materials. 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 MVA Plus® Aspirator and EasyGrip® Cannulae

All aspirators and cannulae up to 12mm are intended for uterine evacuation/uterine aspiration in obstetrics and gynecology clients.

Clinical indication for uterine aspiration with this product

- Treatment of incomplete abortion for uterine size up to 12 weeks after the last menstrual period (LMP)
- First-trimester abortion or MR
- 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.

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 factory 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 (Please see the Clinical Assessment Chapter).

It is important to use a cannula size appropriate to the size of the uterus and amount of cervical dilation present. The cannula size chosen for the MR procedure usually corresponds with the uterine size. For instance, if the uterine size is 7 weeks than a 7 mm cannula can be used. However, if needed the size of cannula can be slightly smaller or slightly bigger. Using a cannula too small is inefficient and may result in incomplete abortion or retained tissue.

Following are the ranges of suggested cannula sizes relative to uterine size for MVA:

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

Precautions

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

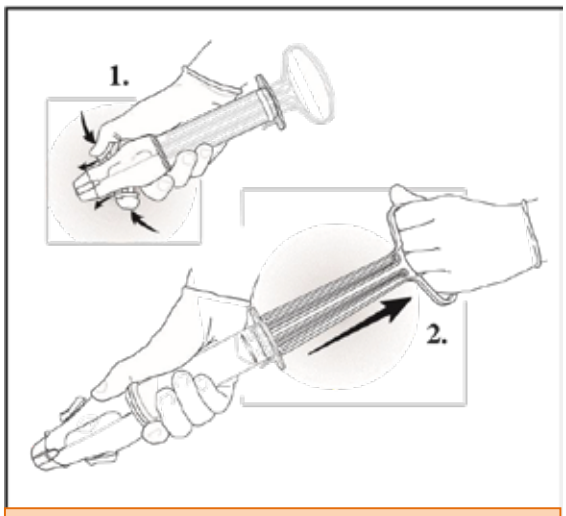
2.4 Functioning of the MVA Plus® Aspirator

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

2.5 Preparing MVA Plus® Aspirator

Preparing a Vacuum and Checking Vacuum Retention

With the 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:



Create a vacuum

1. Begin with the valve buttons open (not depressed), the plunger positioned all the way into the cylinder and the collar stop locked in place, with the tabs pushed down into the holes in the cylinder.
2. Push the buttons down and forward until they lock into place.
3. Create a vacuum by pulling the plunger back until the arms of the plunger snap outward and catch on the wide sides of the cylinder base. Both plunger arms must be fully extended to the sides and secured over the edges of the cylinder. Incorrect positioning of the arms can allow them to slip back inside the cylinder, possibly injecting the contents of the aspirator back into the uterus.

   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:

   a. Is the plunger O-ring intact, rather than nicked or damaged, free of foreign bodies and positioned in the groove?

   b. Is the cylinder firmly placed in the valve?

   c. Has the plunger O-ring been properly lubricated, over-lubricated, or not lubricated at all?
6. Then create a vacuum and test it again. If the vacuum is still not retained, discard and use another aspirator.

Stopping and Starting Suction

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

3.0 Processing and care of Instrument

With the worldwide presence 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. (Please see the Infection prevention Chapter for more information.)

As mentioned previously, MVA aspirators and EasyGrip® cannulae are multiple-use devices. Both of these instruments are reusable after undergoing sterilization or high-level disinfection. 3mm cannulae are single-use devices.

Instead of pre-soaking instruments in chlorine, users should either rinse or soak the MVA device in water (not chlorine or saline) after it is used but before it is cleaned, or spray it with enzymatic spray. Most important is to keep the device moist or wet until cleaning and either sterilization or high level disinfection can be performed. Ipas is no longer calling step 1 of Instrument Processing “pre-soak” or “decontamination soak”; in order to avoid confusion, the first step of instrument processing is now called “point-of-use preparation”.

Ipas no longer recommends soaking of instruments in 0.5% chlorine solution or in any other disinfectant before cleaning when processing instruments for the following reasons:

• It may damage/corrode the instruments

• The disinfectant may be inactivated by blood and body fluids, which could become a source of microbial contamination and formation of biofilm

• Transportation of contaminated items soaked in chemical disinfectant to the decontamination area. May pose a risk to health care workers and result in inappropriate handling and accidental damage

• May contribute to the development of antimicrobial resistance to disinfectants Chemical

Disinfection prior to cleaning is unnecessary, ineffective, and of little value in the presence of organic matter (WHO, 2016)

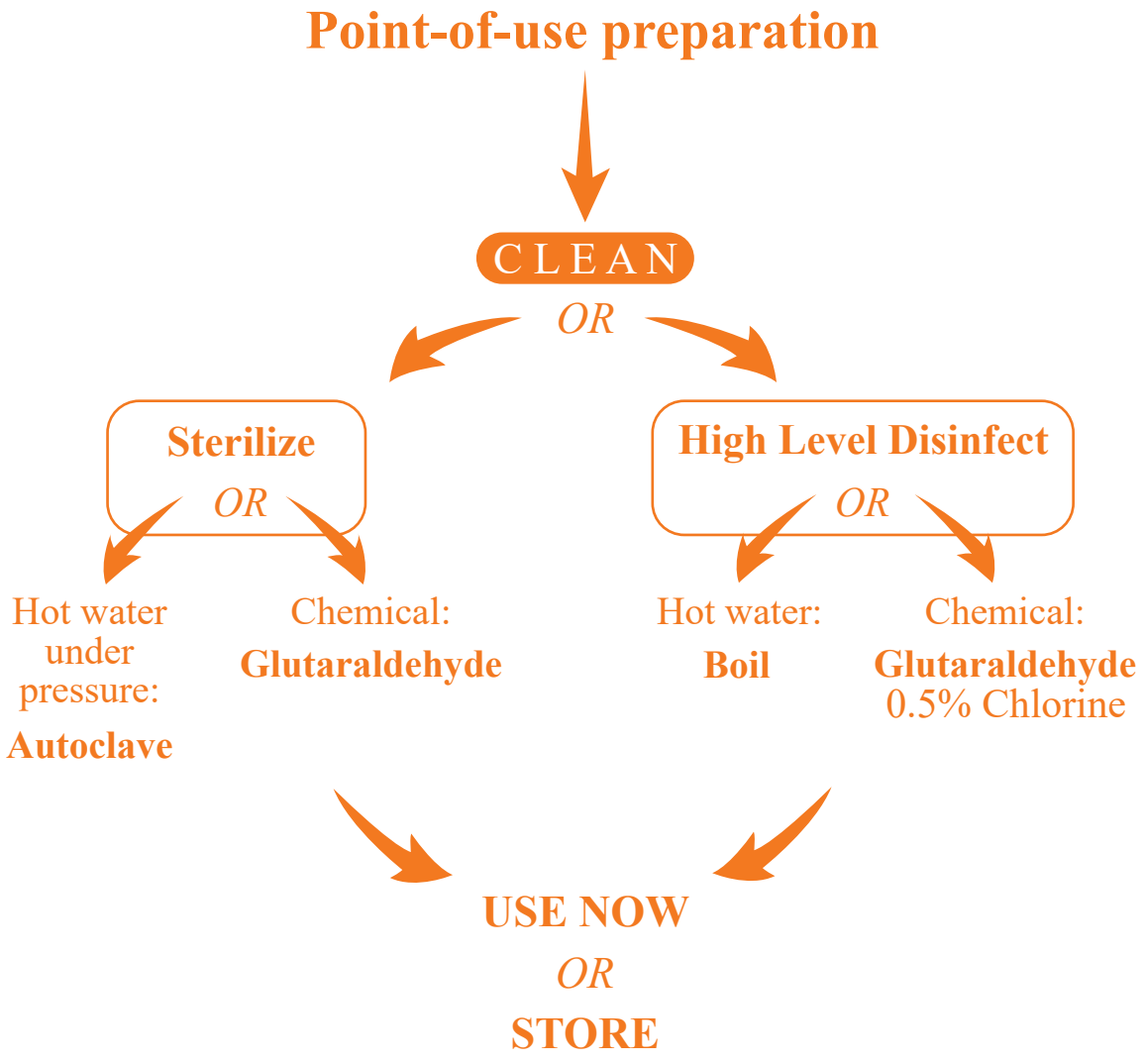
Refer to the chart below to determine a protocol for processing. The four basic steps for processing contaminated MVA Plus®aspirators and EasyGrip® cannulae are:

i. Point-of-use preparation

ii. Cleaning

iii. Sterilization or high-level disinfection

iv. Storage



Processing Options for MVA Instruments

After cleaning, the MVA Plus, the Single-Valve aspirators, EasyGrip cannulae and adapters (if used) must undergo high-level disinfection (HLD) or sterilization between patients to remove contaminants. Devices are then safe to use for the next procedure.

- Aspirators and adapters do not need to remain high-level disinfected or sterile at the time of use.
- Cannulae must be high-level disinfected or sterile at the time of use.

For optimal infection prevention, items should be processed using a method that provides the highest level of effectiveness. When best practices are followed, the following methods are listed in order of effectiveness:

- Sterilization using steam autoclave
- Sterilization using cold methods (Cidex)
- HLD methods (boiling, chlorine)

The chart below shows common processing methods for Ipas instruments. Using inappropriate methods may damage the instruments and render them unusable. (See Annexure: 9 *Appendix C: Methods for Processing MVA Plus® Aspirator and EasyGrip® Cannulae*for more information on the processing methods for these Ipas instruments.)

Summary of Common Processing Instruments

Instrument	How supplied	Minimum level of processing required for use		Processing Method					
				Steam autoclave	Glutaraldehyde*	Ethylene oxide (ETO)	Glutaraldehyde*	Chlorine*	Boiling
				Sterilization			High-level disinfection		
MVA Plus® aspirator	Clean	HLD	All Ipas instruments that are reused should be kept wet until cleaning. Water should be used. CAUTION: Letting instruments dry before cleaning makes it difficult to remove all contaminates. To clean the instruments, wash all surfaces thoroughly in warm water and detergent. Detergent is preferable to soap, which leaves a residue.	Yes	Yes	No	Yes	Yes	Yes
Single-Valve Aspirator	Clean	HLD		No	Yes	No	Yes	Yes	No
EasyGrip® Cannula	Sterile (ETO)	Sterilization or HLD		Yes	Yes	Yes	Yes	Yes	Yes
Flexible Karman cannula				**It is only for single use. Dispose it after single use.**					

*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.

i. Point-of-use preparation

Following the procedure, all instruments to be reused should be kept wet in water until they can be cleaned. Instruments should not be kept wet in chlorine.

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.

Clean thoroughly

ii. Cleaning

The second step in instrument processing is cleaning. Thorough cleaning with a soft brush, detergent, and water is essential before sterilization or HLD to remove organic and inorganic materials on the instruments which can interfere with the effectiveness of these processes. This is the most important step to ensure proper final decontamination of instruments.

❖ **Disassembly of Instruments**

Aspirators must be disassembled before cleaning and further processing, and they must be correctly assembled after processing in order to function properly.

To disassemble the MVA Plus® aspirator

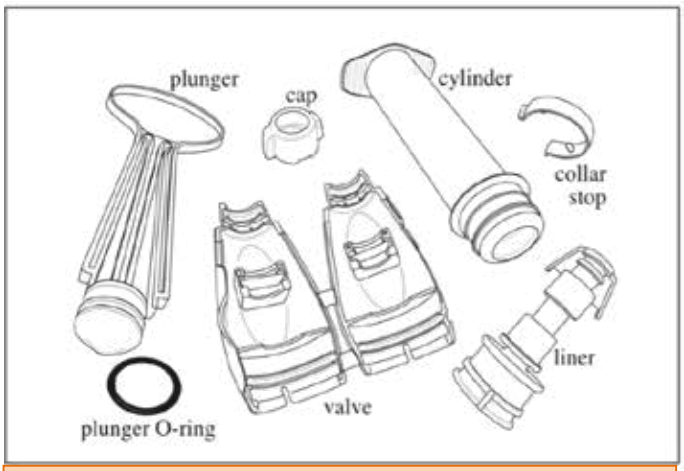
- Pull the cylinder out of the valve.
- With one hand, press down the cap-release tabs; with the other hand, pull the cap off. Then open the hinged valve by pulling open the clasp and remove the valve liner.
- Disengage the collar stop by sliding it sideways under the retaining clip or removing it completely from the cylinder.
- Pull the plunger completely out of the cylinder.
- 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.

Remove the O-Ring

❖ Steps of Cleaning

Disassemble instruments before cleaning.

- 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.



MVA parts disassembled

- Clean the crevices and interior of the cylinder, valve parts and plunger using a soft-bristle brush, being careful not to splash.
- Clean each item until no tissue or blood is visible upon careful inspection, then rinse.
- Allow items to dry.

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

iii. Sterilization and High-Level Disinfection

After cleaning, the MVA Plus® and EasyGrip® cannulae must undergo high-level disinfection or sterilization between patients to remove contaminants. Devices are then safe to use for the next procedure. Aspirators do not need to remain high-level disinfected or sterile for the next use, but they must be stored in a clean place until next use. Cannulae must be high-level disinfected or sterile at the time of use. It is important to note that the method of processing will determine how long cannula can be stored without repeating HLD before next use.

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.

The following is a list of processing methods Ipas devices will withstand, with exceptions noted.

High-level disinfection or sterilization according to one of the options below is required to reuse cannulae and aspirators.

- Steam autoclave instruments at 121°C (250°F) with a pressure of 106kPa (15 lbs/in^2) for 30 minutes.

Note: Ipas double-valve and single-valve aspirators and flexible Karman cannulae will crack or melt if autoclaved.

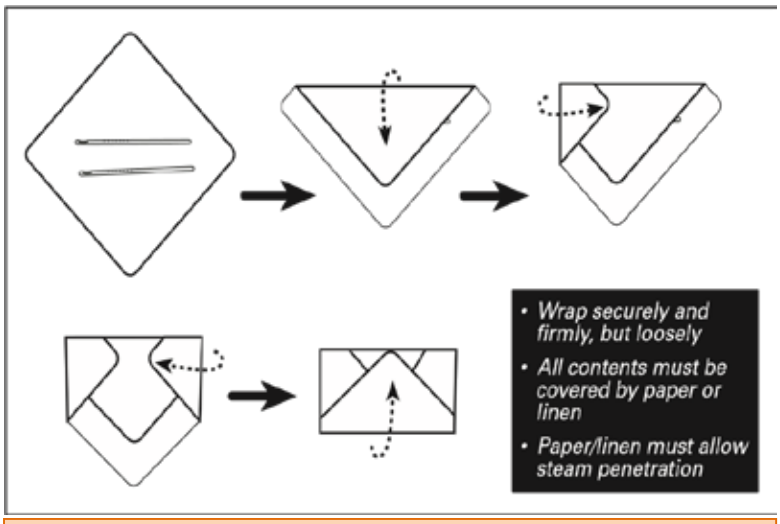
- Sterilize using glutaraldehyde. Soak the clean instruments in glutaraldehyde (Cidex or a similar product) for 10 hours. Follow the manufacturer's recommendations for the product used. (All aspirators can withstand glutaraldehyde processing.)
- High-level disinfection using glutaraldehyde. Soak the clean instruments in glutaraldehyde 2% (Cidex or a similar product) for 20 minutes. Follow manufacturer's recommendations for the product used.
- High-level disinfection using chlorine. Soak the clean instruments in chlorine 0.5% for 20 minutes.
- High-level disinfection by boiling. Place the clean instruments in water at a rolling boil for 20 minutes.

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

Steps to Sterilize Using Steam Autoclave

- All parts of the MVA Plus® aspirator and 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.
- Since the cannulae, particularly the smaller sizes, may curve in a steam autoclave, package them in paper or linen. Place the clean EasyGrip® cannulae and the MVA Plus® aspirator in a single or double layer in a steam autoclave. Note that steam sterilizing unwrapped EasyGrip® cannulae for 30 minutes may result in slight curvature.
- Process instruments in the steam autoclave for 30 minutes at 121^{0}C (250^{0}F).

- Cool all instruments before using.



Paper wrap

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

Steps to Sterilize Using Glutaraldehyde

- Completely immerse the instruments so that the solution fills them completely.
- Soak in glutaraldehyde solution for the time recommended by the manufacturer—for example, 10 hours for Cidex.
- Remove with sterile gloves or forceps.
- Rinse all parts with sterile water. Do not use tap water to rinse.
- Dry with a sterile cloth, if desired.
- 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.

Steps to High-Level Disinfect Using Glutaraldehyde

- Completely immerse the instruments so that the solution fills them completely.
- Soak in glutaraldehyde solution for the time recommended by the manufacturer—for example, 20 minutes for Cidex.

- Remove from solution using HLD or sterile gloves or forceps.
- Rinse all parts with sterile or boiled water.
- Dry with a sterile cloth, if desired.
- Change the solution according to manufacturer's instructions—every 14 days or sooner if the solution becomes cloudy.

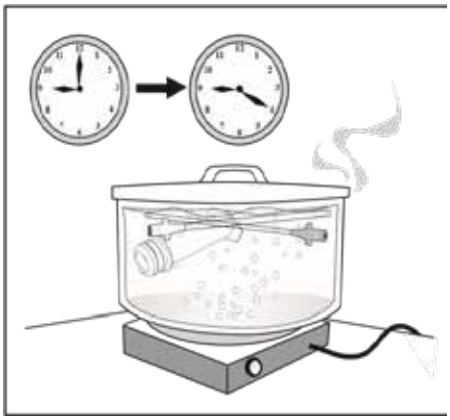
HLD soak and rinse

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

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

Steps to High-Level Disinfect by Boiling

- Place the instruments in water at a rolling boil. Items do not need to be fully immersed.
- Boil for 20 minutes.
- Remove using HLD or sterile gloves or forceps.
- Dry with a sterile cloth, if desired.
- Cool before use. Handle the cannulae by the base ends when removing. Grasping hot instruments may cause flattening. The boiling process may discolor cannulae but this does not affect their function.



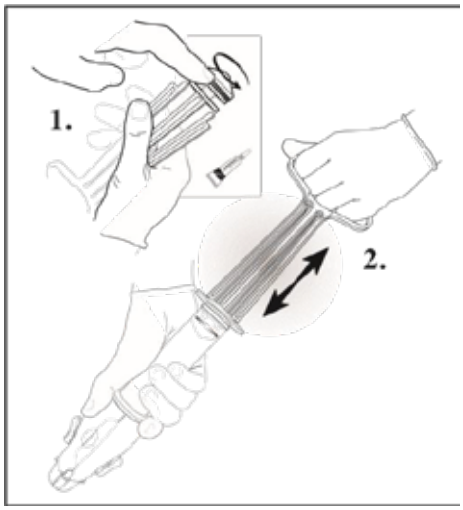
Boiling MVA instruments

- Remember, boiling is an appropriate method of HLD for MVA Plus instruments. Donot boil single-valve or double-valve aspirators.

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

4.0 Assembly and Lubrication of the Aspirator

Aspirators should be reassembled after processing and once dry. The plunger O-ring should also be lubricated before assembly. Aspirators must be correctly assembled after processing in order to function properly. To assemble the MVA Plus® aspirator:



Steps to lubrication

- Place the valve liner in position inside the valve by aligning the internal ridges. Close the valve until it snaps in place.
- Snap the cap into place on the end of the valve.
- Push the cylinder into the base of the valve.
- 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.

- When reassembling the aspirator, ensure that the plunger is introduced straight into the cylinder and not introduced at an angle.
- Squeeze the plunger arms and fully insert the plunger into the cylinder.
- Move the plunger in and out to lubricate the cylinder.
- 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 the previous section *Preparing a Vacuum and Checking Vacuum Retention* for instructions on how to check for vacuum retention.)

iv. 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 recontaminated during storage or handling. After an instrument has been processed, it remains only as clean as the last item with which it came in contact.

Aspirator: The aspirator should be kept in a clean, dry place protected from dust and other contaminants until the next use. Unlike the cannula, the aspirator does not have to remain sterile or HLD until next use. If all the parts are dry, reassemble the aspirator for storage using clean gloves or clean hands. This is because the aspirator does not directly touch the inside of the woman's body during use.

Cannulae: The cannulae need to be sterile or HLD at the time of use. Storage depends on the processing method used. If steam autoclaved, the cannulae need to remain sterile and stored in a sterile place until next use. If sterilized by glutaraldehyde soak, the cannulae need to be stored in a sterile container to maintain sterility, but should be reprocessed prior to use if not used that same day. If HLD with boiling or chemicals, the cannulae need to be stored in a HLD container to maintain HLD status, but should be reprocessed prior to use if not used the same day. 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.

5.0 Disposal and Replacement

With proper handling, maintenance and storage, MVA Plus® aspirators can be used for an average of 25 procedures. Cannulae are less durable and may need to be replaced more frequently.

When disposing of contaminated Ipas aspirators and cannulae, treat them 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

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

6.0 Summary of MVA Instruments

- The 60cc MVA Plus® aspirator comprises a cylinder, plunger and valve body.
- 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 and aspirators must undergo cleaning and high-level disinfection or sterilization between patients to remove contaminants.
- Aspirators do not need to remain high-level disinfected or sterile for the next use. Cannulae must be high-level disinfected or sterile at the time of use.
- 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.
- 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.
- 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.

Uterine Evacuation Procedure with MVA Plus

Uterine Evacuation Procedure with MVA Plus

Key topics in this Chapter:

- Preparation for a MVA procedure
- Pain management
- Uterine evacuation procedure with MVA plus
- Post-procedure care
- Follow-up care
- Special considerations: Young women

1.0 Introduction

The objective of this chapter is to explain the steps involved in a manual vacuum aspiration (MVA) procedure using the MVA plus aspirator and Easy Grip cannulae.

2.0 Preparation

Before the MVA procedure:

- Provide counseling to the woman and obtain informed consent (Please see the Informed Consent, Information and Counseling Chapter.)
- Perform a clinical assessment, including physical examination (Please see the Clinical Assessment Chapter.)
- Discuss her contraceptive needs (Please see the Contraceptive Services Chapter.)

2.1 Explaining the MVA process to women

Before the procedure, the woman should receive instructions about what she may experience, when to follow up, and when and where to seek medical help in case of a problem. Because some words are probably unfamiliar to her, providers should use simple language. Thorough information on what the woman might expect helps her to be prepared. Reassurance and support during the uterine evacuation process can also be helpful. (Please see the informed Consent, Information and Counseling Chapter.)

2.2 Clinical assessment: Physical examination

Clinical assessment prior to uterine evacuation with MVA Plus includes gestational dating, assessment of uterine size, assessment of the woman's general health and any contraindications or precautions.

Precautions prior to performing an MVA procedure

Before beginning, it is important that the provider confirm the uterine size and position to ensure that MVA is the most appropriate method for uterine evacuation. Large fibroids or uterine anomalies may make it difficult to determine the size of the uterus and to perform intrauterine procedures, including MVA. Therefore, providers should be well-trained in determining length of pregnancy prior to using MVA. Prophylactic antibiotics should be administered prior to the VA procedure. (Please see the Clinical Assessment Chapter.)

There are no known contraindications to providing uterine evacuation with MVA Plus.

2.3 Contraceptive needs

A woman may ovulate almost immediately after an MVA procedure. Therefore, all women who do not wish to become pregnant should leave the facility with an effective method of contraception. If a woman desires long acting contraception or sterilization but it cannot be provided, an interim method should be given, and referral made to the appropriate facility. In general, all modern contraceptive methods can be used immediately following first trimester MVA provided that there are no contraindications. Fertility awareness-based methods should only be used after a woman has had at least one postabortion menses and only if she had regular menstrual cycles prior to the abortion. IUDs, implants and injectables may be given in the procedure room.

(Please see the Contraceptive Services Chapter.)

3.0 Pain Management

Most women undergoing first trimester vacuum aspiration will experience pain during the procedure, Many providers underestimate the amount of pain a woman experiences during vacuum aspiration. Women who present for uterine evacuation should be offered all pain management options and provided these services without delay. Providers should always offer gentle, respectful care and provide appropriate information, which can help women stay calm and reduce anxiety and pain.

3.1 Factors influencing pain for women receiving MR & PAC

While most women feel pain during a vacuum aspiration procedure, each woman is unique and there is great variation in their experiences of pain. Providers should avoid stereotypes or assumptions about a woman's pain threshold. Pain management should address both the physical aspects or pain as well as the psychosocial contributors. Physical aspects that have been associated with increased pain during

vacuum aspiration include nulliparity, young age, higher gestational age, and dysmenorrhea. Psychosocial elements such as anxiety and depression have also been associated with increased pain.

Aspects of the procedure that can affect pain levels include cervical dilatation, uterine manipulation, the skill and clinical technique of the provider, and the physical environment. Although some women may have a higher pain tolerance, each woman still needs to be offered and given pain management.

Generally, there are three types of pain during uterine evacuation with MVA—anxiety, cervical dilatation and uterine cramping—and each source of pain requires a different pain-management strategy.

Anxiety: The choice to terminate a pregnancy is likely to be a major decision, and women undergoing MR 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 and uterus transmits this pain.

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

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 MR care is to reduce any physical pain and anxiety the woman experiences, while minimizing medication-induced risks and side effects.

Sample pain-management plan

- Oral analgesics administered 30 minutes prior to the MVA procedure
- Paracervical block
- Non-pharmacological approaches, such as verbal reassurance and gentle clinical technique

Pain during a uterine evacuation with MVA can be reduced with a combination of verbal support, oral medications, paracervical block and gentle clinical technique and

calming environment. Conscious sedation is an option in centers where it is offered. General anesthesia increases the risk of complications and is not recommended for routine procedures.

- 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.

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 MR care.

Verbal and physical Reassurance

Verbal and physical 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 terms "verbacaine" or "vocal anesthetic" for the process of verbal reassurance. It must be stressed, however, the 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.

Positive Statements for Verbal Reassurance by the Health-Care Team

"What can I do that would be most helpful to you?"

"What do you imagine will be the most difficult part of this for you?"

"I can't promise that it won't hurt, but I can promise you that the procedure will be done as gently as possible."

"I'll be right beside you, and you can squeeze my hand during the procedure."

(Adapted from Stewart et al., 2002)

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 toknow 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.

Calming environment

Facility staff can create a calming environment by providing appropriate music and lighting. Music is effective for pain management during vacuum aspiration and may be helpful for uterine evacuation with medical methods as well.

3.4 Pharmacological Methods for Pain Management

The amount and type of pain medication used during MVA 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:

Oral medications

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

Local anesthesia

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.

The term *paracervical block* **refers to the injection of local anesthesia into the cervix.** It is recommended for most women undergoing an MVA procedure. For instructions on administering a paracervical block, see *Section 5, Step 4: Perform Paracervical Block* of this Chapter.

Conscious sedation

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-Procedure Pain Management

Some pain is normal following even uncomplicated MR procedures because the uterus is contracting. Pain that increases over time requires clinical evaluation. Mild analgesics such as ibuprofen or other non-steroidal anti-inflammatory drugs can 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 the *Post-Procedure Care* section of this Chapter for more information). For more information about pain-medication options, see Table 2: *Approaches to Pain Management during MVA.*

4.0 Uterine Evacuation Procedure

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.

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 uterine size and position of the uterus prior to using MVA. (See the *Client Assessment* Chapter for more information).

Key Topics in This Section:

- *Precautions for performing an MVA procedure*
- *Steps for an MVA procedure*

4.2 Provision of Antibiotics

Although rare, uterine infection after an uncomplicated and safe MR with MVA is possible. 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 to 1 hour prior to the procedure.

Recommendations for use of prophylactic antibiotics in safe MR & PAC care

(Reference: Clinical updates in Reproductive Health, Ipas 2020.)

For vacuum aspiration

Recommended Doses (RCOG recommended):

- Doxycycline 200mg orally single dose no more than 2 hours before the procedure, or
- Azithromycin 500mg orally single dose no more than 2 hours before the procedure or
- Metronidazole 500mg orally single dose before the procedure

Pretreatment doses of 200mg or greater of oral doxycycline have been associated with significant nausea and vomiting so consider providing an anti-emetic.

Therapeutic or treatment doses of antibiotics should only be administered to women who are suspected of or who have been diagnosed with an infection.

For medical abortion:Routine prophylactic antibiotics are not recommended.

Women at high risk should be screened for sexually transmitted infections. Women with signs and symptoms of infection should be provided abortion services without delay and receive appropriate antibiotic treatment according to evidence-based regimens. Partners of women with sexually transmitted infection also require treatment.

5.0 Uterine evacuation procedure Steps for Performing MVA

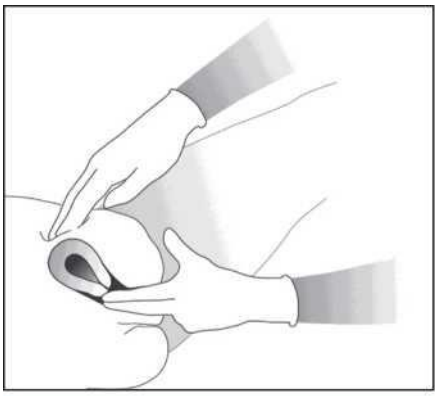
1. Prepare instruments
2. Prepare the woman
3. Perform cervical antiseptic prep
4. Perform paracervical block
5. Dilate cervix
6. Insert cannula
7. Suction uterine contents
8. Inspect tissue
9. Perform any concurrent procedures
10. Take immediate post-procedure steps, including instrument processing

Step 1: Prepare Instruments

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

Step 2: Prepare the Woman

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



Perform bimanual exam

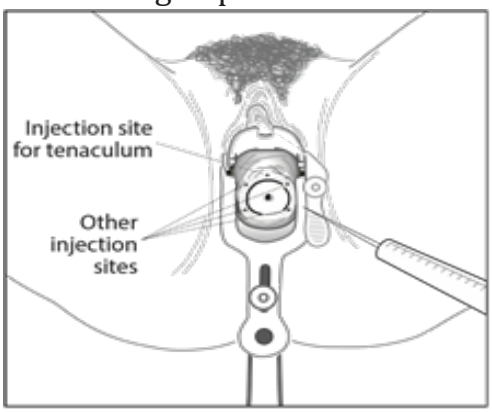
- Wash hands and put on appropriate barriers, including gloves.
- Perform a bimanual examination to confirm or update findings of the earlier clinical assessment. It is crucial to have an accurate assessment of uterine size and position before performing a uterine evacuation. If there is doubt about 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," the provider should use an antiseptic-soaked sponge to clean the cervical os once. Remember that the provider should use the no-touch technique throughout the procedure in order to prevent the introduction of foreign flora that will result in infection. However, as long as the principles of no-touch technique are followed, the provider can safely use one-time use gloves or clean, non-sterile gloves, as they will not be coming in contact with the parts of the instruments that will enter the woman's uterus.

Step 4: Perform Paracervical Block

Performing a paracervical block is highly recommended for all MVA procedures. Evidence around best practice with regard to the paracervical block continues to evolve. To minimize clinical risk when using lidocaine, the recommended dose is always less than 200mg/person, as toxicity occurs at that level.In clinical practice, techniques for administering the paracervical block vary, but the paracervical block described below has been demonstrated to be superior to blocks with fewer injection sites and lower volumes of lidocaine.



Paracervical block

After inserting the needle but before injecting any local anesthesia, always draw the plunger back

slightly to ensure 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:

1. Load a 20mL syringe with 20mL of 1.0% lidocaine OR 10 mL of 2.0% lidocaine
2. Inject 2mL of anesthetic at the site where the tenaculum will be placed (12 o'clock on the face of the cervix).
3. 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.
4. Inject the remaining 18mL in equal amounts at the cervicovaginal junction at the 2, 4, 8, and 10 o'clock injection sites. Inject continuously from superficial to a depth of 3cm, using a slow technique to decrease any pain to the woman. Remember to pull back on the plunger before injecting anesthesia to prevent intravascular injection.
5. If 1% lidocaine is unavailable 10mL of 2% lidocaine may be substituted. Either a two point (4 & 8 o'clock) or a four point paracervical injection technique should be used. Where available and where staff have been trained to do so, sodium bicarbonate (1mL of 8.4% sodium bicarbonate for every 10ml of anesthetic solution) may be added to the paracervical block.

who weighs more than 45kg, no changes are necessary. For example:

A woman that weighs 40 kg will need to receive only 18mL of 1% lidocaine. The correct volume of lidocaine is calculated as follows:
40kg*4.5mg/kg=180mg/10mg/mL=18mL

This calculation is based on:
(Patient weight in kg) x (maximal dose of lidocaine for weight 4.5mg/kg) = (maximal lidocaine dose in mg) divided by (the concentration of lidocaine for 1% this is 10mg/mL) = total amount of lidocaine volume in mL

Additional examples:

Total volume of 1% lidocaine to be received in paracervical block
20mL
18mL
15.5mL

Step 5: Dilate Cervix

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

It is essential to carefully examine the position of the uterus and cervix and to gently use instruments that accommodate the woman's anatomy. Dilate the cervix as necessary to allow allow the cannula size necessary to perform the procedure safely. 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. Start with the smallest dilator or cannula (5mm) and gradually increase. If the cervix is already open, then you can skip to a slightly larger size. 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.

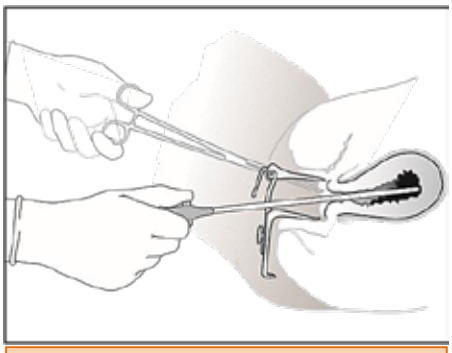
Dilatation or cervical preparation may also be accomplished by administering

osmotic dilators or pharmacological agents such as misoprostol, where available.
In a uterus less than 12 weeks size, cervical preparation can be offered or used, but it does not have to be a routine practice (WHO, 2012). There may be certain situations where cervical preparation may be helpful in a uterine size less than 12 weeks, such as in young or nulliparous women, women with cervical abnormalities or with inexperienced providers. The recommended methods for cervical preparation include:

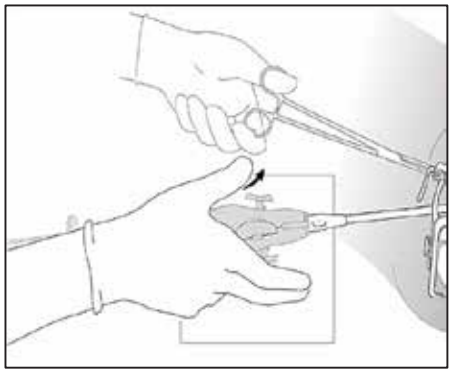
- Misoprostol 400mcg vaginally or buccal three hours before the procedure
- Mifepristone 200mg orally 24 to 48 hours before the procedure

*S*tep 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 cavi.ty until it touches the fundus, and then withdraw it slightly. Rotating the cannula while gently applying pressure often helps insertion.
Do not insert the cannula forcefully through the cervical os into the uterus. Forceful movements may cause damage to the cervix or uterine perforation and damage to pelvic organs and blood vessels. Remain alert to signs that may indicate perforation throughout the procedure, and stop suction immediately if they appear.
It is important to use a cannula size appropriate to the size of the uterus and amount of cervical dilation present. Using a cannula that is too small may result in retained tissue or loss of suction.



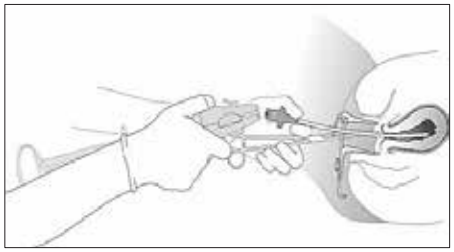
Insert cannula



Release buttons

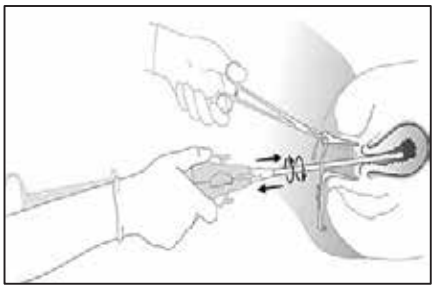
Step 7: Suction Uterine Contents

Attach the prepared MVA aspirator to the cannula, holding the tenaculum and the end of the cannula in one hand and the aspirator in the other hand. Suction is started by pressing the buttons in; suction will start immediately.
Evacuate the contents of the uterus by gently and slowly rotating the cannula 180 degrees in each direction, using an in-and-out motion.

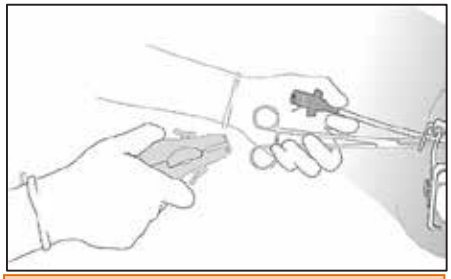


Attach aspirator

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 EasyGrip® cannulae fit firmly into the valve body and care should be used when disconnecting a cannula from the aspirator.



Evacuate uterine contents

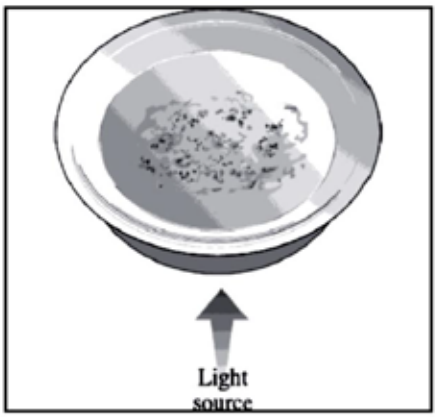


Detach cannula from aspirator

The following signs indicate that the uterus is empty:

1. Red or pink foam appears and no more tissue is seen passing through the cannula.

Detailed Tissue inspection



Inspect Tissue

2. A gritty sensation is felt as the cannula passes over the surface of the evacuated uterus.

3. The uterus contracts around (grips) the cannula.

4. The woman complains of cramping or pain, indicating that the uterus is contracting.

When the procedure is finished, depress the buttons and disconnect the cannula from the aspirator. The wings can aid in this action. Then, remove the cannula. 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
- 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 uterine products are visible, less tissue than expected was removed from the uterus or the tissue sample is inconclusive, this may indicate:

- **Incomplete MR procedure:** The uterine cavity still contains uterine product, 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.**
- **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* Chapter 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 the section *Processing Ipas Instruments* of this Chapter 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.

6.0 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.

6.1 Physical Monitoring

The woman's vital signs should be taken immediately after the procedure has been completed. She should then be allowed to rest and continue her recovery while being monitored, either in the MR-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.

Take vital signs

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 or sanitary pad 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 uterine products, 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 hematometra, which is a pooling of blood in the uterus that can occur following uterine evacuation. 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.

6.2 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.

6.3 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.

Explore feelings

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 MR 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* Chapter for more information.)

6.4 Contraceptive Counseling

Provide Instructions for medication

Contraceptive counseling should be provided during the recovery period or prior to discharge, if it has not yet been offered. The health-care worker should sensitively initiate a discussion with the woman about her desire for future childbearing in the short and long term. If the woman wishes to prevent pregnancy, the provider should ensure that she receives the contraceptive method, including emergency contraceptive if desired and available 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 *Counseling Chapter* for more information.)

MR/PAC service delivery sites should be able to provide most methods in the facility if the woman chooses a method. If the contraceptive chosen by the woman cannot be provided (e.g. sterilization is rarely offered at primary care level), the woman should be given information about where and how she can get it and offered an interim method.

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

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

6.5 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. Women undergoing MR should receive clear, simple, oral and written instructions about how to care for themselves after leaving the health care facility, including how to recognize complications that require medical attention.

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 MR, the woman may have vaginal intercourse and as soon as she desires to do so. If she wants to prevent future unwanted pregnancy, she should use an effective form of birth control when having intercourse. Conception can occur again within 8 days after a first trimester MR. (See the *Contraceptive Services Chapter* 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

Danger Signs after MR Care

Advise the woman to watch for signs and symptoms that require immediate medical care:

- Fever
- Chills
- Vomiting
- Fainting
- Severe pain
- Heavy bleeding (more than normal menstrual bleeding)

The following signs and symptoms should be monitored with regard to trend—that is, if they worsen rather than diminish over time—and severity:

- Prolonged cramping (more than a few days of abdominal pain, cramping or backache)
- Pain in the abdomen or distension of the abdomen
- Prolonged bleeding (more than two weeks of light bleeding)
- Foul-smelling vaginal discharge
- Delay in resumption of menstrual periods (more than eight weeks)
- Dizziness

(Adapted from WHO, 1995)

next four to eight weeks.

- Signs and symptoms requiring immediate emergency attention (as noted in the Danger Signs after MR Care list in this Chapter).
- 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 if desired.

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

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

6.6 Discharge of Women with Complications

Women who experienced complications during or after MR 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* Chapter for more information.)

Women who experience complications of MVA need clear, evidence-based explanations of the situation and should be included in decision making about their treatment options and referrals, if needed. 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.

7.0 Follow-Up Care

Before being discharged from the facility where they received MR/PAC care, women may opt for a follow-up appointment. The timing of the appointment depends on each individual woman's clinical and psychosocial needs. Follow-up is considered optional after noncomplicated MR with MVA and MA. Following a medical abortion or 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 MR-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 MR care that she can present to her follow-up care provider. *(See Annexure 15-Appendix D: 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:

1. To address any lingering concerns, including unresolved physical complications, contraceptive services (including emergency contraception), or emotional issues.
2. 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 MR procedure. At the follow-upvisit, providers should ensure that any existing complications have been resolved and that no new complications have developed. Women who do present at their follow-up visit with acute medical problems should be assessed, stabilized immediately and then treated. If adequate care cannot be provided at the facility, women should be referred or transferred without delay.

In most cases, however, the woman will not be experiencing serious complications, and the visit will allow the provider to spend time with her when she may be less anxious than at the time of her initial visit.

The follow-up visit is also an ideal time for the woman to receive individualized attention and care from a counselor and to learn about or access contraceptive services and other resources that can improve her overall health and well-being. (See the*Counseling* Chapter for more information.)

8.0 Special considerations: young women

Most aspects of providing abortion care for young women are the same as for adult women, but there are some special considerations.
This is likely a young woman's first pelvic exam, and she may be nervous or afraid. Therefore, providers should take special care to:

- Ensure that there is at least visual and preferably auditory privacy.
- Explain what you are doing at each step.

- Perform the examination as gently and smoothly as possible. If a range of specula sizes are available, use the size appropriate to the woman and conductive to the exam or procedure.

A nulliparous woman is more likely to have a tight cervix and thus probably requires a slower dilation process. Although women of all ages need pain management, the perception of pain and use of analgesia has been found to be higher on average in younger women than in older women.

9.0 Considerations for Postabortion Care

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

10.0 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 or MR.
- 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 uterine products and signs of complete evacuation or molar pregnancy.
- No visible uterine product, a lower quantity of tissue than expected or an

inconclusive tissue sample may indicate incomplete MR procedure, completed spontaneous abortion, failed MR, suspected ectopic pregnancy or anatomical anomaly.

- 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 if needed before she leaves the facility
- 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.

Uterine Evacuation with Medical Methods

Uterine Evacuation with Medical Methods

Key topics in this Chapter:

- Eligibility requirements and contraindications
- Regimens using mifepristone plus misoprostol
- Expected effects, side effects, side effects and potential complications
- Pain-management approaches and medication regimens
- Post-procedure care and follow-up visit

1.0 Introduction

Mifepristone and misoprostol can be used for uterine evacuation. In the first trimester, the combination of mifepristone and misoprostol results in successful menstrual regulation with no need for aspiration evacuation in over 95% of cases.

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

Misoprostol, a synthetic prostaglandin, stimulates cervical ripening (softening) and uterine contractions, causing uterine evacuation. Misoprostol is inexpensive and available in many countries for the prevention and treatment of gastric ulcers. Although it is stable at room temperature, the potency of misoprostol can degrade over time depending on its packaging or if it is exposed to high heat or humidity (Hall 2011).

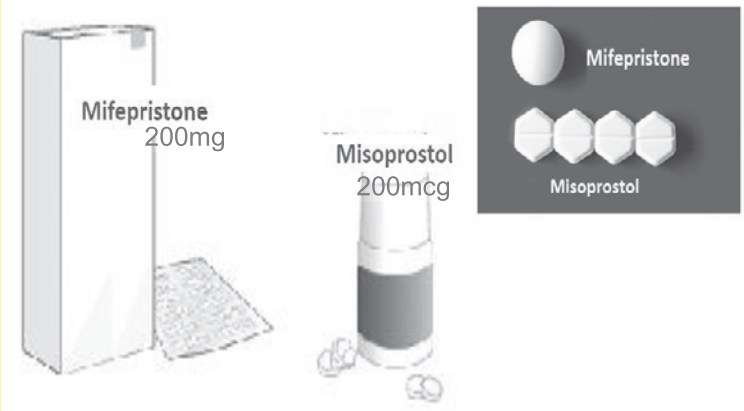
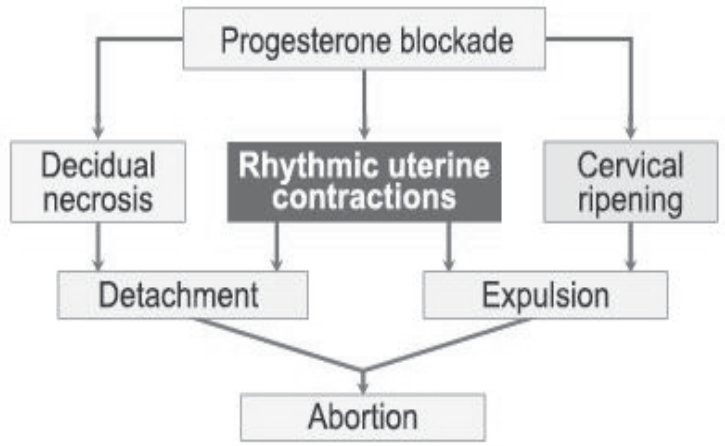
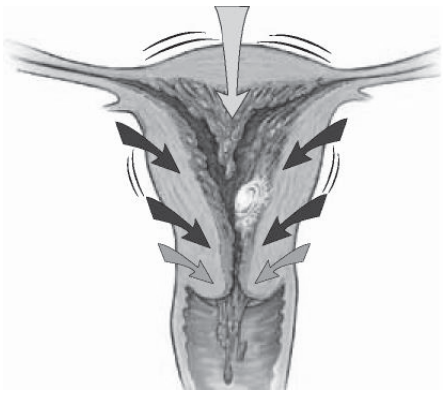


Figure: Menstrual Regulation with medication pills

In 2009, misoprostol was added to the WHO list of essential medications for treatment of incomplete abortion and miscarriage and in 2011 for prevention of postpartum hemorrhage. It can also be used for cervical preparation before vacuum aspiration and other intra-uterine procedures, labor induction and treatment of postpartum hemorrhage.

The image below illustrates the two medications' combined mechanism of action.





2.0 Preparation

Before administering any medications:

- Provide counseling to the woman and obtain informed consent (Please see the informed Consent, Information and Counseling Chapter.)
- Perform a clinical assessment, including physical examination (Please see the Clinical Assessment Chapter.)
- Discuss the woman's contraceptive needs (Please see the Contraceptive Services Chapter.)

2.1 Explaining the MRM process to women

Before taking any medications, the woman should receive instructions about what she may experience, what pills to take, when and how to take them, when to follow up, and when and where to seek medical help in case of a problem. Because some words are probably unfamiliar to her (such as sublingual or buccal), providers should use simple language (such as "under buccal), the tongue" and "inside the cheek" and can even provide drawings to visually side her in understanding how medications should be taken either at home or in the facility.

Thorough information about what the woman might expect helps her to be prepared. Reassurance and support during the abortion process, either by clinic staff or a person at home, can also be helpful. (Please see the Informed Consent, Information and counseling Chapter).

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

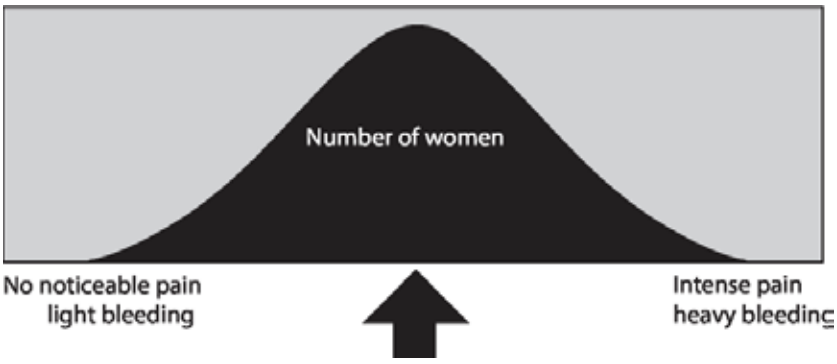
Bleeding and cramping

Clinicians new to MRM, as well as women themselves, will have questions about how to tell the difference between normal and abnormal bleeding and pain. All women should be given information about the bleeding and pain they might experience during MRM, keeping in mind factors that might put them at higher or lower risk of experiencing these symptoms.

Accurately describing the sensations a woman might feel during a MRM can alleviate fear and anxiety that may make pain worse (Kruse 2000). The bell curve (Figure 1) may be helpful for both providers and patients to understand a range of symptoms women might experience. Providers may use the bell curve to explain that most women fall in the middle part under the curve, experiencing symptoms that are of an average duration or intensity. However, some women will be at either ends of the curve and will experience less or more symptoms than most women. Not all women will understand the picture of the bell curve, but they all should be told about the range of symptoms they might experience in a way that makes sense to them.

Although some women do not feel any pain and others experience intense pain, the majority of women fall somewhere in the middle. Similarly, most women have bleeding that lasts around two weeks but some will have more and others less.

Figure 1: The Bell Curve



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

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

Timing of expulsion for medical MR

With the mifepristone and misoprostol regimen before 10 weeks gestation, the median time from misoprostol use to expulsion has been found to be three hours for women who used sublingual misoprostol. The buccal route needs four hours for expulsion.

Normally, women continue to feel better after the day they use misoprostol. Women can resume their usual routines within a few days of taking misoprostol. Nausea and vomiting, which are associated both with misoprostol use and pregnancy symptoms, usually resolve within one to two days of using misoprostol, as does cramping, which is part of the MRM process, not a pregnancy symptom.

What the woman might see

Most women will not see the expelled uterine product but rather just blood and clots, some of which may be large. Occasionally women with pregnancies between 8-9 weeks may see a recognizable product though it is usually not visible. If a woman is concerned about what she might see, especially after 8 weeks of amenorrhea, a life-size drawing of an 8-9 week product may help prepare her. A 9 weeks is about 2.3 cm in length, or less than one inch. Providers may want to have accurately-sized images of product, in case they would help women know what they might see. Please see Appendix B for a life-sized (to scale) illustration of an 8-9 week product.

Disposal

Women may simply flush expelled products down the toilet or dispose of sanitary pads as they would after a normal menstrual period.

2.2 Clinical assessment: Physical examination

Clinical assessment prior to uterine evacuation with medical methods includes gestational dating, assessment of uterine size, assessment of the woman's general health and any contraindication or precautions.

2.3 Eligibility

Indication

- Evacuation of the product of uterus up to 10 weeks amenorrhea.

Contraindications for MRM

If a woman has these specific conditions, under no circumstances should she be offered MRM. MVA should be considered or she should be referred to a facility where she can be offered alternate care.

- Previous allergic reaction to one of the drugs involved
- Inherited porphyria
- Chronic adrenal failure
- Known or suspected ectopic pregnancy

Precautions for MRM

If a woman has these specific conditions, MRM may have higher risks than normal. The risks, benefits and availability of alternatives to MRM must be considered. MRM provision may require a higher degree of clinical judgment, skill and monitoring. Referral to a higher-level facility may be appropriate.

- **IUD in place**. Evaluate for the presence of ectopic pregnancy. If none, remove the IUD and the MRM can proceed normally.
- **Severe uncontrolled asthma or long-term corticosteroid therapy**. No evidence exists regarding use of mifepristone in steroid-dependent women. Providers must use clinical judgment if no other alternatives to safe menstrual regulation exist. Increase steroid dose for 3-4 days and monitor the woman very closely. Conditions such as poorly controlled asthma may still be worsened.
- **Severe/unstable health problems including but not limited to hemorrhagic disorders, heart disease and severe anemia**. No evidence exists on the use of MRM in women with hemorrhagic disorder, heart disease, severe anemia or severe/unstable health problems. Whether to provide MRM to women with these conditions will depend on the available options for MR care, referrals, and clinical judgment. If MRM is given, it should be given under close observation.

2.4 Ectopic pregnancy

Women who are pregnant and have a history of ectopic pregnancy, tubal surgery or have an IUD in place are at a significantly elevated risk of ectopic pregnancy. An ectopic pregnancy occurs when a fertilized egg attaches itself outside of the uterus, most often in a fallopian tube. Ectopic pregnancy is rare, occurring in less than 1% of women presenting for an abortion (Edwards & Creinin 1997). If an ectopic pregnancy is unrecognized, it can cause potentially life-threatening complications from rupture and haemorrhage. For this reason, ectopic pregnancy is a leading cause of maternal mortality in the first trimester (Khan 2006, WHO 1985). Therefore, providers should maintain a high index of suspicion for ectopic pregnancy and carefully evaluate women's risk before providing medical abortion. Uterine evacuation methods, whether vacuum aspiration or MRM using misoprostol with or without mifepristone, will not terminate an ectopic pregnancy.

2.5 Special considerations for MRM

MR with mifepristone and misoprostol may be given to women in the categories listed below.

A. Young women

MRM is safe and effective in adolescents (Phelps 2001). MRM has been shown to be even more effective in women who have not given birth before (Chien 2009, Le Febvre 2008). MRM failure was found to be independently associated with women's older age, previous spontaneous abortions, multigravidity and earlier follow-up visit (Haimov-Kochman 2007). A Finnish study found that adolescents had fewer incomplete abortions, less need for surgical (re)evacuation, fewer haemorrhages, and fewer complications than non-adolescents having surgical and menstrual regulation with medication (Niinimäki 2011).

B. Asthma

Women using asthma inhalers including inhaled corticosteroids may have MRM, because the medications in asthma inhalers are not systemically absorbed. Although some prostaglandins are vasoconstrictors, misoprostol is a type of prostaglandin that promotes bronchodilation, decreases inflammation, and increases oxygen flow (Bernstein & Kandinow 2004)

C. HIV and AIDS

Women living with HIV and AIDS may use MRM. Women living with HIV or AIDS may be at risk for anaemia, especially if they have malaria or are taking certain antiretroviral therapies (Gangopadhyay 2011). As with any woman, if heavy bleeding occurs, treat promptly with vacuum aspiration.

D. Breastfeeding

Women who are breastfeeding may take mifepristone and misoprostol for MRM. Low levels of misoprostol have been detected in breast milk 30 minutes after oral dosing with a peak concentration at one hour. Although no harmful effects have been found in infants after maternal misoprostol ingestion, women who are concerned may nurse immediately before taking medications or wait four to five hours after their last dose of medication (Vogel 2004, Abdel-Aleem 2003, Saav 2010).

E. Sexually Transmitted Infections (STIs)

If a woman is found to have an STI at the time she requests MRM, the STI treatment may be started on the same day she receives mifepristone (Davis & Easterling 2009, Achilles & Reeves 2011).

F. Obesity

There is no difference in efficacy with mifepristone and misoprostol among obese

women compared to non-obese women (Strafford 2009). Thus, no dose adjustment for mifepristone or misoprostol is required.

G. Multiple gestation

A woman who is pregnant with twins (or other multiple gestations) may take mifepristone and misoprostol using the standard dosages of medications. The success rate for women with multiple gestations is comparable to those with single pregnancies (Hayes 2011).

2.6 Contraceptive needs

After MRM, a woman may have vaginal intercourse when she feels comfortable doing so. Because ovulation can occur almost immediately after a uterine evacuation, contraception should be provided immediately to women who want to prevent or delay pregnancy. If a woman desires long acting contraception or sterilization but it cannot be provided, an interim method should be given and referral made to the appropriate facility. In general, all modern contraceptive methods can be used immediately following first-trimester MA provided that there are no contraindications.

Contraception may be started with the first pill of a medical MR. This recommendation is based on expert opinion. A woman's immediate need for reliable contraception after MA, coupled with the risk that delayed contraceptive provision may reduce uptake, supports the recommendation to start these methods immediately.

IUDs may be inserted as soon as it is reasonably certain that the woman is no longer pregnant. Delaying IUD insertion puts women at risk of unintended pregnancy, as rates of return visits are low. Fertility awareness-based methods should only be used after a woman has had at least one postabortion menses and only if she had regular menstrual cycles prior to the abortion. (Please see the Contraceptive Services Chapter.)

3.0 Protocols for MR with Medicine

Recommended mifepristone plus misoprostol regimens

A range of regimens using mifepristone and misoprostol for medical abortion are used around the world. The following instructions on are based on regimens used in clinical trials and evidence-based practice.
The provider should administer mifepristone only after the woman has received the following information:

- When and how to take the medications
- What she should expect to feel and see in the abortion process
- Warning signs and what to monitor as potential problems

- Who to contact in case of questions or an emergency
- Which pain-management drugs to take

Table: Mifepristone and misoprostol regimens for MRM up to 10 weeks LMP (70 days since LMP)

Period of Amenorrhea since LMP	Medication, dose, route and timing for MRM	
	Mifepristone	Misoprostol
Up to 10 weeks	200mg (1 tablet) orally single dose	Following 24 hours to 48 hours of Mifipristone, use 800 mcg (200mcg each, total 4 tablets) buccally or vaginally or sublingually*

*Repeat doses of Misoprostol can be considered when needed to achieve success of the MRM process.

3.1 Administration of mifepristone

- For women up to 10 weeks since the LMP or less, the provider should administer 200mg mifepristone orally. Usually, mifepristone is given in the clinic. A recent study showed that women can safely take mifepristone at home if they choose with no change in safety or effectiveness. Whether women take mifepristone in the clinic or at home, they should be instructed to take misoprostol 24 to 48 hours later.

3.2 Administration of misoprostol

There are a range of options for the route, dosage and timing of misoprostol administration. Buccal, sublingual or vaginal are recommended routes during the first trimester. See Table above for proper timing and number of doses, depending on LMP.

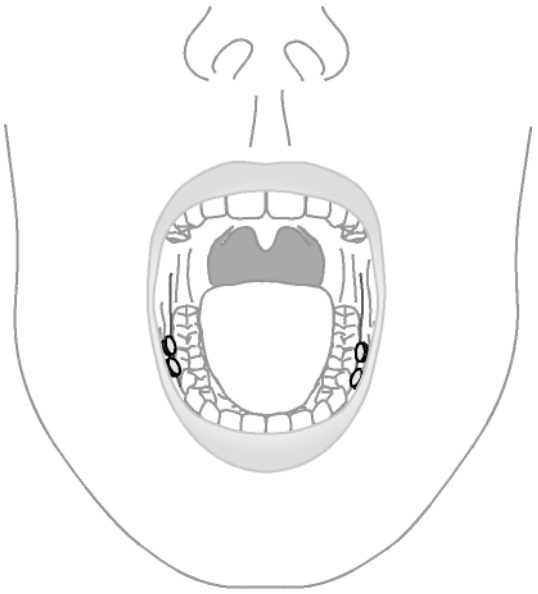
3.2.1 Routes of administration

Buccal use of misoprostol

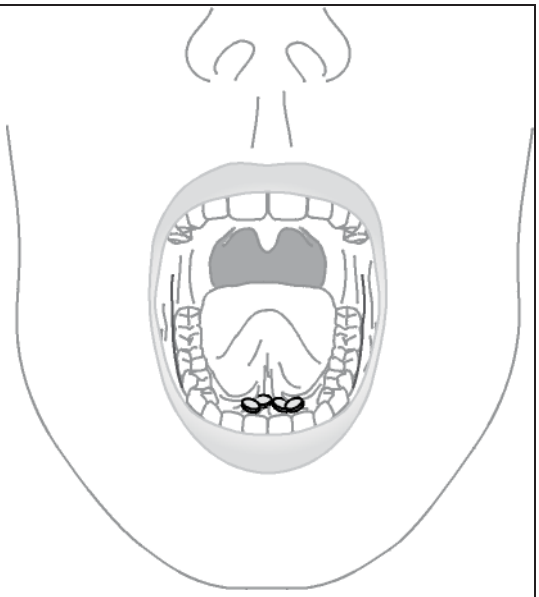
- Place two pills between each cheek and gums (four total)
- After 30 minutes, swallow any remaining pill fragments

Sublingual use of misoprostol

- Place four pills under the tongue after 30 minutes, swallow any remaining pill fragments.

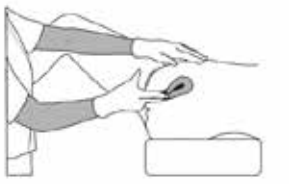


Buccal use of misoprostol



Sublingual use of misoprostol

Vaginal use of misoprostol



- The woman empties her bladder and lies down.
- If a provider is inserting pills, the provider washes hands and puts on clean exam gloves.
- All the misoprostol pills are inserted.
- The pills need to be inserted as far into the vagina as possible; they do not need to be in any special place in the vagina.
- Often the pills will not dissolve but the medication is still absorbed.
- Fragments of the pills may remain visible for many hours.
- After lying down for 30 minutes, if pills fall out when a woman stands up or goes to the bathroom, the pills do not need to be reinserted; the active medicine has absorbed by that time.

3.2.2 Home administration of misoprostol

Multiple studies from different countries have shown that taking misoprostol at home as part of a mifepristone and misoprostol regimen is safe, effective and highly acceptable to women undergoing MA up to 10 weeks LMP. Although studies have not specifically evaluated safety, efficacy and acceptability of home use of misoprostol with misoprostol only regimens, the option of home use has been included in studies of this regimen.

Many women prefer taking misoprostol at home with familiar surroundings, people and personal belongings. Doing this also can save them money in transportation costs as well as time. In turn, it saves the facility staff resources as well.

Staff should give all women completing their abortion at home the following:

- Misoprostol pills or a prescription for them;
- Detailed information on how to take the misoprostol;
- Pain medicine, such as ibuprofen and/or mild narcotics with instructions about how to take it;
- Written and pictorial information on the MA process, side effects and warning signs, what signs indicate that the abortion is successful, and information for follow-up contact, if desired;
- Information on whom to contact (including a telephone number where possible) in case of questions, problems or complications, or the possibility of an unsuccessful MA, and where to go in the case of an emergency;
- Other optional items: Sanitary pads, cotton wool, contraceptive information and supplies.

Many clinics give this information and supplies in a take-home packet. It is also helpful to talk with each woman about her specific situation. For example, does she have a partner or support person who can be with her when she takes the misoprostol and after, when she is likely to begin bleeding? If she has children, has she arranged childcare in case she needs to rest? Does she have concerns about seeing and disposing of the embryo after it expels?

A conversation about what to consider can help women to be most prepared for their at-home medical abortion.

3.2.3 Clinic administration of misoprostol

Whenever possible, women should be offered a choice of taking the misoprostol at home or in the clinic, as different women have different needs and desires. For some women, home may be a more private place but for others, the clinic may afford a greater degree of privacy. If the woman chooses to take misoprostol vaginally in the clinic, she should be offered the choice of inserting the misoprostol herself or to have it inserted by a provider. She may also take the misoprostol buccally or sublingually.

After taking misoprostol, the woman may wait at the clinic for approximately 4-6 hours, depending on how long it takes the pregnancy to expel. A woman who has not expelled the pregnancy within that time may remain longer waiting for expulsion, or she may return to her home if she has transportation and can seek follow-up care if necessary.

Clinics may have rooms with beds or curtained cubicles or, more commonly, a room that has several cots or reclining chairs and a toilet nearby. There should be enough toilet facilities to accommodate the maximum number of women receiving misoprostol at a given time. Women do not need to be restricted to beds but can move around the clinic if they prefer. Depending on space and the ability to ensure the confidentiality of all the women receiving services, facilities should also consider allowing each woman to have her partner or a support person with her during this time. A clinician or counselor should be available to answer questions and to address any medical concerns.

Staff should provide pain medication and hot-water bottles or warm cloths (if possible) to relieve discomfort from cramping.

Expelled tissue should be observed by a clinician to confirm a complete abortion.

If the woman leaves the clinic before she aborts, providers should:

- Give her instructions and supplies relevant to aborting at home.
- Provide her with pain medication to take home.
- Review instructions and provide information on signs of a successful MA, as well as warning signs of complications or an unsuccessful MA. Give her emergency contact information for the clinic.
- Provide a contraceptive method if desired.
- Inform her that she can return to the clinic anytime if she desires follow-up care. If she wants reassurance that the abortion was successful, she should return after two weeks.

4.0 Expected effects

Once a woman takes misoprostol, the process may feel like an intense menstrual period or similar to a spontaneous miscarriage. The normal, expected effects-vaginal bleeding and cramping-should be distinguished form side effects of the medications or waring signs of true complications.

4.1 Pain and cramping

Most women will experience lower abdominal pain and cramping during a uterine evacuation with medical methods, which may be stronger than that typically experience during a menstrual period because contractions are needed to expel the uterine contents. Cramping usually begins within the first few hours after taking misoprostol. As the uterus contracts and its contents are expelled through the cervix, women generally feel some degree of cramping, which will soon diminish. Women's experience of pain is highly individual, which makes it impossible to predict how much pain a particular woman will experience.

However, there are some predictors of pain associated with medical methods. Older age, having given birth before, and a higher number of previous births are associated with reduced pain with medical abortion. Young women and women who have never been pregnant tend to experience increased pain. Women with painful periods may also experience increased pain with medical abortion independent of other factors such as age or reproductive history.

4.2 Pain management

Most women find pain related to uterine evacuation with medical methods to be manageable, especially if they are prepared for the range of pain they might experience and take pain medicines as advised. Women should be provided with pain medication or a prescription at their first clinic visit.

The best regimen for pain control for MA has not been established. NSAIDs such as ibuprofen are more effective than acetaminophen. However, acetaminophen may reduce the dose of narcotics that a woman uses during MA. The dose of acetaminophen must not exceed four grams in a 24-hour period to avoid liver toxicity. Ibuprofen can be given with misoprostol or once cramping starts. Ibuprofen does not reduce the effectiveness of medical abortion. Narcotic analgesics are another option for pain control although the optimal drug, dose and timing is not known. One potential strategy is to provide women with NSAIDs and narcotic analgesics and advise them to begin with NSAIDs either with misoprostol or once cramping starts and alternate the two medications they continue to experience pain.

In addition to medical management, other methods that may help women manage pain during the process are counseling, a supportive environment and applying a heating pad or hot water bottle to the lower abdomen. Music is effective for pain management during vacuum aspiration and may be helpful for medical methods as well. These methods are complementary but not adequate substitutes for pain management with medications.

Research indicates that young women's experiences with medical abortion are similar to those of older women. However, pain perception appears to be related to age. The perception of pain and use of analgesia has been found to be higher in younger women than older women. Lower parity has also been associated with increased perceived pain and/or analgesia needed. Providers should be aware that young women may be more susceptible to pain and take necessary measures to reduce pain and improve a young women's experience.

4.3 Vaginal bleeding

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

In one of the few large studies to follow the bleeding patterns of women choosing MRM or aspiration, the duration of heavy bleeding, menstrual-type bleeding and spotting was significantly longer in women undergoing MRM. Despite the longer duration of bleeding, women who had MRM did not have a clinically significant drop in hemoglobin (>2g/dL) when compared to women who had an aspiration. Most importantly in this study, women who had the proper expectations about duration and level of bleeding were satisfied with their experience with MRM.

After MRM with mifepristone and misoprostol, the average duration of bleeding is approximately 14 days. Approximately 20 percent of women undergoing MRM continued to bleed or spot for 35 to 42 days, which may include start of the first postabortion menses.

5.0 Potential side effects

The following side effects are associated with misoprostol use and apply to women undergoing either mifepristone and misoprostol MRM:

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

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

Over half of women in clinical trials of mifepristone and misoprostol only experience gastrointestinal side effects including nausea, vomiting and diarrhea. Fever and chills are also commonly seen with misoprostol but they are usually short lived and should resolve with antipyretics. Headache, weakness and dizziness are also common. Most of these side effects are mild and self-limited and can be treated at home. However, women who complain of prolonged or severe side effects that continue to occur 24 hours after the last dose of medications should be evaluated.

6.0 Complications

Complications often happen on a continuum. For example, all women will experience bleeding, some women will experience prolonged bleeding that is an annoyance but is

not harmful and very few women will experience heavy bleeding that requires further medical or surgical intervention. Actual complications are rare. For medical abortion, these include ongoing pregnancy, hemorrhage, and infection;

Women should contact their provider immediately if they experience:

- **Excessive bleeding:** Soaking more than two sanitary pads per hour for two consecutive hours, especially if accompanied by prolonged dizziness, light headedness and increasing fatigue
- **Fever of 38°C (100.4°F):** A temperature that occurs any day after the day misoprostol is taken
- **Unusual or bad-smelling vaginal discharge:** Especially if accompanied by severe cramps or abdominal pain
- **Severe abdominal pain:** Pain that occurs any day after the day misoprostol is taken
- **Feeling very sick:** With or without fever, and persistent severe nausea or vomiting after the day misoprostol is used

(For details of complication management please see the chapter of Post MR and Postabortion Complications and Management)

7.0 Instructions prior to leaving the clinic

Before leaving the clinic, the woman should receive instructions about the normal MA experience, what pills to take, when and how to take them, when to follow up, and when and where to seek medical help in case of a problem. Because some words are probably unfamiliar to her (such as sublingual or buccal), providers should use simple language (such as "under the tongue" and "inside the cheek" and can provide drawings to visually aid her in understanding how medications should be taken.

A pamphlet, cared, or handout summarizing these points is often useful. A woman who is unable to read may still find it useful to take written instructions with her; she may have someone read it to her if she has questions. Pictorial resources for women who cannot read, such as illustrated guides outlining the MA regimen, side effects, and possible complications, may be very helpful. for MA-related images, please see the information, education and communication (IEC) materials and job aids in Additional resources, Uterine Evacuation with MVA Plus.

MA information for women should include:

- Regimen and effectiveness
- What she will experience

- How long the process typically takes
- The signs of a successful abortion
- Expected effects, potential side effects and complications
- Warning signs to seek help
- Ensuring access to emergency care
- Contraceptive needs
- When and where to obtain follow-up care if necessary

8.0 Follow-Up Care

A woman who takes medication at home should be given an explanation of how to recognize the signs of expulsion (bleeding and cramping) that occur with a successful MRM. In general, women who feel they have had a successful MRM do not need further care or follow-up care (WHO 2012)

However, if a woman takes the medication and has minimal or no bleeding or still feels pregnant, she should return to the provider to check whether she has had a successful Menstrual Regulation (MR) or if she needs a procedure to complete her MR. If a woman is concerned about ongoing bleeding or other problems, she may return at any time. If a woman desires reassurance after the MRM, she may return in approximately 1 to 2 weeks to confirm that she has had a successful MR, or to receive additional desired services.

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

- Inquire about the woman's experience with the MRM process;
- Confirm success of the MR.

a. Taking history of the MRM process, amount and duration of bleeding cramping and passage of clots;

b. Conducting a physical examination;

c. If there is any doubt, the provider can conduct or refer for an ultrasound to look for a gestational sac or an ongoing pregnancy

3. Provide treatment if there is a persistent gestational sac (incomplete MR), either by:

a. Taking history of the MRM process, amount and duration of bleeding, cramping

and passage of clots;

b. Conducting a physical examination;

c. Performing an ultrasound or checking for decreasing ßhCH levels through serial quantitative tests, if it is unclear whether the MR is complete;

4. Inform the woman of what to expect following completion or continued treatment.

5. Review any laboratory tests results with the woman.

6. Provide a contraceptive method, if desired by the woman.

9.0 Considerations for Postabortion Care

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

10.0 Summary

- Studies indicate that the combination of mifepristone and misoprostol has a somewhat higher success rate than misoprostol only.
- Although misoprostol only for medical abortion is not as effective as the combination of mifepristone and misoprostol, it may be a useful option where mifepristone is not available.
- Vaginal, buccal or sublingual 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.
- Counselling includes the discussion of basic information about medical abortion, risks and benefits, and possible side effects and complications.
- Before taking any medications, the woman should receive instructions about what she may experience, what pills to take, when and how to take them, when to follow up, and when and where to seek medical help in case of a problem.
- Preparation prior to administering mifepristone includes: counselling and obtaining informed consent; performing a client assessment, including physical examination; confirming that the woman knows what to do if there is an emergency; and discussing her contraceptive needs.
- Misoprostol may be administered at home for gestations up to 10 weeks LMP. Appropriate facilities and staff support should be available to women who remain in the clinic during the medical abortion process.
- Vaginal bleeding and cramping are expected and normal components of medical abortion. Other side effects include nausea, diarrhea, vomiting, fever, warmth or chills, headache and dizziness.
- All women should be offered pain medications. Both non-narcotic and narcotic analgesics can be used to treat pain associated with medical abortion. NSAIDs have been shown to be significantly more effective than acetaminophen.
- Although serious complications from medical abortion are rare, complications that can occur are continuing pregnancy, haemorrhage and infection.
- 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.
- A routine follow-up visit after medical abortion with mifepristone followed by misoprostol is not necessary; however, because of lower efficacy, routine follow-up after medical abortion with misoprostol only is recommended.

Postabortion Care Services

Postabortion Care Services

Key topics in this Chapter:
- Key elements of Postabortion Care (PAC)
- Management of postabortion complications

1.0 Introduction

PAC is a comprehensive approach which takes into account a woman's individual physical and emotional health needs and circumstances and ability to access care. It includes treatment of incomplete, missed or unsafe abortion; compassionate counseling; contraceptive services; related sexual and reproductive health services provided onsite or via referrals to accessible facilities; and community-service provider partnerships.

Comprehensive Post-abortion Care, which includes both curative and preventive care, has five key elements. These five key elements are:

- Treatment of incomplete and unsafe abortion and abortion-related complications that are potentially life-threatening.
- Counseling to identify and respond to women's emotional and physical health needs and other concerns.
- Contraceptive and family-planning services to help women prevent an unwanted pregnancy or practice birth spacing.
- Reproductive and other health services that are preferably provided on-site or via referrals to other accessible facilities in providers' networks.
- Community and service-provider partnerships to prevent unwanted pregnancies and unsafe abortion, mobilize resources to help women receive appropriate and timely care for complications from abortion, and ensure health services reflect and meet community expectations and needs.

2.0 International Commitment to Reduce Unsafe Abortion

Millions of women each year have abortions that are unsafe — performed "either by persons lackingthe necessary skills or in an environment lacking the minimal medical standards or both" *(WHO 1992).* Deaths and injuries from unsafe abortions continue to be a serious public health problem that affects women, men, children and entire communities. Postabortion Care is a global initiative in response to the problem of maternal mortality and morbidity resulting from abortion complications.

In recent years, important progress has been made in addressing maternal mortality and morbidity resulting from unsafe abortion. In 1994, at the International Conference on Population and Development (ICPD) in Cairo, governments agreed that timely lifesaving treatment should be provided to women and that contraception should be made available to prevent unwanted pregnancy. Almost all countries also agreed that where abortion is legal, it should be safe.

Governments later reaffirmed and built on this consensus at three global conferences: the 1995 Fourth World Conference on Women (FWCW) in Beijing, the five-year review of ICPD in 1999 (ICPD+5) and the five-year review of FWCW in 2000. In Paragraph 63iii of the ICPD+5 conference document, governments agreed that in circumstances in which abortion is not against the law, health systems have an obligation to "train and equip health-service providers and [to] take other measures to ensure that such abortion is safe and accessible."

Regardless of varying national laws and policies with respect to safe induced abortion, all health systems are confronted with the reality of women in need of Postabortion Care. Women's access to PAC has been recognized as a basic right in the international agreements cited above, and it is an essential part of any safe motherhood initiative. Governments and health-care workers have an ethical obligation to fulfill this right by delivering high-quality, compassionate reproductive health services, including Postabortion Care. Timely, clinically competent Postabortion Care saves women's lives.

3.0 Clinical Assessment – Please see Clinical assessment chapter and also see consideration for PAC below

Considerations for Postabortion Care

- Women who are pregnant and present with vaginal bleeding and/or lower abdominal pain or cramping may have a threatened abortion, a spontaneous missed or incomplete abortion, complications from a safe, self-induced or unsafe abortion, or complications resulting from previous Postabortion Care. Clinical assessment should focus on the health status of the woman and whether she has suffered any abortion-related complications.
- Women presenting for Postabortion Care may show a range of symptoms from mild to severe including:
  - -Light to moderate vaginal bleeding
  - - Severe vaginal bleeding/hemorrhage
  - - Pelvic infection/sepsis
  - -Intra-abdominal injury

- Women who present for Postabortion Care need to have a rapid initial assessment for shock. Women who are unstable due to hemorrhage or sepsis need to be stabilized and treatment started immediately. Treatment may require immediate uterine evacuation.
  - Once a woman has been stabilized, the clinical assessment should focus on the type of abortion (incomplete or missed),whether there are complications that need attention and her eligibility for methods of uterine evacuation.
  - For Postabortion Care, the uterus should be smaller than the woman's report of her LMP.
  - Management of the abortion depends on:
    - Type of abortion (missed abortion or incomplete abortion)
    - Size of uterus
    - Medical eligibility
    - Availability of equipment and supplies
    - Women's preferences

4.0 Diagnosis and treatment of types of abortion

Probable Diagnosis	Signs / Symptoms	Treatment Plan
Incomplete Abortion: Expulsion of some but not all the POC; may be result of spontaneous or of an attempt to terminate the pregnancy	Light to heavy bleeding Open cervix Uterus size corresponds to dates or smaller Sometimes cramping/lower abdominal pain; partial expulsion of POC	Uterine evacuation* without delay. Possibly uterotonic agents. Antibiotics if infected. Pain control.
Missed Abortion: Fetal demise with no expulsion of fetus	Little or no bleeding Closed cervix Uterus size is less than or equal to dates by LMP Fetal demise with delayed expulsion Decrease in pregnancy signs/ symptoms	Uterine evacuation.* Treatment of any coagulopathy. Antibiotics if infection. Pain control.
Complete Abortion: POC are completely expelled	Light bleeding Closed cervix Uterus smaller than dates Sometimes light cramping/lower abdominal pain; history of expulsion of POC	Observation for recovery (decreased bleeding) or signs of complication (infection). Possibly uterotonic agents. Antibiotics if infected. Pain control.

5.0 Managing Uterine Evacuation with MVA and Medication

Evacuation of Uterus

Incomplete abortion, in the absence of evidence suggesting uterine or abdominal injury, is treated by removing the remaining products of conception (POC) from the uterus. The method used for emptying or evacuating the uterus depends on the duration of pregnancy, which is based on the LMP and uterine size, as well as the availability of medications and equipment, supplies and skilled staff.

Recommended methods for uterine evacuation include vacuum aspiration (VA) and medications.

5.1 Vacuum Aspiration for PAC

For details see chapter of Uterine Evacuation Methods and Uterine Evacuation Using MVA Plus® Aspirators and Easygrip cannula

5.2 Medication for PAC

Treatment for incomplete abortion, missed abortion :

Recommended medical regimen up to 12 weeks uterine size

Medical Up to 12 weeks uterine size:

— Incomplete abortion:
  - Misoprostol 600mcg orally in a single dose or 400mcg in a single dose sublingually or, in the absence of vaginal bleeding, vaginally

— Missed abortion:
  - Mifepristone 200mg orally 1-2 days before misoprostol
  - Misoprostol 600mcg sublingually or, in the absence of vaginal bleeding, 800mcg vaginally every 3 hours until expulsion (generally 1-3 doses)

5.3 Pain Management

- Offer pain medication to all women undergoing medical abortion.
- Nonsteroidal anti-inflammatory drugs (NSAIDs) are recommended either prophylactically or at the time cramping begins.

5.4 Misoprostol Product Quality

- Providers should track medical abortion success rates to help ensure they are using an effective misoprostol product.
- Purchase misoprostol in double-aluminum blister packs, and keep the misoprostol in its original packaging; check the integrity of packaging before use.

- Store misoprostol in a cool, dry place
- Degradation (due to heat and moisture during storage) decreases the effectiveness of misoprostol, leading to decreased success rates of medical abortion and unsuccessful treatment of incomplete abortion.

5.5 Use of antibiotics

When using misoprostol to treat incomplete and missed abortion, infection rates are very low (Clark, 2007).To date, there is no evidence supporting routine antibiotic use with misoprostol for post-abortion care. Antibiotics should be used if history and physical exam are suggestive of infection or risk to infection (Blum, 2007).

Benefits of Using Misoprostol to Treat Incomplete and Missed Abortions

Ease of Clinical Use

- The drug can be self-administered.
- It avoids having to use instruments in uterus.
- There is no need to wait for equipment availability and processing.
- The medication can be provided in the remotest of health facilities and can improve coverage in resource restricted settings.
- It is inexpensive.
- It does not require refrigeration.
- It has several routes of administration, hence enhances women's convenience.

(WHO, 2012; You & Chung, 2005)

6.0 Management of Complications :

Please see the chapter of post MR and postabortion Complications and management

7.0 Postabortion Counseling

Postabortion counseling must be a part of all PAC services. Postabortion counseling can address the specific needs and concerns of the woman. Effective postabortion counseling can provide psychological and emotional support before, during and after the procedure of definitive treatment. (See *Counseling* Chapter for more details.)

8.0 Postabortion Contraceptives

The goals of postabortion contraceptive counseling are:

- To respond to each woman's situation and contraceptive needs
- To help her and her partner to understand that various contraceptive methods are available
- To help her and her partner to choose an appropriate contraceptive method and to use it effectively and timely

During counseling, the counselor must keep in mind that some women will seek contraceptive services while others will be interested in becoming pregnant again in the near future. *(See Chapter Contraceptive Services, Appendix A: Individual Factors and Counseling Recommendations and Rationalesfor information on postabortion contraception.)*

9.0 Linkages to Other Reproductive Health Services

A PAC client may have other reproductive health concerns, or additional health problems may be identified during the initial assessment. For example, the womanmay have an abnormal vaginal discharge. Linking to other reproductive health services is thus essential and logical, yet these services have remained separate in most of the country's health delivery outlets. This separation and non-integration frequently results in postabortion patients having no access to other reproductive health care services.

Therefore, service providers need to identify the reproductive health services that each of the PAC clients may need and offer her as wide a range of services as possible. For example, providers need to be alert to symptoms of reproductive tract infection (RTIs) to include sexually transmitted infections (e.g., Trichomoniasis or mucopurulent cervicitis) and provide the appropriate treatment. Also, it may be possible to offer cervical cancer screening at the time of treatment or to provide referral to a facility where screening is available. Finally, women treated for spontaneous abortion may have special reproductive health care needs, such as special follow up for management of infertility. The different levels of health-care facilities must be able to identify high-risk clients and provide instructions for reproductive health care.

Integrating Postabortion Care services to existing services in the hospital—particularly the ob/gyn department, family planning services or other services providing reproductive health—is more beneficial and sustainable compared to setting up an entirely new service center. However, creative solutions should be found to ease the workload of the concerned staff. The process should not be viewed by the staff as additional work or as a burden but as a part of the routine provision of

treatment to postabortion clients.

The client may need the following other health services:

- RTI/STI diagnosis and management
- Management of gynecological pathology (e.g. fibroid, uterine prolapse, cervical disease)
- Infertility counseling and services
- Routine health maintenance: cervical cancer screening, blood pressure, anemia screens
- Management of other medical problems such as: thyroid disease, heart disease
- Social services : women terminating pregnancies may be victims of rape,coerced sex, abuse, or depression

10.0 Community and Service-Provider Partnerships

- Health-care facilities can train community health workers and other leaders to educate women, as well as women's partners and families, about the dangers of unsafe abortion and the importance of seeking abortion-related care only from trained providers.
- Health-care workers can collaborate with community leaders to organize town meetings to educate community members about sexual and reproductive health and rights issues. One place to begin is to facilitate a discussion about how the International Planned Parenthood Federation's Charter on Sexual and Reproductive Rights is being applied in their community.
- Health-care workers and community members can exercise their right to freedom of assembly and political participation by organizing a grassroots campaign to encourage politicians and the government to prioritize sexual and reproductive health and rights.
- Health-care workers can join with community leaders to educate the community about their health-care facility's confidentiality policies and their means of enforcing them. Facilities can establish an anonymous reporting system through which community members can report violations of these policies.

11.0 Summary

- Key elements of comprehensive Postabortion Care include:emergency management for complications of spontaneous or induced abortion, postabortion contraception counseling and services, and coordination between emergency postabortion treatment and comprehensive reproductive health care services.
- Systematic introduction of Postabortion Care (PAC) services, if it can be started in a systematic manner at all levels of the health care system, would result in a significant reduction in maternal morbidity and mortality.
- Misoprostol in correct dosage can be used to manage postabortion complications.
- Postabortion contraception will prevent unwanted pregnancy and reduce unsafe abortion.

Post MR and Postabortion Complications and Management

Post MR and Postabortion Complications and Management

Key topics in this Chapter:

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

1.0 Introduction

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

2.0 Presenting complications

Typically, women presenting for Postabortion Care are ambulatory and complaining of vaginal bleeding and pain and fever or chills and need treatment for incomplete abortion. Women who have suffered more severe complications may present with shock, hemorrhage, sepsis and intra-abdominal injury. Severe complications are more likely in settings where unsafe abortion is common. In this Chapter we will discuss the more severe complications briefly.

3.0 Procedural complications

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

4.0 Pregnancy-related complications

Some women may have pregnancy-related or gynecologic complications such as molar pregnancy, ectopic pregnancy or uterine abnormalities that require specific clinical consideration and management. These conditions are often discovered during

the clinical assessment and can be addressed before the procedure is performed. Some may not become evident until during or after the uterine evacuation. (Please see the Clinical Assessment Chapter and the Uterine Evacuation with Medical Methods Chapter.)

5.0 Complications of vacuum aspiration or medical abortion

Several types of complications may infrequently occur with either vacuum aspiration or medical abortion. These include: incomplete abortion; infection; continuing pregnancy; hemorrhage; and ectopic pregnancy.

5.1 Incomplete abortion

After uterine evacuation, some tissue may remain in the uterus. Large amounts of retained tissue can result in heavy bleeding and infection if untreated. If a woman has heavy bleeding or signs and symptoms of infection, the recommended treatment is immediate repeat vacuum aspiration. Small amounts of retained tissue may pass spontaneously without requiring further intervention. Close monitoring until the retained products are expelled may be sufficient or a woman may be offered misoprostol for Postabortion Care. Otherwise, treatment involves evacuation of the uterus, preferably using vacuum aspiration.

5.2 Infection

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

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

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

5.3 Continuing pregnancy

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

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

Examining the aspirate immediately after abortion can decrease the risk of failed vacuum aspiration. If a woman presents a week or more after the abortion and still

has pregnancy symptoms, she should be evaluated for continuing pregnancy and offered repeat uterine evacuation.

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

Treatment of continuing pregnancy after medical MR:

MRM up to 10 weeks since last menstrual period (LMP)

- **Mifepristone and misoprostol**

  The standard treatment for ongoing pregnancy is vacuum aspiration. Taking a repeat dose of misoprostol for an ongoing pregnancy is a less studied option. In one trial, only a third of women with gestations under nine weeks who had an ongoing pregnancy after mifepristone and misoprostol and took a second dose of misoprostol had a successful abortion. Although it is not a first-line recommendation, in areas where access to safe services for uterine evacuation is limited, a second dose of misoprostol with close follow-up can be considered.

- **Misoprostol only**

  When pregnancy continues after taking misoprostol only for abortion, vacuum aspiration is recommended.

Vacuum aspiration is recommended for pregnancies continuing after MRM from 10-12 weeks.

5.4 Hemorrhage

Hemorrhage requiring transfusion is rare after safe abortion, occurring in less than 1 in 1,000 women after a medical abortion with mifepristone and misoprostol and vacuum aspiration. Hemorrhage may occur because of incomplete abortion, infection or uterine atony.
Indications that bleeding requires immediate attention are:

- Abundant gushing bleeding
- Bleeding like a heavy period that persists for weeks leading to significant anemia and hypovolemia
- Pale appearance accompanied by weakness, agitation or disorientation
- Blood pressure drop or woman feels faint when she stands up
- Rapid pulse especially when associated with low blood pressure

Other concerning signs and symptoms include paleness around the inner eyelids, mouth, palms or fingertips; dizziness and fainting; and decreased urine output.

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

Uterine atony

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

- Copious vaginal bleeding
- Large, soft, boggy uterus

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

- Conduct bimanual massage
- Give uterotonics therapies (Please see Uterotonics sidebar)
- Proceed with uterine aspiration
- Perform intrauterine tamponade
- Perform hysterectomy if bleeding cannot be stopped by other measures

Uterotonics

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

postpartum hemorrhage include:

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

These therapies may also be effective *after a medical abortion.*

5.5 Ectopic pregnancy

All women should be evaluated for the possibility of ectopic pregnancy prior to receiving MA or VA. (Please see the Clinical Assessment Chapter.) Neither vacuum aspiration nor medical abortion will end an ectopic pregnancy.

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

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

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

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

5.6 Persistent pain

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

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

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

5.7 Allergic reactions

Allergic reactions to mifepristone and misoprostol are rare, but have been reported occasionally. These reactions have been accompanied by swelling of the hands or feet, rashes or wheezing. Allergic reactions can be managed conventionally, for example with an antihistamine.

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

6.0 Complications of vacuum aspiration related the procedure

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

6.1 Cervical, uterine and abdominal injuries

Minor cervical lacerations can occur from movement of the tenaculum or dilatation. Applying pressure by clamping a ring forceps over the tear will usually stop the bleeding. It can also be repaired by suturing or applying silver nitrate.

6.2. Uterine perforation

Uterine perforations that occur during vacuum aspiration are usually very small and undetected, and may resolve without the need for surgical intervention. However, some perforations may result in injury to other organs or intra-abdominal bleeding. Depending on experience, availability and the extent of the injuries, laparoscopy or laparotomy can be used to investigate the perforation, diagnose any abdominal injuries and perform repairs.

Signs and symptoms of Uterine perforation

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

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

6.3 Medication-related complications

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

- Overdose
- Intravascular injection of local anesthesia
- Hypersensitivity reaction

General anesthesia increases the rate of abortion complications and is not recommended for routine vacuum aspiration. 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

6.4 Hematometra

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

Signs and symptoms

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

6.5 Vasovagal reaction

Vasovagal reaction is fainting as a result of vagal-nerve stimulation during a vacuum-aspiration procedure. In most cases, women will recover within less than a minute and will not require further treatment. 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

6.6 Asherman syndrome

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

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

7.0 Complications in women who present for Postabortion Care

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

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

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

- For women presenting with signs and symptoms of pelvic infection or sepsis or hemorrhage due to incomplete abortion, prompt uterine evacuation is a part of the emergency management and stabilization.

For more detailed information about the treatment of complications, please see Ipas's Woman-Centered Postabortion Care: Reference Manual, Second Edition.

8.0 Emergency response

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

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

9.0 Referral

It is important to put in place referral agreements (such as a memorandum of understanding) about transferring a woman to the referral center if necessary; it is preferable to refer women to the most accessible site. If possible, providers can establish a relationship with emergency room staff and gynecologists at their referral hospital. It can be helpful to provide an information session for the staff that serve as emergency referrals for women. The session could include an overview of both MA and VA, the continuum of expected effects and side effects, the types of complications that may be seen, and how to triage a woman having a postabortion emergency. Invite hospital staff to the clinic providing abortion. (Please see Appendix D: Sample Clinical Referral Form in the Uterine Evacuation with MVA Plus® Chapter.)

Information sharing

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

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

Practicing for emergencies

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

Supplies

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

Links to communities

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

10.0 Post-procedure care

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

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

(Please see the Informed Consent, Information and Counseling Chapter and the Contraceptive Services Chapter.)

Serious Adverse Event

Serious Adverse Event

Key topics in this Chapter:

- Types of adverse event and importance of reporting
- Documentation and reporting of Serious Adverse Event
- Learning from adverse event

1.0 Introduction:

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

2.0 Types of adverse events

An adverse event (AE) / complication is a problem requiring intervention or management beyond what is normally necessary that is related to a procedure or anesthesia.

- A serious adverse event (SAE) results in death, life threatening injury, permanent impairment, or necessitates medical or surgical intervention to prevent permanent impairment.
- A near miss is an event that has potential to harm a patient but does not because chance, prevention or mitigation. Some examples of adverse events and serious adverse events are listed below.

Table 13-1: Examples of complications/serious adverse events (SAEs)

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

3.0 Frequency of adverse events

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

4.0 Why adverse events occur

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

Client factors

The client may not be able to communicate information or disclose other relevant medical problems or have high-risk medical conditions. In abortion care, we know that increasing gestational age increases the risk of adverse events. Therefore, a woman at 18 weeks is at higher risk than a woman at 10 weeks. Other factors that may make adverse events more likely are complex medical problems, obesity or altered uterine anatomy.

Human error

Human error comes in two forms: slips and lapses & mistakes. Slips & lapses are when a plan of care is adequate but does not go as intended because of improper actions. This may be related to inattention, fatigue, or failure of memory. Mistakes are when the plan of care is improper for a certain situation. Most mistakes are due to problems with training, experience or knowledge.

Institutional errors

These errors occur when institutions do not adequately protect patient safety. For example, to save money an institution may not order the appropriate medications and supplies needed for treatment. A clinical setting that is not supportive may turn a minor complication into a serious life-threatening event.

5.0 How to approach adverse events

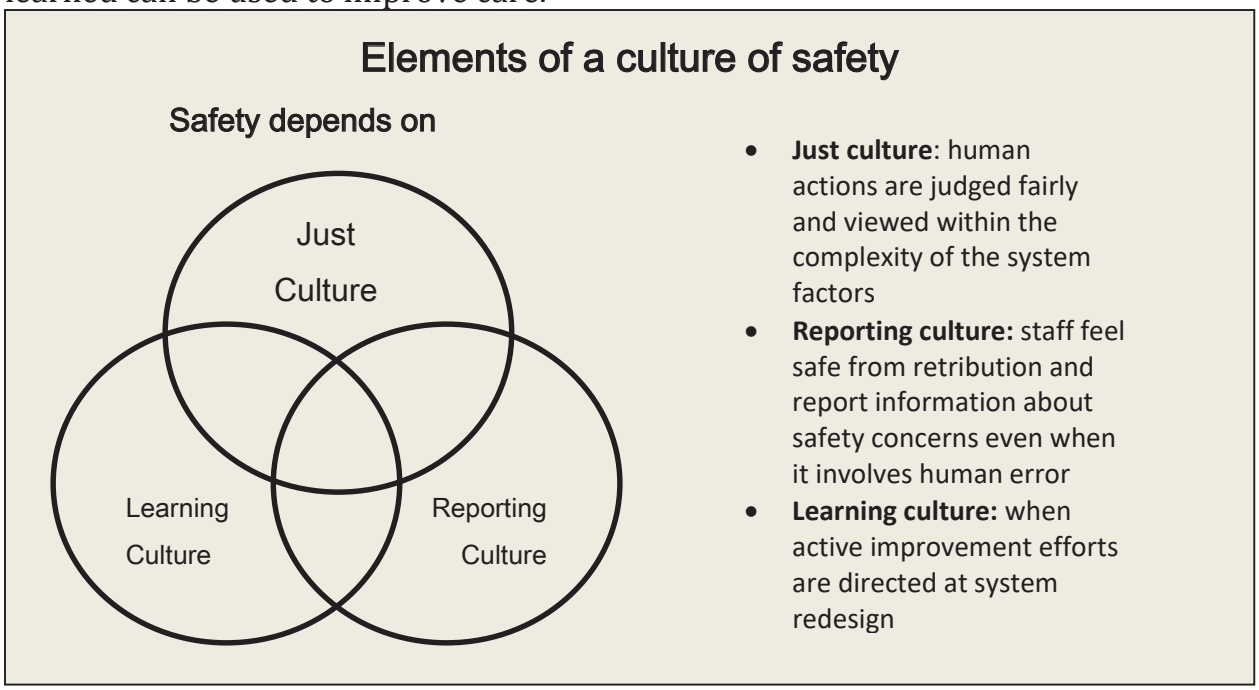
After an adverse event has occurred and the patient has been cared for, there are two ways that events can be evaluated. The first way is in a culture of blame.

In a blame culture, a hospital or clinic might look to see which person caused the error so that they can be made to take responsibility or be punished. The goal is not necessarily to improve care, but to focus on individual responsibility.

In a safety culture, open dialogue is encouraged by all the people involved in the adverse event including the providers, assistants, administrators, the patients and their family (if appropriate). When adverse events occur, facility staff can hold discussions with family and community members to prevent misunderstandings and even potential threats, while respecting the woman's privacy. In a safety culture, the goal is to see where the system failed and to improve the system so that in future, the same adverse event does not happen again.

6.0 Adverse event reporting

Once an adverse event has been identified, and the woman has been cared for, it is important that the event is documented, reported and analyzed so that information learned can be used to improve care.



Record all information required on the woman's chart and the facility abortion logbook. Report the AE to local authorities according to established guidelines.

7.0 Learning from adverse events

Learning from the adverse event is best accomplished through a team discussion with all relevant staff members. Conduct the meeting in the "spirit of learning," that is, non-punitive and everyone is allowed and encouraged to speak.

As a team, discuss and answer these questions:

1. What happened?

2. Why did it happen?

3. What can be changed to prevent similar events in the future?

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

Root Cause Analysis

Root cause analysis is one of the ways of digging deeper into a problem to see where changes can be made to prevent an adverse event from happening in the future. One technique of doing root cause analysis is called "The Multiple Whys." With the multiple whys, you keep asking why an event occurred until you arrive at a problem where action can be taken

8.0 Considerations for Postabortion Care

Women present for Postabortion Care because of complications resulting from spontaneous, safe, unsafe or self-induced abortion. Please see Section 8.0 of this Chapter and Ipas's Woman-Centered
Postabortion Care: Reference Manual, Second Edition for more information.

9.0 Summary

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

- Possible complications related to medical methods include: failure of MA, persistent pain, and allergic reactions to the medications.
- Women presenting for Postabortion Care need a rapid initial assessment and immediate treatment for life-threatening conditions
- It may be necessary to refer women to another facility if lifethreatening complications or pre-existing conditions require additional resources.
- Health systems should partner closely with communities to help ensure that women, including young women, with abortion-related emergencies can recognize signs and symptoms and access care in a timely manner.
- Women with abortion complications must be closely monitored, informed about necessary follow-up care and counseled on any medical and emotional consequences.
- Although abortion is extremely safe, like with any medical procedure, adverse events can and will occur.
- Adverse events should be documented, reported and analyzed so that information learned can be used to improve care and client safety.

Infection Prevention

Infection Prevention

Key topics in this Chapter:

- Common routes of infection transmission
- Essential elements of infection prevention, including standard precautions
- Management of occupational exposures

1.0 Introduction

MR and PAC procedures and care involve contact with blood and other body fluids. All clinical and support staff in all facilities that provide these services should understand and apply universal precautions for infection prevention and control, for women's and their own protection.

This chapter describes knowledge, skills and attitudes which the health-care workers must have in order to successfully prevent infection to themselves, clients, co-workers and communities while providing comprehensive MR and PAC services. This chapter addresses the application of infection-prevention principles in MR and PAC service 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. Bacteria, viruses, protozoa, fungi and parasites are examples of pathogens that can be present in blood and certain other body fluids and can cause infection and disease in humans. These pathogens include, but are not limited to, viruses such as HIV, HBV, HCV and Ebola.

Most blood borne pathogens:

- Cannot be seen with the human eye alone
- Can be transmitted through blood, secretions, excretions and certain other body fluids
- Can cause infection when 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

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, at all times when in contact with all clients and other workers, as a person may carry infection without showing any noticeable signs or symptoms.

Key Elements of InfectionPrevention:

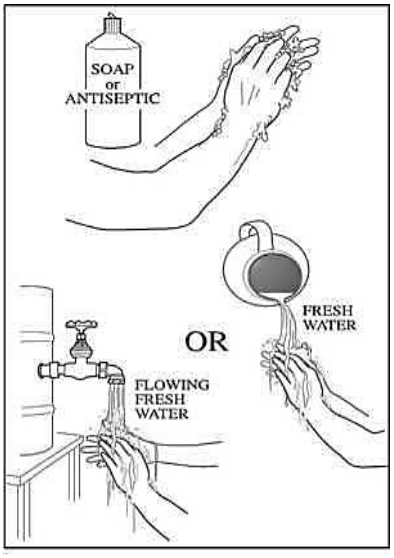
- **Hand hygiene**
- **Use of personal protective equipment**
- **Prevention of sharps injuries**
- **Processing of instruments**
- **Environmental cleanliness**
- **Safe handling of linen**
- **Respiratory Hygiene**
- **Waste management**
- **Aseptic technique**
- **Appropriate use of antiseptics and disinfectants**
- **Post exposure prophylaxis (PEP)**

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.

Proper handling of blood and body fluids and the use of appropriate prevention techniques will reduce the risk of transmission of bloodborne infections. Consider all blood and other body fluids from every person to be infectious, regardless of their actual or perceived health status, and wash your hands immediately before and after contact with contaminated items, even if gloves were worn.

3.1 Hand Hygiene

Hand hygiene is the single most important step in infection prevention. The World Health Organization (WHO) states usinga 60–95% alcohol based rub using gel or solution is the preferred hygiene method over hand washing.



Hand Washing

Alcohol hand rub and hand washing facilities should be available in all client care areas.

Hand hygiene must be performed:

- Before touching client
- Before cleaning/aseptic procedure
- After body fluid exposure risk
- After touching client
- After touching client's surroundings

Use flowing water, not standing pools of water (Using basins where water is not flowing and everyone dips hands spreads contamination from person to person.)

Use a clean or individual towel

Process of Normal Hand Hygiene: 1) Soap and water

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the handwash (steps 2-7): 15-20 seconds
Duration of the entire procedure: 40-60 seconds

0

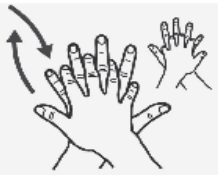
Wet hands with water;

1

Apply enough soap to cover all hand surfaces;

2

Rub hands palm to palm;

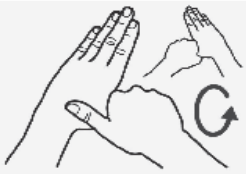
3

Right palm over left dorsum with interlaced fingers and vice versa;

4

Palm to palm with fingers interlaced;

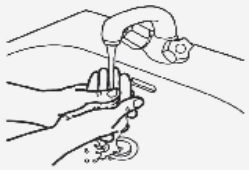
5

Backs of fingers to opposing palms with fingers interlocked;

6

Rotational rubbing of left thumb clasped in right palm and vice versa;

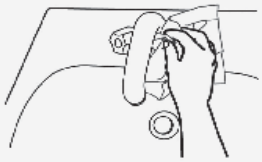
7

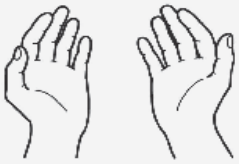
Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8

Rinse hands with water;

9

Dry hands thoroughly with a single use towel;

10

Use towel to turn off faucet;

11

Your hands are now safe.

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | SAVE LIVES — Clean Your Hands

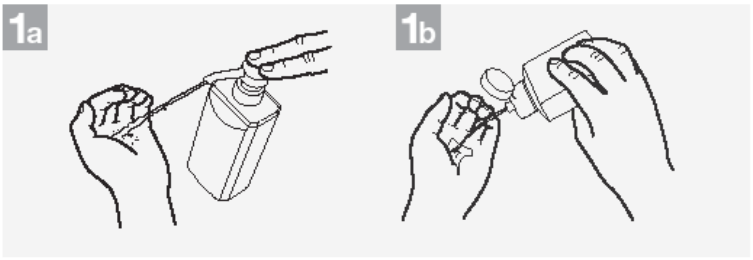
May 2009

Process of Normal Hand Hygiene: 2) Alcohol hand rub

How to Handrub?

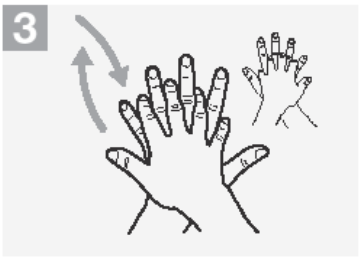
RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

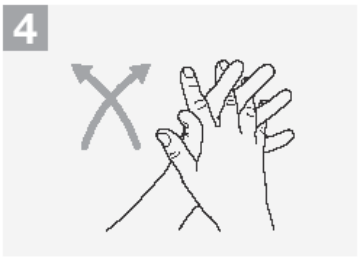


Apply a palmful of the product in a cupped hand, covering all surfaces;

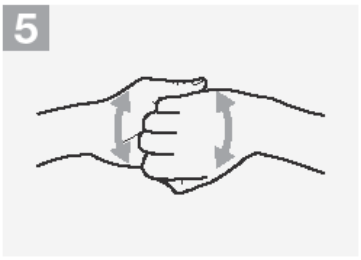
Rub hands palm to palm;



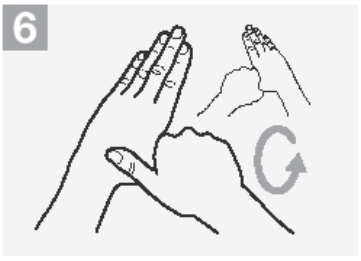
Right palm over left dorsum with interlaced fingers and vice versa;



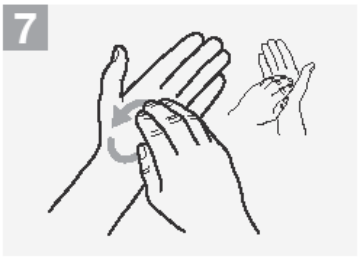
Palm to palm with fingers interlaced;



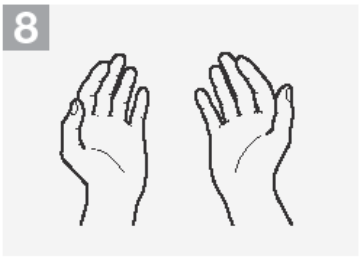
Backs of fingers to opposing palms with fingers interlocked;



Rotational rubbing of left thumb clasped in right palm and vice versa;



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



Once dry, your hands are safe.

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | SAVE LIVES Clean Your Hands

WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

May 2009

3.2 Use of personal protective equipment (PPE)

Put on PPE used for manual vacuum aspiration (MVA) procedures: face protection, such as a mask and eyewear or a face shield; arm protection, such as a gown or lab coat; and gloves.

- PPE must be worn whenever a particular part of the body is likely to be exposed to blood or body fluids. Use PPE when processing instruments, even if they have been soaked in a chlorine solution.

Personal Protective Equipments

When to use gloves:

- Wear gloves when contact with body fluids is likely.
- Change gloves between clients.
- Remove gloves before touching other items.

3.3 Correct Handling of Sharps

"Sharps" is a collective term for medical equipment that can pierce or puncture the skin e.g.

- Single-use disposable injection needles and syringes
- Suture needles
- Scalpel blades
- Glass items such as used vials

The average rate of transmission of infection from infected source via a sharps injury is 0.3% for HIV, 1.8% for Hepatitis C and 6 – 30% for Hepatitis B (if subject is not vaccinated) (CDC, 2013)

3.3.1 Correct handling of sharps:

- When giving injections, prepare the client to prevent sudden movements which can lead to needle prick injuries
- When passing sharps use a 'hands free' technique in which person A places the sharp in a 'safe zone' on an instrument tray and notifies person B of its location for them to pick up.
- Do not recap, bend, break or remove needles from syringes prior to disposal.
- Place used sharps in a puncture proof plastic container immediately after use.

3.3.2 Sharps containers should be:

— Located in each room where sharps are used

— Made of puncture-proof plastic or heavy cardboard

— Clearly labelled

— Disposed of when ¾ full by incineration or per local government regulations

— Single-useonly (i.e. disposed of and never re-filled)

— Handled and disposed of while wearing utility gloves

3.3.3 Dealing with sharps injuries

All staff are at risk of sharps injury. Sharps injuries occur when staff are accidentally pricked by a needle or other sharp instrument which has been in contact with a client's blood or body fluids. Injuries can occur by needlestick while giving injections, when taking blood, suturing, when passing needles and syringes from one health care worker to another, and if sharp instruments and needles and syringes are left in linen, the staff who sort linen and process instruments and medical waste must know how to protect themselves from accidental exposure to blood and body fluid, and they must knowhow to report and what action is needed should an accidental exposure occur:

- Wash injured area thoroughly with soap and water
- Notify appropriate person such as the centre manager or area coordinator
- Assess type of exposure and associated risk of transmission of infection
- Based on assessment consider administering post-exposure prophylaxis (PEP) as a short-term antiretroviral treatment

Irus	Post-exposure Prophylaxis (PEP)
Hepatitis B virus	• PEP with HBIG and/or Hepatitis B vaccine series after evaluation of the HBsAG status of the source and the vaccine-response of the exposed person Perform follow-up anti • HBs testing in persons who receive Hep B vaccine • Test for anti HBs 1-4 months after last dose of vaccine
Hepatitis C virus	PEP not recommended Perform baseline and follow-up testing for anti HCV if possible 4-6 months after exposure Perform HCV RNA at 4-6 weeks if earlier diagnosis of HCV desired or if source known to be HCV positive
HIV	• Start PEP *within 72hrs of possible exposure* • Offer pregnancy testing to all women of childbearing age not known to be pregnant • Administer PEP for 4 weeks • Perform follow-up testing and provide counselling • Advise exposed persons to seek medical Evaluation for any acute illness occurring during follow-up • Perform HIV antibody testing for at least 6 months post-exposure (baseline, 6 weeks, 3 months,6 months) • Perform HIV antibody testing if illness compatible with an acute anti-retroviral syndrome occurs • Advise exposed persons to use precautions to prevent secondary transmission during the follow-up period. Evaluate exposed persons taking PEP within 72h after exposure and monitor for drug toxicity for at least 2 weeks

3.4 Environmental Cleanliness

3.4.1 General guidelines

- Separate areas to be cleaned according to the risk of infection they Present (low and high risk) and cleaning routine modified according to area. Low risk areas require less frequent cleaning
- When dusting, use a damp cloth so the dust will not get into the air
- Always clean from top to bottom, working from highest to lowest point,
- Finishing with the floor
- Always wear utility gloves
- Disinfect and clean spills immediately
- Do not use the same disinfection solution for both instrument processing and housekeeping. Make up a separate solution for housekeeping and place it in

a spray bottle

- Change cleaning solution frequently, especially when it looks dirty
- Keep mops and scrubbing brushes clean and disinfected
- Provide clear instructions on where, how andwhen to clean (cleaning rota) should be displayed clearly for the intended audience.

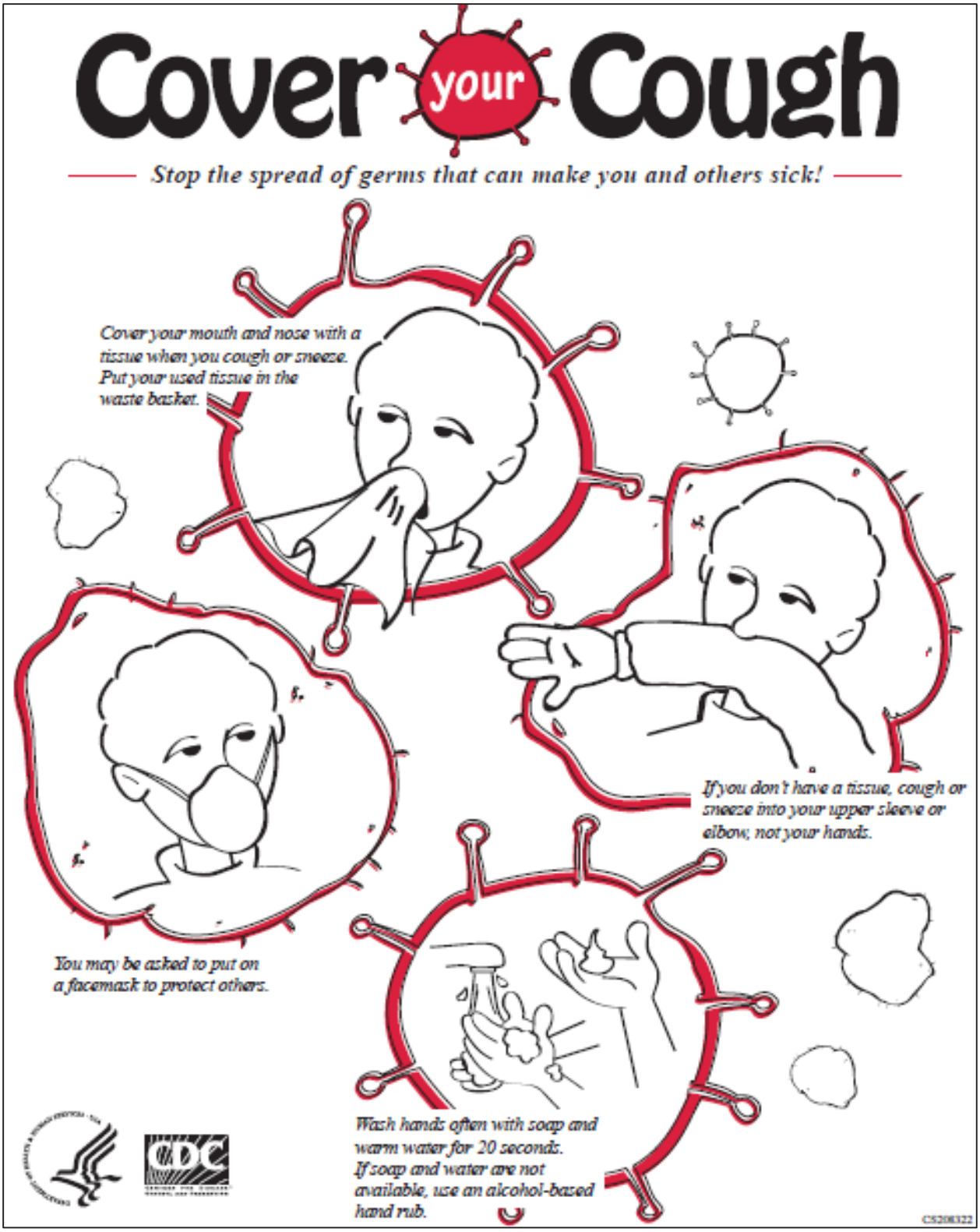
3.4.2 Low risk areas

- Include waiting rooms, administration areas
- Clean with detergent and water
- Clean daily, and whenever dirty

3.4.3 High risk areas

- High risk areas include procedure rooms, recovery rooms, post-operative rooms, instrument processing areas, client beds, examination couches, instrument trolleys and toilets
- Clean areas visibly contaminated by blood or body fluids with 0.5% chlorine solution
- Never dry dust or sweep as thisspreads dust and micro-organisms
- When cleaning exam tables use 0.5% chlorine solution which is changed daily
- When cleaning instrument trolleys and client trolleys use 0.5% chlorine

3.5 Respiratory Hygiene



3.5.1 Airborne infectious agents, or those present in saliva or mucus, can be spread by coughing or sneezing

3.5.2 Both team members and clients should take care to prevent this as follows:

- When coughing or sneezing, cover mouth and nose with a tissue or the crook of the arm
- Discard tissue in waste basket
- Clean hands immediately w ith alcohol rub or soap/running water
- Providers and clients with symptoms of influenza should be encouraged to wear face masks

3.5.3 Clear instructions on correct etiquette when coughing or sneezing should be prominently displayed for the intended audience

3.6 Processing Linen

- Handle soiled linen as little as possible and place in a leak-proof container at place of use
- Wear utility gloves and other protective attire when handling, transporting and processing used linens

Washing linens

— Sort to ensure no sharps, instruments or waste

— Use detergent and warm water, if available, rinsing with clean water

— Machine wash if possible to reduce risk of exposure to infectious materials

— If hand washing, wear utility gloves

– With long cuffs, apron and eye/face shield

3.7 Handling and Processing Instruments and Materials

Microorganisms can live on instruments and materials used during MR/PAC 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 Uterine Evacuation using MVA Plus® Aspirator Chapter, section: Instrument Processing.*

3.8 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 cervix prior to inserting an instrument. The provider should, and swab the cervix with a water-based (not alcohol-based) antiseptic solution, such as Betadine®, using sponge forceps and gauze or cotton wool.

Cervical preparation:

- Antiseptic cervical preparation is needed because resident vaginal flora can very easily be introduced when inserting the cannula into the uterus during an MVA procedure.
- The cervix must be cleaned with antiseptic prior to inserting an instrument.
- If germs from the cervix or vagina get onto the tips of instruments and then into the sterile uterus during a procedure, infection can result.

No-touch technique

Tips of instruments should not touch any contaminated surfaces—including gloved fingers or the woman's vaginal walls—before being inserted into the uterus. No-touch technique must be used throughout the MR procedure with MVA. As long as the principles of no-touch technique are followed, one-time use gloves or clean gloves can be used.

3.9. Use of Antiseptics and Disinfectants

3.9.1 Antiseptics are antimicrobial substances that are applied to living tissue/ skin to reduce the possibility of infection (e.g. for skin, cervical or vaginal preparation prior to a procedure, or surgical scrub)

3.9.2 Using antiseptics (chlorohexidine, povidone iodine, alcohol > 60%)

- Store in a cool dark area
- When decanting antiseptic from a storage bottle pour the amount needed into a smaller container

- Discard any left over antiseptic following the procedure or service
- Do not keep gauze or cotton soaked in antiseptic solution

3.9.3 Disinfectants are used on inanimate objects to kill micro-organisms (e.g. for decontaminating instruments or work surfaces)

3.9.4 Using disinfectants (glutaraldehyde, chlorine)

- There are three types of disinfection commonly used

— **Low-level:** used for housekeeping and cleaning surfaces – 0.5% chlorine

— I**ntermediate-level:** used for cleaning vial tops, some equipment – 70% alcohol

— **High-level:** items are soaked in glutaraldehyde for 20 minutes for HLD and 10 hours to kill all pathogens

- Disinfectant solution should be kept covered so it does not evaporate and change concentration
- Disinfectant solution like chlorine solution should be disposed of after 24 hours

3.9.5 When using chlorine as a disinfectant the correct concentration to be prepared is 0.5% chlorine solution calculated as follows:

Parts of water for each part of liquid bleach = (percentage of active chlorine in liquid bleach x 2) – 1

For example, the formula for making a 0.5% chlorine solution using 5.25% active chlorine bleach is: (5.25x 2) – 1= 9.5 parts of water for 1 part of bleach

3.9.6 Grams of bleaching powder per litre of water = (0.5 ÷ % of active chlorine in bleach powder) x1000

For example, to make 0.5% chlorine solution from bleaching powder containing 33% active chlorine, grams of bleaching powder to be dissolved in1litre of water is as follows:

(0.5 ÷ 33) x 1000 = (.015) x 1000 = 15 grams

3.10. Disposal of Infectious Waste

- All disposable material that has come in contact with body fluids should be considered infectious waste.
- Proper waste disposal protects the community.
- If infectious waste from a clinic gets into the community, risks include: accidental needle sticks and exposure to infected blood and other body fluids in solid waste or contamination of water sources.
- Waste should be secured (NO open piles).
- Incineration is ideal, but not recommended by the authorities in Bangladesh.
- Solid waste can be buried (protected by a fence, away from water source).
- Liquid waste can be buried or poured down a drain.

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.

Contraceptive Services

Contraceptive Services

Key topics in this Chapter:

- Post MR & postabortion contraceptive counseling and method provision
- Service-delivery models
- Effective contraceptive counseling
- Medical appropriateness of contraceptive methods following MR & PAC
- 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.

The term "contraception" is used in this Chapter rather than "family planning." While the term "family planning" is more culturally acceptable in some settings. Many women receiving contraceptive services are 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.

Providing contraceptive counseling and methods as part of menstrual regulation (MR)/PAC services can improve contraceptive acceptance and help break the cycle of repeated unwanted pregnancies. Every woman, including young women, undergoing MR/PAC 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 or MR, contraception should be provided immediately to women who want to prevent or delay pregnancy.

Diverse circumstances apply to women receiving MR 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 MR will have chosen to terminate their pregnancies. The reasons that pregnancies are unwanted differ, but often women feel a loss of control over the situation. Some women may have desired the pregnancy, but for medical reasons may have terminated it. Each woman's

individual clinical situation will determine her contraceptive needs. The common factor among women receiving abortion care is that they are at a critical juncture in their reproductive lives and can benefit from compassionate counseling about their sexual health, goals and contraceptive options.

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

This chapter explains why contraceptive counseling and method provision are critical parts of MR/PAC. It also addresses how to successfully counsel women receiving MR/PAC 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 Contraceptive counseling and method provision after MR & PAC

The goal of contraceptive counseling is to help a woman decide if she wants to prevent pregnancy in the short or long term and to assist her in choosing an appropriate contraceptive method. In woman-centered contraceptive counseling, providers focus on each woman's unique needs, reproductive intentions, life circumstances and clinical conditions.

Contraceptive use can promote women's health and rights by:

- Allowing mothers to achieve spacing between births and a small family size, which improves infant health and saves infant lives;
- Improving women's quality of life by allowing her to be in control of her reproductive health including the number and timing of her children;
- Helping women avoid unwanted pregnancies, which prevents unnecessary exposure to potential risks during pregnancy and delivery.

Postabortion contraceptive services are effective when they are based on individual women's needs. contraceptive counseling should help each woman assess her situation and needs and make an informed decision for herself. Contraceptive use is most effective when the woman has been informed about the advantages, risks, side effects, and likelihood of success of all appropriate options and their alternatives.

3.0 Models of Service Delivery

There are many people who, with proper training, can provide contraceptive counseling and method provision. Options include training MR/PAC service providers for this role, training additional staff members, or relying on staff from a local family-p lanning service. Community volunteers can also be trained to provide these services, as long as strict confidentiality protocols are enforced.

Offer contraceptive methods

Contraceptive counseling and method provision can take place at various points and in different ways during MR services. Ideally contraceptive counseling is conducted prior to the procedure, but if needed can also happen during or after MR procedures.

Service-delivery models include:

- Offering counseling and interim methods, as well as permanent methods, if available, at the facility providing MR services and Postabortion Care
- Offering counseling at the MR-service facility with a referral for method provision at another site
- Arranging for service providers from a family-planning clinic to come to the MR and postabortion-care service 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 MR or after Postabortion Care if the woman is incoherent. 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 using MVA. In these cases, counseling and consent must be completed before the MR procedure begins.

4.0 Women's Fertility Goals Following MR/PAC

Although some women seek MR for medical reasons and desire to become pregnant again soon, most women who seek elective, induced MR 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 abortionthat 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.

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

- She could become pregnant again within 08 days after the abortion procedure
- Safe contraceptive methods to prevent or delay pregnancy are available
- Where and how she can obtain contraceptive services and methods, including emergency contraception (EC)
- Most contraceptive methods can be used immediately after abortion care

(Wolf and Benson, 1994)

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 an 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, repeat MRs and 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 or the woman cannot consistently for barriers reasons such as:

- 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.

Assess fertility goals

- The woman had non-consensual sex.
- Social stigma discourages unmarried woman/adolescents to obtain contraceptive methods.

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

- 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 MR-care and PAC settings.

- Ideally, women should receive counseling in a private area where they are not seen or overheard by others. If this is not possible, the facility should make arrangements to come as close to this ideal as possible. 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 MR/Postabortion 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 woman should be asked whether or not she wants her partner included in contraceptive counseling. In some cases, inclusion of partners in contraceptive counseling can increase the effectiveness of the counseling. Male partners support of contraception is a strong predicator of contraceptive use. Counseling male partners can increase their awareness and use of male contraceptive methods, such as male condoms and vasectomy.

Provide contraceptive counselling

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 helpthe woman explore how she would protect herself in such an event and should provide referrals to appropriate services. (See the *Counseling* Chapter for more information.)

7.0 Essential steps for Contraceptive Counseling

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

A provider who counsels effectively does more than describe the various contraceptive methods available; he or she establishes trust with the woman, comes to understand her 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* Chapter 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 MR 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 MR or had 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 pregnancy

Although most women choosing an MR 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 underwent a uterine evacuation procedure for medical reasons are not interested in delaying pregnancy. However, 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.

Explain characteristics of available methods

The counselor should explain the characteristics, use, side effects and effectiveness of the methods available at the facility and within her community which meet her needs, preferences, and personal situation, and let her know from 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 Uterine Evacuation

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 first-trimester MR with MVA 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-MRmenses, provided that she historically had normal menstrual cycles *(WHO, 2009).*
- 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 condoms
- Hormonal methods such as combined oral contraceptives, combined injectables, and implants
- Intrauterine methods such as IUDs
- Fertility awareness-based methods such as basal body temperature and calendar methods
- Emergency Contraception (EC), which must be used within five days after unprotected intercourse and includes insertion of an IUD or a specific regimen of oral contraceptive pills
- Surgical methods such as male and female sterilization

8.1 Uncomplicated uterine evacuation using medical methods

Medical eligibility after a medical MR is not different from that of other first-trimester methods.

Most modern hormonal contraceptive methods can be used immediately with misoprostol, provided that there are no contraindications. this recommendation is based on expert opinion. Delaying provision of contraceptive methods puts women at risk of unintended pregnancy. A woman who wants contraception should be provided her preferred method as soon as possible.

Uncomplicated vacuum aspiration

All modern contraceptive methods can be used immediately.

8.2 Vacuum aspiration with complications

In cases where an infections is evident or presumed, the provider should advise the woman to avoid intercourse until the infection is resolved or ruled out. All methods of contraception can be given after an abortion complicated by an infection, except for the intrauterine device and female sterilization. An intrauterine device may be

inserted or sterilization performed once the infections is resolved.

Genital injuries or excessive blood are not medical eligibility contraindications, but providers need to take these conditions into consideration. Genital injury includes uterine perforations, cervical tears, vaginal trauma and lacerations. These injuries may require a delay in the use of certain contraceptive methods. Method that may be temporarily restricted include female sterilization, IUD and barrier methods other than the male condom.

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 MR 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, 2009; Dunn et al, 2003).*
- Emergency contraceptive pills (ECPs): When used within five days after unprotected intercourse, ECPs are 75 to 95 percent effective in preventing pregnancy *(Ellertson etal., 2003; Grimes, 2002; Rodrigues et al., 2001; TFPMFR, 1998).*

- ECPs can be used as many times as needed by a woman to prevent pregnancy after unprotected intercourse. 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.
- ECPs are a less effective method of contraception than using a regular, routine form of contraception.

EC Protocol: Dosages of EC pill

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 (progesterone-only pills): Single dose of 1.5mg of levonorgestrel taken within five days of unprotected intercourse *(WHO, 2010).* 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 (combined oral contraceptives): 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.

9.1 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. Initiating certain methods of contraception are not recommended if there is an infection including performing female sterilization or placement of an IUD or an impant.

Female sterilization is not appropriate until infection is either ruled out or resolved, as the presence of infection may increase the risk of post-surgical infection. Intrauterine methods are not appropriate until infection is resolved because insertion may substantially worsen the condition. Short-term methods can be used to "bridge" the time until a woman can have her sterilization procedure or her IUD placed.

9.2 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 andIUDs. Short-term methods can be used to "bridge" the time until a woman can have her sterilization procedure or her IUD placed.

9.3 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.Short-term methods can be used to "bridge" the time until a woman can have her sterilization procedure or her IUD placed.

Note: For postabortion contraception please see Chapter on Postabortion Care Services.

10. Use of Contraception after MRM

Most methods of contraception, including condoms, modern hormonal methods (contraceptive pills, implants and injectables) may be started on the day a woman is given mifepristone. IUDs and sterilization can be used when it is determined that the woman is no longer pregnant; meanwhile, an interim method of contraception should be offered.

Table : Summary of Contraception Initiation for each UE Method

** Provided that there are no complications*

When to Start a Contraception after MVA	
Contraceptive Method	**Initial Timing***
Male Condom	Immediately following MVA procedure
Oral contraceptive pills	Immediately following MVA procedure
Implant	Immediately following MVA procedure
Injection	Immediately following MVA procedure
IUD	Immediately following MVA procedure
Female Sterilization	Immediately following MVA procedure
Natural Family Planning	Following one post-MR menses in a woman with a history of regular periods
Emergency Contraceptive Pills	As needed, within 5 days of unprotected sexual intercourse

When to Start a Contraception after MRM	
Contraceptive Method	**Initial Timing***
Male Condom	Day 1 of MRM regimen
Oral contraceptive pills	Day 1 of MRM regimen
Implant	Day 1 of MRM regimen
Injection	Day 1 of MRM regimen
IUD	As soon as reasonably sure that woman is not pregnant/confirm the complete expulsion of product
Female Sterilization	As soon as reasonably sure that woman is not pregnant/confirm the complete expulsion of product
Natural Family Planning	Following one post-MRM menses in a woman with a history of regular periods
Emergency Contraceptive Pills	As needed, within 5 days of unprotected sexual intercourse
When to Start a Contraception after PAC	
Contraceptive Method	**Initial Timing***
Male Condom	As soon as woman feels ready to begin having sexual intercourse
Oral contraceptive pills	Immediately following procedure
Implant	Immediately following procedure
Injection	Immediately following procedure
IUD	Immediately following procedure
Female Sterilization	Immediately following procedure
Natural Family Planning	Following one post-PAC menses in a woman with a history of regular periods
Emergency Contraceptive Pills	As needed, within 5 days of unprotected sexual intercourse

11.0 Special contraceptive counseling considerations

For the following women and issues, there are certain specialized considerations providers should keep in mind. Information on how providers can meet the specific contraceptive needs of women in these circumstances is provided in Appendix C: Special contraceptive counseling considerations. Special considerations include:

- Young women
- Multiple abortions
- Violence
- Living with HIV
- Women engaged in sex work
- Women with cognitive and developmental disabilities and mental illness
- Refugees and displaced persons
- Female genital cutting

12.0 Considerations for Postabortion Care

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

13.0 Summary

- Every woman receiving MR, MRM, or Postabortion Care should be offered contraceptive counseling and, if she desires, a contraceptive method.
- Idealy contraceptive counseling is conducted during the MR and MRM counseling session, If not, during or after MR and MRM are alternative opportunities to discuss contraceptive options, if desired by the client
- 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 MR, MRM, or Postabortion 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.

Monitoring to Improve Services

Monitoring to Improve Services

Key topics in this Chapter:

- Definition of monitoring
- Key steps of monitoring
- What to monitor

1.0 Introduction

Every health service can benefit from routine monitoring. Monitoring helps ensure that services achieve and maintain a level of quality that is satisfactory to both the clients and providers. This chapter includes:

- Key characteristics of effective monitoring systems
- Steps involved in monitoring
- Aspects of abortion service delivery that should be routinely assessed
- Importance of adverse event monitoring and reporting

2.0 What Is Monitoring and Why is it Important?

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

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

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

Monitoring should be conducted at both public-sector and private-sector health

facilities. The number and complexity of activities will vary according to the availability of staff and resources. In larger health facilities, administrators and managers usually conduct monitoring activities. In smaller facilities, providers may need to 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.

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.

Objective	Current Monitoring Data	Previously Collected Data	Improvement Plan
100% of clients receive individualized counseling with a counselor.	65% of clients receive individualized counseling with a counselor.	Compared with data one year prior, individualized counseling has increased 40%.	Private counseling spaces will be expanded and additional counselors trained to increase individualized counseling.
Essential supplies to high-level disinfect MVA instruments available 100% of the time.	Instrument processing chemicals are available 70% of the time. Deliveries of these chemicals are often one to three weeks late.	Compared with data six months prior, availability of instrument-processing chemicals increased 10%.	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.

3.0 Keys to Effective Monitoring Systems

Using indicators

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

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

Monitoring is most effective when it:

...is integrated into routine work

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

...uses simple indicators

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

...is participatory and open

When the monitoring process is genuinely inclusive of all health-care staff members, they are more likely to feel a sense of ownership of the results. Staff 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.

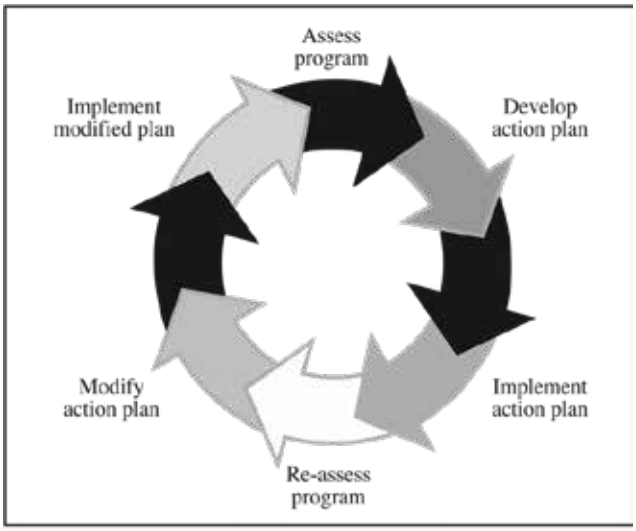
...is conducted in an ethical manner

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

....**is not punitive**Monitoring is most effective when staff 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 Adverse event monitoring

Adverse events are complications that a woman suffers during care that are not a result of disease. Although adverse events are rare in routing abortion care, it is important to monitor for adverse events because each event offers the opportunity to learn about how to provide better, safer care for women. A distinction should be made in the logbook between any complications the woman may present with and complications arising from Postabortion Care services.



Monitoring is a continuous process

5.0 Four Steps of Effective Monitoring

Monitoring involves four basic steps:

5.1 Planning:

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

The plan should include:

- Members of the monitoring team, comprising a range of staff and recipients of services, including young women and how team members will be trained.
- Aspects of services to be monitored
- Quality standareds and indicators to measure them
- Sources of information, such as logbooks with service statistics and client records
- Methods for gathering information, such as interviews, focus groups, observation and records review
- Tools that will be used to guide information gathering, including checklists and consent forms
- A plan for sharing results with staff and the community, improving services, if needed
- A timeline for the monitoring process, with information about activities and persons responsible for their completion

The following table illustrates aspects of MR and PAC services that could be monitored and provide some sample questions.

Examples of Aspects of MR & PAC Care to be Included in Monitoring Plan			
Types of services	**Indicators**	**Information sources**	**Checklists, questionnaires and exit interviews**
Which services should be monitored?	What will we use to measure our activities?	Where can we get this information?	What type of questions should we ask?
Infection prevention	Percentage of cases in which infection-prevention practices were fully adhere to	Observe services using performance checklists	Was no-touch technique performed? Were MVA instruments properly processed?
Management and organization of services	Average amount of total time clients spend in the facility Average amount of time from arrival to procedure Hours during which services are available	Observe and evaluate clinic flow Review client records and conduct interviews with staff	During what times of the day does client waiting time increase?
Counseling	Number and percentage of women receiving high- quality counseling services	Observe counseling services using performance checklists Review recent cases in logbooks	Were women with special needs given appropriate referrals when necessary?
Contraceptive counseling and services	Number and types of contraceptives dispensed on site Number and percentage of women who received contraceptive counseling Number and percentage of women desiring	Observe contraceptive counseling services using checklists Conduct exit interviews with women Review recent cases in logbooks	How well was the woman counseled about which contraceptive methods are available? Did the woman leave with the desired method or information? Did the woman have to go to another facility to receive a contraceptive

	contraception who received a method		method? Were young women's needs taken into consideration for method provision?
Client satisfaction	Percentage of women who indicate that they received respectful care Percentage of women who agree that clinic costs are reasonable	Conduct exit interviews with women Review financial records	Did you feel that you were treated respectfully? Do you think the amount you had to pay for services was reasonable?

5.2 Information Gathering

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

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

5.3 Analysis

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

a. Reveal problem areas
b. Develop improvement plans
c. Assess progress in improving care

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

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

Once the staff has a better understanding of the issues, they can look deeper into the underlying causes of the identified problems. Health-care staff must ask, "What factors contributed to these problems?" In the example above, poor-quality counseling services might stem from inadequate training of newly hired staff and a client-intake process that leaves insufficient time for counseling. The staff review may also identify causes that are more pervasive-for instance, an underlying belief that counseling is not an important part of services. Staff should also seek input from clients and community members to determine the root cause of a problem or issue.

5.4 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.

Creative Thinking

- Identify problems that are feasible for the staff to work on, given available human and financial resources
- Determine what can be done without additional resources
- Choose problems with feasible and timely solutions
- Focus on a few problem areas—no more than three—at any one time
- Select problems that the team has the ability to manage

(Otsea et al., 1999)

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.

6.0 Considerations for Postabortion Care

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

7.0 Summary

- Monitoring, or the routine tracking of services, is essential to ensuring that women receive high-quality MR andPAC 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.

Appendix

Appendix: High-Quality Service Provision Checklist

1.0 Introduction of Service Provision

To provide high-quality MR and PAC services, several factors need to be in place. An enabling environment is essential for better site and provider performances. Facilities, supplies, personnel, referral systems and quality assurance mechanisms all contribute to the provision of high-quality services, which will be discussed in this Chapter.

Several service checklists are provided to assess providers' skills and monitor service provision in the facilities.

2.0 Factors Contributing to the Provision of High-Quality MR Care

2.1 Facilities and Health Services

- Accessible hours and days of available MR/PAC services
- Private areas for information and counseling (both visual and auditory privacy)
- Separate area for adolescent and young women for waiting and recovery (if services are provided)
- Infection prevention practices and supplies (for example, clean gloves for pelvic exams, chlorine solution)
- Sufficient number of toilets to accommodate women
- Procedure room and equipment for MVA available
- Effective referral system for complications and other reproductive health needs
- Integrated family planning service (e.g., provision of postabortion contraception)

2.2 Medication and Supply Management

- Availability of recommended drug regimens to be used at clinic site
- Pain management - ibuprofen, diazepam
- Other medications as needed - antibiotics (if used) and iron tablets
- Clean drinking water (to take pre-procedure medication)
- Sanitary pads or cotton wool
- Contraceptive supplies
- Systems for procurement of medications
- Supply forms
- Adequate storage

2.3 Staff Knowledge, Attitudes and Skills

- ***Knowledge of****:* clinical assessment including gestational dating, counseling and informed consent, process for uterine evacuation using MVA or medications,

misoprostol for PAC, need of follow-up, laws and policies affecting certain women (for example in case of young unmarried women and adolescents).

- ***Attitudes that are:***positive, helpful, non-discriminatory toward women seeking MR and PAC services, independent of the women's age, marital status, or any other personal characteristic.
- ***Skills to:***perform clinical assessment, provide misoprostol for Postabortion Care information, provide counseling including postabortion contraceptive counseling and obtaining informed consent, perform MVA procedure, conduct follow-up and assessment of MR completion, perform or refer women for emergency care.
- ***Criteria for Staff training*:**educational background and years of related experience to obtain training on MVA and Postabortion Care.

2.4 Client Information

- Clear, simple information to help women make an informed decision about MR
- Informed consent forms
- Simple information about what to expect, and when and where to seek follow-up and emergency care
- Contraceptive information and referrals

2.5 Record Keeping

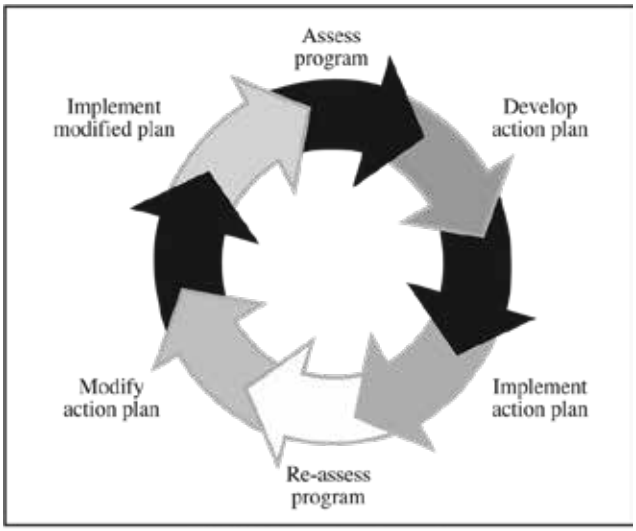
- Policies about which information to record
- Record-keeping that protects women's privacy (such as lists of women waiting for their follow-up visit which are not visible to anyone other than staff)
- Properly filling up log-sheets
- Monthly registers or logbooks
- Individual client records
- Referral and adverse event reporting forms

2.6 Monitoring and Evaluation

- A monitoring and evaluation plan should be in place that contains:
  - Clear Definitions Of Services To Be Evaluated
  - Sources Of Information
  - Indicators For Measurement Identified
- Mechanisms for obtaining feedback from women for improving services (e.g., exit client interviews.)

4.0 Adverse event monitoring

Adverse events are complications that a woman suffers during care that are not a result of disease. Although adverse events are rare in routing abortion care, it is important to monitor for adverse events because each event offers the opportunity to learn about how to provide better, safer care for women. A distinction should be made in the logbook between any complications the woman may present with and complications arising from Postabortion Care services.



Monitoring is a continuous process

5.0 Four Steps of Effective Monitoring

Monitoring involves four basic steps:

5.1 Planning:

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

The plan should include:

- Members of the monitoring team, comprising a range of staff and recipients of services, including young women and how team members will be trained.
- Aspects of services to be monitored
- Quality standareds and indicators to measure them
- Sources of information, such as logbooks with service statistics and client records
- Methods for gathering information, such as interviews, focus groups, observation and records review
- Tools that will be used to guide information gathering, including checklists and consent forms
- A plan for sharing results with staff and the community, improving services, if needed
- A timeline for the monitoring process, with information about activities and persons responsible for their completion

4.0 Service Site Equipment Guidelines

The required equipment and supplies will depend on the type of MR procedures offered by providers and by the capacity at the site. This in turn depends on the usual gestational limits which the provider performs, the clinic distance from a referral site, the profile of most clients and other similar factors.

Physical Structure

- A space for registration and record keeping
- A well-lit space for waiting, history taking and physical examination, counseling
- Toilet for clients
- Soap and source of fresh water for hand washing
- A well-lit procedure area
- A space for recovery of the client
- Facilities for disposal of the products of conception
- A means of transporting clients who need referral

Suggested Equipment (this list is not exhaustive)

- Procedure table
- Instrument Cart
- Cupboard for storing contraceptive methods and other inventory
- Table and chairs for the providers and revolving chair for the procedure room
- B.P instruments, thermometer, stethoscope
- IV stand and IV sets and bottles
- Reclining chairs or beds for recovery and observation
- Spot light
- Stainless steel container with lid for storing instruments
- Autoclave drums
- Sieve and magnifying glass
- Heat source for HLD of instruments
- Leak-proof waste container for sharp needles and materials
- Buckets for instrument processing
- Soft brush for instrument cleaning
- Plastic aprons
- Face protection
- Referral forms

- Informed consent forms
- Record keeping forms/registers
- IEC materials

Instruments

- Bivalve graves or other speculum (medium, and small)
- Tenaculum or volsellum
- Emesis pan
- Kidney dish
- Sponge forceps
- 10 ml syringe for paracervical block
- MVA aspirator (MVA plus®)
- Plastic cannula of different sizes (4-12)
- Stainless tray with cover
- Oxygen cylinder with Ambu bag and oxygen mask

Essential Drugs:

- Antibiotic: Doxycycline/Azithromycin /Ciprofloxacin, Metronidazole
- Analgesic: Ibuprofen/ Diclofenac/ or a suitable alternative
- Local anaesthetic: Injection lidocaine (1-2 per cent)
- Injection/Tab-Diazepam
- Uterotonics: Injection Oxytocin, Methylergometrine Maleate and Misoprostol
- Tab Misoprostol (for Incomplete abortion, missed abortion, cervical ripening)
- Normal saline/ Dextrose 5 per cent in Normal Saline/Ringer lactate solution with IV sets and cannulae
- Drugs for Medical MR (Mifepristone 200mg and Misoprostol 800 mcg in Combi-pack)
- Tab Mifepristone 200 mg (MRM, Missed abortion)

Drugs for Treatment of Emergencies (preferable):

- Injection Adrenaline
- Injection Aminophylline/Salbutamol inhaler
- Antiemetics: Injection Metoclopramide or a suitable alternative
- Antihistamine: Injection Promethazine hydrochloride or a suitable alternative
- Steroid Injection: Hydrocortisone Succinate
- Injection Frusemide
- Injection Atropine

Consumable supplies

- Materials for packing the metal instruments
- Chromic catgut suture material
- Silicone for lubricating MVA aspirator
- Swabs/gauze
- Antiseptic solution (e.g. Betadine), detergent powder
- Gloves (surgical, examination and utility gloves)
- Linens
- Sanitary pads

Personnel

- Trained service provider(s)
- 2 Nurses or paramedics
- Aides (cleaning staff)

5.0 Uterine Evacuation Counseling Skills Checklist

Instructions for observer: Silently observe and evaluate the counseling session. Do not interact with the woman or counselor. Check "yes" or "no" depending on whether the counselor demonstrated the skill during the counseling session, and write comments. Offer your evaluation and comments to the counselor at the end of the session.

Skill	Yes	No	Remarks
Positive Rapport and Woman-Centered Approach			
Greets and welcomes the woman by name			
Sits facing her without barriers between them			
Assesses her emotional state, medical condition, cultural background and level of understanding			
Assesses her needs			
Ensures all her questions are answered and that she understands information			
Verbal Communication			
Speaks in a reassuring tone of voice			
Uses clarifying and open-ended questions			
Validates the woman's feelings and decisions regardless of cultural norms			
Uses medical and other language in a manner the woman understands			
Nonverbal Communication			
Maintains appropriate eye contact			
Gives the woman full attention			
Shows interest and concern			
Uses open, receptive body language			
Touches the woman when appropriate			
Confirms differences between the woman's verbal and nonverbal cues			

Skill	Yes	No	Remarks
Adapts nonverbal communication, depending on culture and age			
Empathy			
Conveys warmth and compassion			
Demonstrates understanding			
Communicates openness			
Shows desire to understand the woman's point of view			
Avoids judgement			
Privacy and Confidentiality			
Counsels privately where no one else can see or overhear			
Asks the woman in private whether she wants to invite anyone else in			
Informs her of confidentiality			
Professionalism			
Treats every woman with respect			
Separates own values and biases from the woman			
Refers the woman when unable to meet her needs			
MR-Specific Content			
Helps clarify feelings and decisions about missed periods, miscarriage and options			
Discuss sexual and reproductive health			
Discuss broader life circumstances when appropriate			
Ensures voluntary, informed decision-making			
Determines scope of physical and emotional needs			
Resources and Referral			
Refers to contraceptive counseling and other health services			
Provides contact information for follow up or referral			

Skill	Yes	No	Remarks
Maintains confidential referral logbook			
Provides written information or alternatives			
Special Populations in the MR Setting			
Screens for violence, reproductive-tract infections and other issues			
Meets needs of special populations:			
• For women with repeat uterine evacuations, discusses why and helps to resolve			
• For women who have experienced violence, discusses issues and provides referrals			
• For women living with HIV/AIDS, helps manage their condition vis-à-vis menstrual regulation care and provides referrals			
• For adolescents, avoids judging sexual activity, refers to adolescent reproductive health programs			

6.0 Contraceptive Counseling Skills Checklist

Instructions for observer: Silently observe and evaluate the counseling session. Do not interact with the woman or counselor. Check "yes" or "no" depending on whether the counselor demonstrated the skill during the counseling session, and write comments. Offer your evaluation and comments to the counselor at the end of the session.

Skill	Yes	No	Remarks
Establishes Rapport			
Greets client in friendly way, demonstrating interest and concern			
Establishes privacy			
Assures confidentiality			
Asks for permission prior to including others in session			
Assesses Woman's Needs			
Asks questions to determine woman's personal circumstances and needs			
Explores factors that led to the need for an MR			
Determines if the pregnancy was unplanned, unwanted or wanted			
Explores woman's current desire to delay or prevent pregnancy			
Provides information on the health benefits of child spacing, if needed			
If she was using contraception, assesses reasons for failure of method			
Explains human reproduction (if necessary)			
Asks if she has used any methods in the past that she did not tolerate			
Discusses potential barriers to successful use of contraception and ways to resolve them			
Explains Characteristics of Available Methods			
Of the methods available at the facility (and within client's			

Skill	Yes	No	Remarks
community, if applicable), offers thosemethods which meet the woman's needs.			
Provides basic information about the characteristics, use, side effects and effectiveness of each methods			
Explain the need of F/up visit for the method (if applicable)			
Helps the Woman Choose Her Method			
Supports the woman in selecting the best method for her situation			
Confirms medical eligibility for her preferred method			
Ensures informed choice of method			
Ensures Understanding of Chosen Method			
Ensures woman fully understands the method she has chosen			
Helps her plan for continued use, ensuring she knows where and when to re-supply or change her method if necessary			
Provides chosen method or referral for method			
Discusses EC and provides ECPs with instructions for use as a back-up method, if desired and available			
Ensure she understands the f/up visit needed for the method chosen			
Refers to Other Resources as Needed			
Manages needs of special populations			
Has resource lists available to make referrals			
If unable to offer specialized counseling or services or meet clients' needs, makes referrals to appropriate services			

7.0 Infection-Prevention Skills Checklist

Instructions for observer: Silently observe. Do not interact with the person you are evaluating. Check "yes" or "no" depending on whether or not the skill was performed, and write comments. Offer your evaluation and comments afterwards.

Skill	Yes	No	Remarks
Standard Precautions			
Treats all clients the same with infection-prevention practices.			
Regards as contaminated all client and staff blood, body fluids, secretions and excretions and wet body surfaces (except sweat), regardless of any diagnosed disease.			
Handwashing			
Always washes their hands with soap and water/Alcohol handrub before and after contact with a client.			
Washes their hands with fresh, flowing water.			
Always washes their hands that have touched a client's blood or body fluid, whether or not disease has been diagnosed.			
Personal Protective Equipments			
Wears gloves, face protection and a gown when there is a risk of their hands, face or arms being contaminated with the blood or body fluid of a client or staff.			
Handling of Sharps			
Cautiously avoids injury from used needles.			
Immediately disposes of used needles in a sharps container without putting the needle caps back on and without bending or cutting them.			
Environmental Cleanliness			
Their entire clinic area and everything in it is clean at all times.			
Ensures that a 0.5% chlorine solution is used to clean the clinic environment.			
Infectious Waste			

Ensures that infectious waste is securely contained to prevent infection from spreading to the community.			
Aseptic Technique			
Ensures that instruments are properly processed between clients.			
Always prepares a client with antiseptic before beginning an invasive procedure.			
Avoids touching the tip or end of a sterile instrument that will be used on a client, either with their hand or any other non-sterile surface.			

8.0 Clinical Assessment Skills Checklist

Instructions for observer: Silently observe and evaluate the assessment. Do not interact with the woman or provider. Check "yes" or "no" depending on whether the provider demonstrated the skill during the assessment, and write comments. Offer your evaluation and comments at the end of the session.

Skill	Yes	No	Remarks
Records Client History			
Determines first day of last menstrual period (LMP)			
Obtains history of previous pregnancies and no. of living children			
Determines drug allergies			
Asks about any known medical conditions			
Asks about her surgical history			
Asks about her sexual history			
Asks about HIV and STI status			
Asks about any bleeding or clotting disorders			
Notes history of contraceptive use			
Notes history of alcohol or drug use, smoking			
Notes physical or cognitive disability, including mental illness			
Asks about any recent MR or Postabortion Care			
Asks about recent medications taken, including misoprostol or herbs			
Addresses or Refers for: Hypertension, seizure disorder, anemia, bleeding disorders, diabetes, heart disease, asthma, suspected ectopic pregnancy, cervical stenosis, alcohol or drug abuse			
Conducts a Psychosocial Assessment			
Assesses her emotional state using a gentle, nonjudgmental tone			

Skill	Yes	No	Remarks
Encourages discussion of the circumstances that led to her seeking abortion care			
Uses caution with adolescents and women who have experienced violence			
If there are signs of violence, encourages discussion to determine if she is in a dangerous situation and how to help or refer her			
Conducts a Physical Examination			
Prerequisite before conducting the examination:			
Asks the woman to empty her bladder before the pelvic exam			
Ask her permission to allow a third person in the examination room			
Uses towel, sheet, etc. to ensure her privacy is protected			
Explains to the woman what to expect, reassures her			
Evaluates general health:			
Checks her vital signs			
Notes general health, weakness, lethargy, anemia, malnourishment, dehydration			
Checks her abdomen for masses, tenderness			
Conducts a pelvic exam			
Performs a speculum exam:			
Notes ulcers or signs of STIs on the external genitalia			
Gently inserts a warm, appropriate-sized speculum			
Checks amount and source of any vaginal bleeding			
Notes if there are any hanging POC in the cervical OS			
Notes any pus, discharge, lesions, mass of the cervical os			
Takes culture, if possible, if infection is suspected			
Removes the speculum			

Skill	Yes	No	Remarks
Administers prophylactic antibiotics before evacuation			
Performs a bimanual exam:			
Assesses size, consistency, position of the uterus and adnexa			
Compares size of uterus with history of amenorrhea			
Evaluates woman for possible ectopic pregnancy			
Uses ultrasound or asks another provider if uncertain of uterine size			
Orders Laboratory Tests			
Obtains any needed tests without delay of evacuation			
Ideally, administers Rh immunoglobin, if routine protocol, at time of MVA			
Uses Ultrasound Exam for Suspected Ectopic Pregnancy			
Evaluates woman's history and physical exam for possible ectopic pregnancy			
Uses quantitative fi-hCG, if available, to detect ectopic pregnancy			
Refers or treats the woman as soon as possible			
Manages RTIs			
Administers prophylactic antibiotics, if available, to women without infection before vacuum aspiration			
Does not administer prophylactic antibiotics to women without infection before medication menstrual regulation			
Performs abortion even if prophylactic antibiotics are not available			
Assesses for and treats active infection, regardless of uterine- evacuation method			
Performs vacuum aspiration once antibiotic coverage has been established			
Prescribes a course of antibiotics to take after the uterine evacuation if infection present			

9.0 Instrument Processing Skills Checklist (MVA Plus® and EasyGrip® Cannulae)

Instructions for observer: Silently observe. Do not interact with the person you are evaluating. Check "yes" or "no" depending on whether the skill was performed, and write comments. Offer your evaluation and comments afterwards.

Skill	Yes	No	Remarks
Point-of-use preparation			
Wears gloves and face protection			
Fills a container with plain water			
Draws solution into the aspirator and cannulae and flushes 2-3 times with the water			
Submerges MVA instruments			
Uses gloves or forceps to remove instruments from the water when ready to clean them			
Cleaning			
Wears PPE—gloves, gown, apron, face protection			
Cleans all instruments, removes tissue or blood, washes all surfaces in warm water and detergent if possible			
Flushes soapy water through the cannula; uses a cotton-tipped probe, soft brush or soft cloth to gently remove material			
Disassembles aspirator			
Uses a small brush to clean crevices and inside			
Cleans until no material is visible upon careful inspection			
Dry with a clean cloth if desired			
Discards the cannula if not possible to remove all matter			
HLD or Sterilize			
Method: Steam Autoclave (Sterilization)			
Places cannula and disassembled aspirator in paper or linen			
Places to allow steam contact to all surfaces, not obstructing openings			
Sterilizes at 121^{0}C (250^0 F) for 30 minutes			
Cool before use			
Method: Glutaraldehyde (Sterilization)			
Immerses cannula and aspirator so that solution fills them			
Soaks according to manufacturer's instructions (10 hours for Cidex)			
Removes with sterile forceps or gloves			

Skill	Yes	No	Remarks
Rinses with sterile water			
Changes the solution every two weeks or per manufacturer's instructions			
Method: Glutaraldehyde (HLD)			
Immerses instruments so that solution fills them			
Soaks according to manufacturer's instructions (20 minutes for Cidex)			
Removes using HLD or sterile gloves or forceps			
Rinses with sterile or boiled water			
Changes the solution every two weeks or per manufacturer's instructions			
Method: 0.5% Chlorine (HLD)			
Immerses cannula and aspirator so that solution fills them			
Soaks in 0.5 % chlorine solution for 20 minutes			
Removes using HLD or sterile gloves or forceps			
Rinses with boiled or sterile water			
Changes chlorine solution every 24 hours			
Method: Boiling (HLD)			
Ensures water is at a rolling boil			
Boils cannula and aspirator for 20 minutes			
Cools before removing			
Remove using HLD or sterile gloves or forceps			
Handles cannula by non-aperture end			
Handling, Storage, Reassembly			
Stores equipment after cleaning and processing by HLD or sterilization			
Keeps in dry, covered containers, protected from contaminants			
Processes instruments every day if processed using chemicals or boiling			
Keeps only a few instruments in each container			
Uses forceps to remove cannula by the non-aperture end; avoids touching the rest of the cannula			
Reassembles and tests vacuum of aspirator			

10.0 Uterine Evacuation Procedure Skills Checklist

Instructions for observer: Silently observe. Do not interact with the person you are evaluating. Check "yes" or "no" depending on whether the skill was performed, and write comments. Offer your evaluation and comments afterwards.

Skill	Yes	No	Remarks
Creates pain management plan			
Tailors pain management according to the woman's needs			
Discusses sources of pain, options, potential side effects			
Includes combination of support and pharmacological measures			
Takes into account her medical and psychological status, nature of the procedure and availability of supplies			
Prepares the instruments			
Checks vacuum retention of aspirator			
Has more than one instrument available			
Prepares the woman			
Administers pain medication in timely fashion			
Asks woman to empty her bladder			
Asks what supportive measures she would like and provides them			
Asks for permission to start			
Puts on PPE and washes hands			
Performs pelvic exam to confirm assessment findings			
Warms and inserts speculum gently			
Performs cervical antiseptic prep.			
Follows No-Touch Technique			
Uses antiseptic sponges to clean os and, if desired, vagina			
Administers paracervical block			
Uses 10mL of 2% lidocaine or 20mL of 1% lidocaine (or less, depending on weight of client)			
Aspirates before injecting 1-2mL at tenaculum/volsellum site (12 o'clock)			
Places tenaculum/volsellum			

Skill	Yes	No	Remarks
Applies slight traction to expose tissue transition (cervical vaginal junction)			
Slowly injects 4mL lidocaine (2%) at 4 and 8 o'clock or 4-5mL lidocaine (1%) at 2, 4, 8 and 10o'clock in each site			
Waits 3 minutes from placement of paracervical block to begin dilation			
Insertion of the cannula			
Gently dilates cervix until cannula fits snugly (if needed)			
Completes cervical preparation, if needed			
Applies gentle traction to cervix			
Inserts the appropriate size of the cannula			
Rotates cannula while gently applying pressure			
Inserts cannula just past internal os into uterus OR to fundus and pulls back the cannula approximately 1 cm			
Suctions uterine contents			
Holds tenaculum and end of cannula in one hand			
Attaches charged aspirator			
Releases buttons to start vacuum			
Rotates cannula 180 degrees in each direction			
Uses an "in and out" motion			
Does not withdraw aperture beyond os			
Uses gentle operative technique			
Uses positive, respectful, supportive reassurance			
Stops when pink foam without tissue passes through cannula, gritty sensation is felt, uterus contracts around cannula and uterine cramping increases			
Removes the instrument			
Is ready to evacuate again after inspecting tissue if needed			
Inspects tissue			
Empties aspirator into container			
Inspects the aspirated tissues under the light box			
Evaluates amount of uterine contents based on estimated length of amenorrhea			

Skill	Yes	No	Remarks
Determines all uterine contents have been removed			
Completes remaining steps			
Wipes cervix to assess bleeding			
InsertsIUD **(if chosen)**			
Considers if pelvic exam is advisable			
Reassures woman that procedure is finished			
Performs post-procedure care			
Removes PPE and washes hands			
Ensures woman is escorted to recovery area			
Processes instruments			
Resolves technical problems that arise			

11.0 Post-Procedure Care Skills Checklist

Instructions for observer: Silently observe. Do not interact with the person you are evaluating. Check "yes" or "no" depending on whether the skill was performed, and write comments. Offer your evaluation and comments afterwards.

Skill	Yes	No	Remarks
Monitors the woman's physical status			
Ensures the woman is resting comfortably			
Takes vital signs immediately			
Reviews chart for condition and history			
Monitors physiological status, including vital signs			
Evaluates bleeding and cramping at least twice			
Continues therapy for any existing problems			
Assesses and manages complications (if any)			
Manages pain			
Evaluates pain levels			
Administers and monitors desired options for pain relief			
Administers antibiotics, if needed			
Provides emotional monitoring and support			
Responds sensitively to emotions			
Monitors emotional status			
Provides counseling and referrals for emotional-health needs			
Addresses other physical-health issues			
Addresses other physical-health needs and provides referrals if needed for: anemia, RTIs/HIV, cervical cancer, violence, infertility			
Administers Rh-immunoglobulin, as per protocol			
Provides contraceptive counseling			
Determines desire for future pregnancy and reproductive needs			
Provides contraceptive counseling, method and resupply information			
Arranges for follow-up care			
Schedules follow-up appointment according to her			

condition			
Secures her consent before releasing records to other providers			
Discharges the woman			
Ensures recovery before discharging according to protocols			
Provides instruction on: self-monitoring normal recovery; pain relief/medications; when and how to seek treatment for complications; follow-up care visit			

12.0 Follow-Up Care Skills Checklist

Instructions for observer: Silently observe. Do not interact with the person you are evaluating. Check "yes" or "no" depending on whether the skill was performed, and write comments. Offer your evaluation and comments afterwards.

Skill	Yes	No	Remarks
Performs clinical elements of a follow-up visit			
Obtains referral information if woman agrees			
Reviews medical and records with woman			
Assesses general status of woman • Vital signs, bleeding, pain • Medications, contraceptive use • Anything in vagina since procedure; intercourse • Signs of physical abuse			
Conducts pelvic exam • Assesses uterine size, tone, tenderness • Pays special attention if she is an adolescent or has experienced sexual violence • Evaluates for completion of evacuation, infection • Re-evacuates if necessary			
Follows up on any tests administered			
Manages conditions, complications			
Performs psychosocial elements			
Provides emotional support, continues counseling started during MR care			
Identifies, treats and/or refers women needing special care			
Offers contraceptive services			
Provides information on access to emergency contraception			
Records information in woman's record			
Obtains results if woman receives follow-up care at another facility			
Provides referrals			
Provides health education, assesses for reproductive and sexual health needs, facilitates receiving services			
Refers to other health care or social services such as assistance for RTIs, prenatal care, infertility services, violence, nutrition, well-woman check-ups, adolescent services, etc., if needed. Tells woman she can return if unable to access a referral.			

13.0 Complications Management Skills Checklist

Instructions for observer: Silently observe. Do not interact with the person you are evaluating. Check "yes" or "no" depending on whether the skill was performed, and write comments. Offer your evaluation and comments afterwards.

Skill	Yes	No	Remarks
Retained Uterine Contents With Infection			
Obtains cervical culture, if possible; administers antibiotics			
Monitors status: if symptoms are mild, observes for response to antibiotics; if otherwise, evacuates uterus			
Continuation of Previously Undiagnosed Pregnancy			
Performs uterine evacuation with vacuum aspiration			
Uterine Atony			
Performs uterine massage			
Administers uterotonics			
Cervical, Uterine or Abdominal Injury			
Clamps, forceps or sutures or applies silver nitrate on minor lacerations			
Monitors status; performs or refers for laparotomy, if needed			
Medication-Related Complication			
Treats respiratory and cardiac depression			
Stabilizes convulsions			
Administers IV reversal agents, if applicable			
Hematometra			
Evacuates or reevacuates the uterus with vacuum aspiration			
Vasovagal Reaction			
Protects the woman so she does not injure herself			
Monitors vitals			
Waits 60 seconds until the woman recovers			
Administers smelling salts			
Injects atropine if prolonged			
Hemorrhage			
Performs vacuum aspiration			
Administers fluids/transfusion			
Infection			
Starts antibiotics			
Considers evacuating the uterus with vacuum aspiration			

14.0 Counseling Appendix B: Informed Consent Form

Informed Consent Form for MR and PAC Procedure

Name and address of the Centre: _____

I, the undersigned, wish to undergo Menstrual Regulation (MR) or Postabortion Care (PAC) procedure and state the following:

1. I have received detail information about MR and PAC procedure and the options related to the procedure.
2. I am informed that, like many medical/surgical procedures, there are some risks and side-effects of MR/PAC procedure. These risks and side-effects have been thoroughly explained to me.
3. All the above information has been explained to me in a language I can understand.
4. I have requested the MR/PAC procedure on my own with free will, without coercion or inducement.

_____	_____	_____
Client's name	Client's Signature/ Thumb Print	Date

_____	_____
Husband/Guardian's Name and Signature (If required)	Date

_____	_____
Name of Provider/Counsellor	Signature of Provider/ Counsellor and Date

15.0 Uterine Evacuation Procedure with MVA Plus® Appendix D: Sample Clinical Referral Forms

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:

Clinical 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)	Location (hospital, Clinic)
Signature	Date

16.0 Uterine Evacuation Procedure with MVA Plus® Appendix F: Sample Follow-Up Visit Medical Form

Name_____

Date _____

Contact information _____

MR/ Postabortion Care using vacuum aspiration:

Date of procedure_____

Name of provider and facility_____

Postabortion Care using Misoprostol:

Date of administration:_____

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 _____

Hb /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)

17.0 Serious Adverce Event

Ipas Partners for Reproductive Justice
BANGLADESH

Serious Adverse Event (SAE)

Entered by Ipas only:
Facility ID: _____

This form is filled in by Ipas staff, consultants or mentors **only**. Use this form to gather the necessary information in preparation for officially reporting the SAE in Terra.

Site Information

1a. * **Site Name:**	
1b. If this is not an Ipas intervention Site, complete address information for the site.	Street _____ Town/City _____ State/Province_____ Country _____

Patient Information

2. Sex	☐ Female ☐ Male
3. Age	_____
4. Unique identifier	_____ **(medical record #; date of birth; serial #, etc.)**
5. Total number of pregnancies: (for female clients)	
6. Total number of live births: (for female clients)	
7. Gestation age in weeks	

Serious Adverse Event Information

8. **When did the serious adverse event/complication occur?**		_____/_____/_____ MM / DD / YYYY
9. **Was there a death?**	☐ Yes → ☐ No	**If "Yes," Report to Quality of Care within 5 working days of learning of the SAE event** **AND** **Enter this form into Terra within 10 days**
10. **Was there a life-threatening injury?**	☐ Yes → ☐ No	**If "Yes," Report to Quality of Care within 5 working days of learning of the SAE event** **AND** **Enter this form into Terra within 10 days**

11. **Did Ipas clinically train the provider associated with the SAE?**	☐ Yes ☐ No	
12. Is Ipas actively supporting this site? (This means that quarterly site progress reports are submitted for the first year after training, then biannually until the program is discontinued or graduated.)	☐ Yes ☐ No	
13. Provide a brief description of Ipas's relationship with this site and provider.		
14. Was this SAE only related to contraceptives?	☐ Yes ☐ No	**IF "Yes," Skip to question 18** **IF "No," Skip to question 16**
15. **Was MVA involved?**	☐ Yes ☐ No	
15a. **Was the aspirator an Ipas device?**	☐ Yes → ☐ Do not know → ☐ No	**If "Yes" or "Do not know", obtain the device if possible and send to Quality of Care**
15b. **Was there a malfunction of the device which could have caused or contributed to a death or serious injury?**	☐ Yes ☐ Do not know ☐ No	
16. **Which technology was used for UE before the SAE?**	☐ MVA ☐ EVA ☐ MA ☐ D&E ☐ Other, specify _____	
17. **Select any/allSAEs** related to the UE	☐ Perforation requiring surgery ☐ Anesthesia related complication requiring hospitalization ☐ Ectopic pregnancy unrecognized at time of abortion ☐ Reactions to medications requiring hospitalization ☐ Bleeding requiring a blood transfusion and/or facility admission ☐ Infection requiring intravenous antibiotics and/or hospital admission ☐ Death ☐ Other, specify_____	

18. **Were contraceptives involved in this SAE?**	☐ Yes ☐ No	☐ Hormonal contraceptives: Thromboembolism ☐ Implants: Infection at insertion site requiring intravenous antibiotics ☐ Implants: Difficult removal resulting in tissue injury, impairment or scarring beyond small scar ☐ IUCDs: Uterine perforation ☐ Male sterilization: Severe scrotal/testicular pain lasting months to years ☐ Female sterilization: Damage to the bowel or bladder, improper wound healing or infection, prolonged pelvic or abdominal pain ☐ Other, specify_____
	If "Yes", select any/all complications (SAE)	
19. **Describe the client's clinical condition before, during, and after the procedure. Include specifics such as date of service, reason for the procedure, type of procedure, vital signs, when and where the SAE was first noticed, and what happened.**		
20. **If applicable, describe any evidence of instrument (such as MVA) malfunction or direct relationship to the adverse event.**		
21. **Describe initial actions taken to treat SAE at the primary site or the referral facility, or both.**		
22. Was the client referred to another facility for treatment?	☐ Yes ☐ No	**If yes, describe all actions taken to treat the SAE at the referral facility.**
23. **Describe the woman's final clinical outcome and condition on discharge**		
24. Did a case review occur? ☐ Yes ☐ No		**If no, please describe why not, and what plans, if any, there are to hold a case review.** **Then skip to question 27.**
25. **If a case review occurred, were Ipas country staff or clinical mentors involved?**	☐ Yes ☐ No	**If yes, answer question 26** **If no or not applicable, what are the challenges and suggestions to facilitate case reviews/team meetings?**
26. **Describe any preliminary suggestions proposed by the care team to reduce recurrence risk.**		
27. **Contact information of person completing form:**		**a.** Name _____ **b.** Position_____ **c.** Phone # _____ **d.** Email _____
28. **Date this form was completed:**		____/____/_____ MM / DD / YYYY

18.0 Counseling Contraceptive Services Appendix D: Contraceptive Counseling for Special Populations

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

Women with Repeat MRs

If a woman does not want to become pregnant and has experienced repeat unwanted pregnancies and MRs, 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 MRs:

- Explore with the woman her history of contraceptive use. If she has not been using contraception, ask her about this, using non-judgmental language and tone of voice.
- 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 Living With HIV/AIDS

The following information should be presented when discussing contraception with an HIV-positive woman:

- 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 condoms for STI/HIV protection with another, more effective contraceptive method for pregnancy prevention, or the consistent and correct use of 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 MR or MRM 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 counseling and testing (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 a method choice that does not need a regular resupply like long-term, reversible family planning methods. Correct information about these methods should be provided.

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

- Dual protection, which helps to prevent sexually transmitted disease transmission, is particularly important for adolescents. Counselors should recommend dual protection through the use of a 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 inform women that an IUD does not protect them against STIs and that dual protection should be used. If an STI is present at the time of insertion, it may increase the risk of a pelvic infection immediately following insertion or exposure to an STI during IUD use may increase the risk of a pelvic infection.
- 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 (if available)—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 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.

Young women (ages 10-24)

Physically, young women's clinical needs are mostly similar to those of adult women; however, their life and social circumstances are often very different, requiring care tailored to their unique circumstances, especially concerning counseling and provider attitudes. Providers should make a conscious effort to keep personal beliefs from limiting their ability to give the best care possible to young women.

When a young woman requests MR, she is likely to have carefully considered her options and decisions prior to seeking care. However, young women may want more information on which to base their decision. For the purpose of informed consent, it is important that counselors review the woman's medical condition and the basic options available to her: to continue the pregnancy to term and then parent or release the child for adoption; or to terminate the pregnancy. Young women should be allowed to make a free, informed decision and that decision should be respected. Because of inadequate or inaccurate information on sexual and reproductive health, counseling may take longer for young women than adults. If the young woman must, by law, notify or get consent from a third party, and she is not eligible for any exemption or alternative, providers should explain this obligation and offer to help her talk to the third party.

Decision making on MR often takes place mostly outside the clinic setting, and a young woman may be particularly susceptible to adult's influence. Providers should ask questions to ensure that she has not been pressured or coerced by anyone, including a partner, family, community or friends, to make her decision.

In Bangladesh, the consent of a guardian is required for young women under the age of 18 years to access MR services. Adolescents and young women have the right to consent (or assent if third party consent is legally required) to services – or not. No

adolescent or young woman should be forced against her will to have an abortion even if her parent/caregiver/partner requests it. Even with third party consent requirements, adolescents and young women still have the right to private medical counseling. This allows the counselor to ensure that the young woman has not been pressured or coerced by anyone. If a third party is involved in the counseling, the young woman should be asked in private first if she wants to involve the third party in her decision-making. Support persons should be allowed to accompany young women through their appointment once informed consent has been given and assessment for coercion has been conducted.

Women who have experienced violence

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

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

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

Women with advanced gestational age

Women who present at more advanced gestational ages often have faced multiple barriers that prevented earlier presentation, including not knowing they were pregnant, needing more time to make their decision and poor access to health services. Moreover, one they do present for care they may be met with negative or stigmatizing attitudes which further delay care. Understanding the social and emotional issues that are often a part of second trimester abortion and providing prompt, sensitive care or referral are an essential part of woman-centered care.

19.0 Uterine Evacuation Procedure with MVA Plus® Appendix A: Comparison of Ipas Instruments

The charts below highlight design features and compatibility between Ipas aspirators and cannulae.

Comparison of Ipas Aspirators

Characteristic	MVA Plus®	Ipas Single-Valve
Holding capacity	60cc	60cc
Suction capacity	24-26 inches (609.6-660.4mm) of mercury	24-26 inches (609.6-660.4mm) of mercury
Compatibility with cannulae	Compatible with EasyGrip® cannulae, all sizes, no adapters needed	Not compatible with EasyGrip® cannulae
	Compatible with all sizes of flexible Karman cannulae; 12mm does not require separate adapter	Compatible with flexible Karman cannulae sizes 4, 5 and 6mm only; no separate adapters needed
Common processing methods*	• Must be high-level disinfected or sterilized between uses • Sterilization with steam autoclave for 30 minutes at 121^{0}C (250^{0}F) with pressure of 106 KPa (15 lbs/ in^2). DO NOT EXCEED 121°C (250^{0}F). • Sterilization with glutaraldehyde • High-level disinfection by boiling • High-level disinfection with glutaraldehyde • High-level disinfection with chlorine	• Must be high-level disinfected or sterilized between uses • DO NOT USE IN STEAM AUTOCLAVE • Sterilization with glutaraldehyde • DO NOT BOIL • High-level disinfection with glutaraldehyde • High-level disinfection with chlorine
Valve design	Valve liner is removable by opening hinged valve body	Valve liner is removable 1 valve button

	2 valve buttons No valve O-ring	No valve O-ring
Cylinder design	Collar stop can be displaced or removed for processing	Collar stop must be removed for processing
Plunger design	Plunger O-ring can be displaced or removed for processing Ergonomic handle	Plunger O-ring can be displaced or removed for processing

Comparison of Ipas Cannulae

Characteristic	EasyGrip® Cannulae	Karman Cannulae
Flexibility	Semi-rigid	Flexible
Compatibility with Ipas aspirators	Fit with: —MVA Plus® aspirator (all sizes)	Fit with: —MVA Plus® aspirator (all sizes) —Single-Valve aspirator (4-6mm only)
Need for separate adapter	No	Yes, except 12mm
Common processing methods	• Sterilization with steam autoclave for 30 minutes at 121^{0}C (250^{0}F) with pressure of 106 KPa (15 lbs/in^2). DO NOT EXCEED 121^{0}C (250^{0}F). • Sterilization with glutaraldehyde*Sterilization with ethylene oxide • High-level disinfection by boiling • High-level disinfection with glutaraldehyde • High-level disinfection with chlorine*	**These are only for Single use. Dispose canulae after use.**
Adapter design	Permanently integrated winged base Color coded by size	4mm-10mm: Detachable adapter 12mm: No adapter needed Color coded by size
Apertures	2 opposing apertures (4-8mm); large single scoop aperture (9, 10 and 12mm)	2 opposing apertures (4-8mm); large single scoop aperture (9, 10 and 12mm)
Configuration of dots	First dot is 6cm from the tip of the cannula, others follow at 1cm intervals; all cannulae have 6 dots	First dot is 6cm from the tip of the cannula, others follow at 1cm intervals; number of dots varies according to cannula size
Sizes available	4, 5, 6, 7, 8, 9, 10 and 12mm	In Bangladesh 4, 5,6 and 7 are available

*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.

20.0 Uterine Evacuation Procedure with MVA Plus® Appendix C: Methods for Processing EasyGrip® Cannulae and MVA Plus® Aspirator

1.1 EasyGrip® Cannulae

Note: Only sterilization or high-level disinfection are acceptable methods for processing EasyGrip® cannulae.

Method	Agent	Time	Precautions
Sterilization	Steam autoclave	Sterility is achieved at 121^{0}C (250^{0}F) for 30 minutes with pressure of 106kPa (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").	Steam must reach all surfaces of item. Cannulae should not touch and should be arranged to permit drainage. EasyGrip® cannulae, particularly the smaller sizes, may curve in steam autoclaves. To minimize this, recommends packaging them by wrapping in paper or linen. Cool before use.
	2% Glutaraldehyde* (Cidex): Follow manufacturer's instructions for mixing.	10 hours	Items must be fully immersed. Discard 14 days after mixing or sooner if solution becomes cloudy. Do not use below 25^{0}C (77^{0}F).
Glutaraldehyde (other solutions): Follow manufacturer's instructions for mixing.	Glutaraldehyde (other solutions): Follow manufacturer's instructions for mixing.	Follow manufacturer's instructions.	Items must be fully immersed. Usually discard 14 days after mixing or sooner if solution becomes cloudy.
High-Level Disinfect	Boiling water	20 minutes at rolling boil	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.
	2%Glutaraldehyde(Cidex): Followmanufacturer's instructions for mixing	20 minutes	Items must be fully immersed. Discard 14 days after mixing or sooner if solution becomes cloudy. Do not use below 25^{0}C (77^{0}F).
	Glutaraldehyde (other solutions): Follow manufacturer's instructions for mixing.	Follow manufacturer's instructions.	Items must be fully immersed. Usually discard 14 days after mixing or sooner if solution becomes cloudy.
	0.5% Chlorine	20 minutes	Items must be fully immersed. Change solution daily or sooner if it becomes cloudy.

**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.*

1.2 MVA Plus® Aspirators

The MVA Plus® aspirator must undergo high-level disinfection or sterilization between patients to remove contaminants. Devices are then safe to use for the next procedure. Aspirators do not need to remain high-level disinfected or sterile for the next use.

Method	Agent	Time	Precautions
	2%Glutaraldehyde (Cidex): Followmanufacturer'sinstructions for mixing.	10 hours; follow manufacturer's instructions.	Discard 14 days after mixing or sooner ifsolution becomes cloudy. Do not use below 25^{0}C (77^{0}F).
	Glutaraldehyde (other solutions): Followmanufacturer's instructions for mixing.	Follow manufacturer's instructions.	Usually discard 14 days after mixing or sooner if solution becomes cloudy.
High-Level Disinfect	Boiling water*	20 minutes at rolling	Items do not need to be fully immersed. Cool before use.
	2%Glutaraldehyde(Cidex): Followmanufacturer'sinstructions. Glutaraldehyde (other solutions): Followmanufacturer's instructions for mixing. 0.5% Chlorine	20 minutes Follow manufacturer's instructions 20 minutes	Discard 14 days after mixing or sooner if solution becomes cloudy.Do not use below 25^{0}C (77^{0}F) Usually discard 14 days after mixing or sooner if solution becomes cloudy. Change solution daily or sooner if it becomes cloudy.

***Caution:** Never boil or steam autoclave the plungers from the Ipas single valve aspirator as they will emit formaldehyde.

21.0 Contraceptive Services

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

If the woman...	Recommendations	Rationales*
Does not want to be pregnant soon	Consider all temporary methods.	Seeking an MR or unsafe abortion usually suggests that the woman does not want to be pregnant at this time.
Is under stress or in pain	Consider all temporary methods. Do not encourage use of permanent methods at this time. Provide referral for continued contraceptive care.	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.
Was using a contraceptive method when she became pregnant	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.	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.
Has stopped using a method	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.	Unacceptability or lack of access may have led to unwanted pregnancy. These factors may still be present and may lead to another unwanted pregnancy.
Has a partner who is unwilling to use condoms or will prevent use of another method	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.	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.
Wants to become pregnant soon	Do not try to persuade her to accept a method. Provide information or a referral if the woman needs other reproductive health services.	If the woman has had a spontaneous abortion or a medically indicated abortion, she may want to become pregnant again soon.

Contraceptive Services Appendix B: Guidelines for Selection of Contraception by Method

Method	Timing After UE	Advantages	Remarks
latex and vinyl male condoms,	May be used immediately after MR, PAC or MRM	• No method-related health risks • Inexpensive • Good interim method if initiation of another method must be postponed • No medical supervision required • Latex and vinyl condoms provide protection against RTIs and STIs (HBV and HIV/AIDS) • Easily discontinued • Effective immediately	• In typical use, lesseffective than IUD or hormonal methods • Requires use with each incident of intercourse • Requires continued motivation • Resupply must be available • May interfere with intercourse
Oral Contraceptive Pills: Combined and progestin-only pills	May be used immediately after MR, PAC or MRM	• Highly effective • Can be started • immediately, even if infection is present • Can be provided by non-physicians • Does not interfere with intercourse	• Requires continued motivation and daily use • Resupply must beavailable • No protection against STIs/HIV • Effectiveness may be lowered with long-term use of certain medications,including rifampin,dilantin and griseofulvin
Progestin-Only Injectables DMPA, NET-EN*	May be given immediately after MR, PAC or MRM May be appropriate for use if the woman wants to delay choice of a longer-term method	Highly effective Can be started immediately, even if infection is present Can be provided by nonphysician Does not interfere with intercourse Not user-dependent, except for remembering to get the injection every two or three months No supplies needed by woman	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
Progestin-Only Implants	May be inserted immediately after MR, PAC or MRM	• 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

Method	Timing After UE	Advantages	Remarks
IUD: Copper T 380A	IUD can be inserted after MR or PAC, provided the risk or presence of infection can be ruled out. IUD can be inserted at a follow-up visit after MRM, once non-pregnancy is confirmed.	Highly effective Long-term contraception; effective for at least10 years Immediate return to fertility following removal Does not interfere with intercourse No supplies needed by user	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
Voluntary Sterilization (VS) (Female VS orTubectomy. And Male VS, or Vasectomy)	Female VS procedures usually can be performed immediately after an MR unlessinfection or severe blood loss ispresent. If infection is present, do not perform until fully resolved. Female VS can be performed at a follow-up visit after MRM, once non-pregnancy is confirmed. Male VS can be performed at any time.	Permanent method Highly effective Once completed, nofurther action required Does not interfere with intercourse No change in sexual function No long-term side effects Female VS is immediately effective	• Adequate counseling and fully informed consentare required before VSprocedures • Slight possibility of surgical complications • Requires trained staff and appropriate equipment • Male VS requires the use of a temporary method until effective

Post-abortion medical eligibility recommendations for female surgical sterilization

Post abortion condition	Category
Uncomplicated	A
Post-abortion sepsis or fever	D
Severe post-abortion haemorrhage	D
Severe trauma to the genital tract; cervical or vaginal tear at time of abortion	D
Uterine perforation	S
Acute haematometra	D

Definition of categories:

A = (Accept): There is no reason to deny sterilization to a person with this condition.

C=(Caution): The procedure is normally conducted in aroutine setting, but with extra preparationand precautions.

D = (Delay): The procedure should be delayed until the condition is evaluated and/or corrected. Alternative temporary methods of contraception should be provided.

S = (Special) The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anaesthesia, and other back-up medical support. For these conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen is also needed. Alternative temporary methods of contraception should be provided, if referral is required or there is otherwise any delay.

22.0 Monitoring to Improve Services

Monitoring to Improve Services Appendix A: Performance Improvement Action Plan

#	Issue - Problem Priority Ranking	Describe Issue	Causes	Plan to Improve		Responsible Person(s)	Date to be Done
				Immediate	Long-Term		
1							
2							
3							
4							
5							

Monitoring Appendix B: Performance Improvement/Quality Assurance Checklist for MR andPAC Services

Date: _____

Start time of observation: _____ End time of observation:_____

Observer's Name: _____ Provider's Name:_____

Facility: _____

Instructions : Place a checkmark "U" 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 (U) : 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.

	Cases				
	1	2	3	4	5
1. **Receive client and obtain medical history:** Greet woman, make her feel comfortable and make an effort to understand her needs. Ask about last menstrual period (LMP); menstrual, obstetric, and general medical history; contraceptive history and current use.					
2. **Counsel:** Provide information on what to expect during the MVA procedure and obtain informed consent.					
3. **Examine:** Perform a bimanual examination to determine uterine position and length of pregnancy. Give pregnancy test if inconclusive.					
4. **Determine pain management:** Talk with the woman to determine an appropriate strategy for pain management, such as use of analgesics, anxiolytics and local anesthetic.					

	Cases				
	1	2	3	4	5
Administer any pre-procedure medications.					
5. **Prepare the woman:** Ensuring she has emptied her bladder, help the woman into lithotomy position. Wash hands and put on gloves and other barriers, such as gown and face protection.					
6. **Prepare instruments:** Charge the aspirator and check that all other instruments are in place.					
7. **Perform cervical antiseptic prep:** Following no-touch technique, insert the speculum and clean cervix.					
8. **Perform paracervical block:** Administer local anesthetic at the tenaculum site and at 2, 4, 8, and 10o'clock. Withdraw plunger slightly before injecting to avoid injecting into a vein.					
9. **Dilate cervix:** If necessary, dilate the cervix using dilators or cannulae.					
10. **Insert cannula:** Insert cannula through cervix, attach aspirator.					
11. **Suction uterine contents:** Release buttons and perform MVA procedure. Watch for signs of completion and when complete, close buttons, remove aspirator and empty contents into bowl or tray.					
12. **Inspect tissue:** Check that appearance and volume are consistent with length of pregnancy.					
13. **Perform any concurrent procedures:** When MVA is complete, proceed with any contraceptive or other procedures needed at this time.					
14. **Take immediate post-procedure steps, including instrument processing:**Process or discard all instruments, remove barriers, assist the women to recovery area.					
15. **Monitor status and provide instructions:** Monitor vital signs and bleeding, provide instructions for after-care, follow-up and antibiotic regimen as well as any needed contraceptive services.					

OBSERVER COMMENTS:

Appendix C: Client record-review checklist fo comprehensive abortion care

Site: _____	Reviewer: _____	Date: _____

(Select 10 records at random and place a check mark if each of the items in the checklist was recorded on the corresponding client record.)

Checklist Itme	1	2	3	4	5	6	7	8	9	10	Total	Remarks
1. Client registration no. and/or identification information												
2. Date of visit												
3. Woman's age or year of birth												
3. Woman's parity												
5. Health history												
6. Physical Exam												
7. Vital signs (temp., pulse, blood pressure)												
8. Uterine size (in weeks) and position												
9. Any presenting complications												
10. Diagnosis												
11. Medications and dosages used for pain management												
12. Signed informed consent form												
13. Uterine evacuation techniques												
14. Provision of comprehensive counseling												
15. contraceptive method selected and received prior to discharge												
16. Other sexual and reproductive health services provided on-sie (if needed)												
17. Referrals to other sexual and reproductive health services (if needed)												
18. Follow-up plans												
19. Provider's name and signature												
20. Detailed dscription of complication												
21. Detailed description of complication management												
22. Medications and dosages given												
23. Discharge status												
24. Informed consent form signed and included in record												

23.0 Woman-Centered Abortion Care: Glossary

0.5% chlorine solution: A chlorine (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.

Aseptic technique: The combination of efforts made to prevent entry of microorganisms into any area of the body where they are likely to cause infection. Examples of aseptic technique are using antimicrobial cleansers on the skin or mucous membranes before a procedure and using a no-touch technique when handling instruments that will enter the uterus.

Back-up method of contraception: Any method of contraception that is used with another method of contraception in case the first method fails.

Barrier methods: Methods of contraception that prevent pregnancy by preventing 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 male and female condoms, diaphragms and dental dams.

Coercive sex: includes all forms of sexual behavior that are engaged in through force, deception, cultural expectation, economic circumstances, and so on, and which the person was forced to perform against his or her will.

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 which includes physical examination of the client, review of the client's medical and surgical history, and laboratory and other diagnostic testing such as ultrasound, if needed.

Contraceptive counseling: Listening to a woman's needs and desires regarding pregnancy, and, if she wishes to delay or prevent pregnancy, explaining the proper use, risks and benefits of the available methods and helping her choose the methods that are best for her. Also known as family-planning counseling.

Contraceptive services: Contraceptive counseling and method provision. Also known as family-planning services.

Contraindication: If a woman has these specific conditions, under no circumstances should she be offered the contraindicated service or method. Alternatives should be considered or she should be referred to a facility where she can be offered alternate care.

Emotional support: Gentle, caring assistance to allay a person'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: Keeping the surroundings clean. 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: See contraceptive services

Woman-Centered Abortion Care: Glossary

GATHER technique: Used widely in family-planning counseling, this acronym stands for Greet, Ask, Tell, Help, Explain and Refer.

Gender: The socially constructed expectations, appearances, behaviors, roles, activities and attributes that a given society considers appropriate for men and women. These ideas and expectations often vary from culture to culture, over time and are largely shaped by and indicative of societal values.

Hematometra: An accumulation of blood in the uterine cavity that occasionally occurs after a uterine evacuation procedure.

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.

Indicator: A quantitative measure for monitoring or evaluating performance or achievement or to determine accountability. Indicators are also used to provide information about the quality of an activity, project or program.

Infertility: The diminished ability or the inability for a couple to conceive or bear children.

Instrument processing: The removal of microorganisms from instruments to make them safe for use on clients.

Intrauterine device (IUD): A contraceptive device that is inserted through the vagina into the uterus. Intrauterine devices are long acting, reversible and highly effective at preventing pregnancy.

Laparotomy: An operation to open the abdomen.

Lithotomy 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 such as condoms or sterilization.

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.

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.

Nulliparous: A woman who has never given birth.

Pain management: Using medicine, psychological support and other means to decrease a pain.

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 to the person who is being counseled. For example, an adolescent who is seeking contraception may be counseled by another adolescent.

Perineum: In a woman, the area between the vulva and the anus.

Personal protective barriers: Gowns, gloves and face protection used to protect a health care provider from germs and pathogens.

Postabortion Care (PAC): A continuum of care to treat potentially life-threatening complications from incomplete and unsafe abortion and therefore reduce abortion-related morbidity and mortality. The five essential elements of PAC include: community and service provider partnerships, counseling, uterine evacuation treatment, contraceptive and family planning services and reproductive and other health services.

Precaution If a woman has these specific conditions, the method has higher risks

than normal. The risks, benefits and alternatives must be considered. Provision of the method may require a higher degree of clinical judgment, skill and monitoring. Referral to a higher level facility may be appropriate.

Quality of care: Healthcare services that are effective, efficient, accessible, acceptable, client-centered, equitable, safe and conform with accepted local standards, guidelines and practices.

Reproductive goals: The number of children one would like to have and the spacing of those children.

Sexual health: The health of one's physical reproductive system, as well as the ability to express sexuality in psychologically healthy ways.

Sharps container: Container that is 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.

Standard precautions: Infection-control measures, such as hand washing, use of personal protective barriers, environmental cleanliness, respiratory hygiene, preventing injury with sharps and correct instrument processing that are designed to block transmission of potential infection. Standard precautions are an expansion of universal precautions to include practices that reduce the risk of infection in both health care workers and among clients and visitors to health facilities.

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.

Woman-Centered Abortion Care: Glossary

Teratogenic: Able to disturb the growth or development of the fetus or embryo. Teratogens may lead to pregnancy loss (miscarriage) or birth defects in the child.

Tools: Materials, forms or other items that are utilized in conveying or collecting Information or assessing or evaluating services.

Unsafe abortion is defined by the World Health Organization as a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

Vagal reaction: Also known as vasovagal syncope, it is a transient reaction marked by a drop in blood pressure and heart rate. Signs of a vagal reaction are pallor, nausea, sweating and loss of consciousness. A vagal reaction is often evoked by stress associated with fear or pain.

Verbal support: Caring, spoken encouragement to ease a person'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

24.0 Training Schedule

Training Schedule for Doctors: Woman-Centered MR and Postabortion Care Services with the MVA Plus®

Time	Content
DAY ONE	
08:30-09:00 am	Registration Introduction
09:00-09:30 am	Participants' Expectations Goal & Objectives of the course Group Norms, Daily work group Review logistics, schedule, course materials
09:30-10:00 am	**Pretest**
10:00-10:15 am	**Tea Break**
10:15 -10:30 am	Brief on Ipas Bangladesh & Comprehensive MR and Postabortion Care Services
10:30–11:00 am	Overview of MR Policy and Abortion Law in Bangladesh
11:00 -11:30 am	Overview on Woman-Centered MR and PAC services Uterine Evacuation methods
11:30-12:15 pm	Introduction of MVA Plus & Easy Grip Cannula; Different Parts; Assembly, Disassembly and Maintenance of MVA
12:15-01:15 pm	Clinical Assessment for MR and PAC client Pain management & Para cervical block
01:15-02:00 pm	**Lunch (Energizer)**
02:00-02:45 pm	Demonstration of MVA procedure on model for MR & PAC
02:45-03:00 pm	Summary & Evaluation of day 1
DAY TWO	
08:30-08:45 am	Recap & Agenda of the day
08:45-10:00 am	Menstrual Regulation with Medication and PAC Management with Misoprostol
10:00-10:15 am	**Tea break**
10:15-11:15 am	Counseling on MR & PAC services Post procedure Family Planning methods
11:15-12:15 pm	Infection Prevention Use of Liquid Bleach

Time	Content
12:15-01:30 pm	Clinical practicum/Model practice
01:30-02:00 pm	**Lunch (Energizer)**
02:00-02:45 pm	Youth Friendly Services
02:45-03:00 pm	Summary & Evaluation of day 2
DAY THREE	
08:30-09:00 am	Recap & Agenda of the day
09:00-10:00 am	Complication Management Introduction to Adverse Event & Complication form
10:00-10:15 am	**Tea Break**
10:15-11:00 am	Postabortion Care (PAC) Services
11:00-01:30 pm	Clinical practicum & Model practice
01:30-02:00 pm	**Lunch (Energizer)**
02:00-02:45 pm	VCAT; Why did she die?
02:45-03:00 pm	Summary & Evaluation of day 3
DAY FOUR	
08:30-09:00 am	Recap & Agenda of the day
09:00-09:30 am	**Post test**
09:30-09:45 am	**Tea Break**
09:45-10:45 am	Service Provision & Logistics Management Orientation on Important Govt. Orders/Letters
10:45-11:45 am	Record Keeping & Orientation to Logbook/MR, PAC & FP register Case stories for practice on MR/PAC
11:45 am-01:30 pm	Clinical practicum & Model practice
01:30-02:00 pm	Evaluation of Training
02:00-02:30 pm	**Lunch**
02:30-03:00 pm	Certificate distribution and closing

Training Schedule for FWVs: Woman-Centered MR and Postabortion Care Services:

Time	Content
DAY ONE	
09:00-09:10 am	Registration
09:10-09:30 am	Introduction Icebreaker Participants' Expectations Goal & Objectives of the course
09:30-10:00 am	**Pretest**
10:00-10:15 am	**Tea Break**
10:15-10:25 am	Trainers and participant's roles Group Norms Daily work group Review logistics, schedule, course materials
10:25-10:45 am	Brief on Ipas Bangladesh & Comprehensive MR and Postabortion Care Services
10:45-11:35 am	Woman-Centered MR and PAC services components IPPF Charter on RH Rights
11:35-12:30 pm	Overview of Uterine Evacuation methods
12:30-1:30 pm	Introduction of MVA Plus & Easy Grip Cannula; Different Parts; Assembly, Disassembly and Maintenance of MVA
01:30-02:00 pm	**Lunch (Energizer)**
02:00-03:00 pm	Anatomy of Female Genital Tract, Menstrual Cycle, Type of Abortion and Diagnosis of Abortion
03:00-03:10 pm	Discussion on Pre-test Questionnaire and result
03:10-03:20 pm	Summary & Evaluation of day 1
DAY TWO	
08:30-09:30 am	Warm up, recap and reflections of day 1 Agenda of day 2
09:30-10:30 am	Values Clarification & Attitude Transformation (VCAT): Cross the line
10:30-10:45 am	**Tea Break**
10:45-12:00 pm	Counseling on MR & PAC services Post procedure Family Planning methods
12:00-12:45 pm	Pain management including paracervical block
12:45-01:30 pm	Demonstration of MVA procedure on model for MR & PAC services

Time	Content
01:30-02:30 pm	**Lunch (Energizer)**
02:30-03:30 pm	Clinical Assessment
03:30-03:40 pm	Summary & Evaluation of day 2
DAY THREE	
08:30-09:00 am	Warm up, recap and reflections of day 2 Agenda of day 3
09:00-10:00 am	Community Linkages
10:00-10:45 am	Values Clarification & Attitude Transformation (VCAT): Last Uterine Evacuation
10:45-11:00 am	**Tea Break**
11:00-1:00 pm	Model and Clinical Practice
01:30-02:00 pm	**Lunch (Energizer)**
02:00-03:00 pm	Assessment of skills
03:00-03:10 pm	Summary & Evaluation of day 3
DAY FOUR	
08:30-09:00 am	Warm up, recap and reflections of day 3 Agenda of day 4
09:00-10:00 am	Youth-friendly Services
10:00-10:15 am	**Tea Break**
10:15-01:45 pm	Model and Clinical Practice
01:45-02:30 pm	**Lunch**
02:30-02:45 pm	Summary & Evaluation of day 4
DAY FIVE	
08:30-09:00 am	Warm up, recap and reflections of day 4 Agenda of day 5
09:00-10:00 am	Infection Prevention including use of Liquid Bleach
10:00-01:45 pm	Clinical Practicum **(Tea Break Included)**
01:45-02:30 pm	**Lunch**
02:30-02:45 pm	Case Discussion
02:45-03:00 pm	Summary & Evaluation of day 5
DAY SIX	
08:30-09:00 am	Warm up, recap and reflections of day 5 Agenda of day 6

Time	Content
09:00-10:15 am	Introduction to MRM and PAC management with MVA & Misoprostol
10:15-01:45 pm	Clinical Practicum **(Tea Break Included)**
01:45-02:30 pm	**Lunch**
02:30-02:45 pm	Case Discussion
02:45-03:00 pm	Summary & Evaluation of day 6
DAY SEVEN	
08:30-09:00 am	Warm up, recap and reflections of day 6 Agenda of day 7
09:00-10:00 am	Complication Management
10:00-01:30 pm	Clinical Practicum **(Tea Break Included)**
01:30-02:00 pm	**Lunch**
02:00-02:15 pm	Case Discussion
02:15-02:30 pm	Summary & Evaluation of day 7
DAY EIGHT	
08:30-09:00 am	Warm up, recap and reflections of day 7 Agenda of day 8
09:00-10:00 am	Service provision, Quality of Care, Referral & Checklist
10:00-10:30 am	Record Keeping & Orientation to Logbook/MR, PAC & FP register
10:30-10:45 am	**Tea Break**
10:45-11:30 am	Record Keeping and Orientation to Logbook/MR, PAC & FP register
11:30-1:00 pm	Post-Test Including Model Test
01:00-01:30 pm	**Lunch**
01:30-02:30 pm	Certificate Distribution and Closing Evaluation of Course

Training Schedule for Nurses: Woman-Centered MR and Postabortion Care Services: Clinical Support-Staff Skills

Time	Content
DAY ONE	
09:00-09:30 am	Registration Introduction Icebreaker Participants' Expectations Goal & Objectives of the course
09:30-10:00 am	**Pretest**
10:00-10:15 am	**Tea Break**
10:15-10:25 am	Brief on Ipas Bangladesh & Comprehensive MR and Postabortion Care Services
10:25-10:45 am	Trainers and participants' roles Group Norms Daily work group Review logistics, schedule, course materials
10:45-11:45 am	Overview of Uterine Evacuation methods
11:45-12:30 pm	Anatomy of Female Genital Tract, Menstrual Cycle, Type of Abortion and Diagnosis of Abortion
12:30-1:30 pm	Woman-Centered MR and PAC services components IPPF Charter on RH Rights
01:30-02:00 pm	**Lunch (Energizer)**
02:00-02:10 pm	Discussion on Pre-test Questionnaire and result
02:10-02:20 pm	Summary & Evaluation of day 1
DAY TWO	
08:30-09:00 am	Warm up, recap and reflections of day 1 Agenda of day 2
9:00-9:30 am	Introduction of MVA Plus & Easy Grip Cannula; Different Parts; Assembly, Disassembly and Maintenance of MVA
09:30-10:15 am	Clinical Assessment
10:15-10:30 am	**Tea Break**
10:30-11:30 am	Pain management including paracervical block
11:30-12:15 pm	Infection Prevention Including Use of Liquid Bleach
12:15-01:00 pm	Demonstration of MVA procedure on model for MR & PAC services

Time	Content
01:00-01:30 pm	**Lunch (Energizer)**
01:30-02:15 pm	Model Practice
02:15-02:30 pm	Summary & Evaluation of day 2
DAY THREE	
08:30-09:00 am	Warm up, recap and reflections of day 2 Agenda of day 3
09:00-10:00 am	Values Clarification and Attitude Transformation
10:00-10:15 am	**Tea Break**
10:15-11:15 am	Community Linkages
11:15-01:00 pm	Model Practice
01:00-01:30 pm	**Lunch (Energizer)**
01:30-02:15 pm	Model Practice
03:00-03:10 pm	Summary & Evaluation of day 3
DAY FOUR	
08:30-09:00 am	Warm up, recap and reflections of day 3 Agenda of day 4
09:00-10:00 am	Introduction to MRM and PAC management with MVA & Misoprostol
10:00-10:15 am	**Tea Break**
10:15-11:30 am	Complication Management
11:30-01:00 pm	Postabortion Care (PAC) Services
01:00-01:30 pm	**Lunch (Energizer)**
01:30-2:15 pm	Model Practice and Skills Assessment
02:15-02:30 pm	Summary & Evaluation of day 4
DAY FIVE	
08:30-09:00 am	Warm up, recap and reflections of day 4 Agenda of day 5
09:00-9:30 am	Counseling on MR & PAC services Post procedure Family Planning methods
9:30-10:30 am	Record Keeping & Orientation to Logbook/MR, PAC & FP register Case stories for practice on MR/PAC Supervision, Monitoring, Mentoring plan
10:30-01:00 pm	Clinical Practicum (Tea Break Included)
01:00-01:30 pm	**Lunch**
01:30-02:00 pm	Case Discussion
02:00-02:30 pm	Summary & Evaluation of day 5

Time	Content
DAY SIX	
08:30-09:00 am	Warm up, recap and reflections of day 5 Agenda of day 6
09:00-09:30 am	Service provision, Quality of Care, Referral & Checklist
09:30-01:00 pm	Clinical Practicum and Complication Management **(Tea Break Included)**
01:00-01:30 pm	**Lunch**
01:30-02:00 pm	Case Discussion
02:00-02:30 pm	Summary & Evaluation of day 6
DAY SEVEN	
08:30-09:00 am	Warm up, recap and reflections of day 6 Agenda of day 7
09:00-01:00 pm	Clinical Practicum **(Tea Break Included)**
01:00-01:30 pm	**Lunch (Energizer)**
01:30-02:15 pm	Model Practice and Case Discussion
02:15-02:30 pm	Summary & Evaluation of day 7
DAY EIGHT	
08:30-09:00 am	Warm up, recap and reflections of day 7 Agenda of day 8
09:00-01:00 pm	Clinical Practicum **(Tea Break Included)**
01:00-01:30 pm	**Lunch (Energizer)**
01:30-02:15 pm	Model Practice and Case Discussion
02:15-02:30 pm	Summary & Evaluation of day 8
DAY NINE	
08:30-09:00 am	Warm up, recap and reflections of day 8 Agenda of day 9
09:00-01:00 pm	Clinical Practicum **(Tea Break Included)**
01:00-01:30 pm	**Lunch (Energizer)**
01:30-02:15 pm	Case Discussion
02:15-02:30 pm	Summary & Evaluation of day 9
DAY TEN	
08:30-09:00 am	Warm up, recap and reflections of day 9 Agenda of day 10
09:00-01:00 pm	Clinical Practicum **(Tea Break Included)**
01:00-01:30 pm	**Lunch (Energizer)**

Time	Content
01:30-02:15 pm	Case Discussion
02:15-02:30 pm	Summary & Evaluation of day 10
DAY ELEVEN	
08:30-09:00 am	Warm up, recap and reflections of day 10 Agenda of day 11
09:00-01:00 pm	Clinical Practicum **(Tea Break Included)**
01:00-01:30 pm	**Lunch**
01:30-02:15 pm	Case Discussion
02:15-02:30 pm	Summary & Evaluation of day 11
DAY TWELVE	
08:30-09:00 am	Warm up, recap and reflections of day 11 Agenda of day 12
09:00-01:00 pm	Clinical Practicum **(Tea Break Included)**
01:00-01:30 pm	**Lunch**
01:30-02:15 pm	Case Discussion
02:15-02:30 pm	Summary & Evaluation of day 12
DAY THIRTEEN	
08:30-09:00 am	Warm up, recap and reflections of day 12 Agenda of day 13
09:00-01:00 pm	Clinical Practicum **(Tea Break Included)**
01:00-01:30 pm	**Lunch**
01:30-02:15 pm	Case Discussion
02:15-02:30 pm	Summary & Evaluation of day 13
DAY FOURTEEN	
08:30-09:00 am	Warm up, recap and reflections of day 13 Agenda of day 14
09:00-01:00 pm	Clinical Practicum **(Tea Break Included)** Training Evaluation
01:00-01:30 pm	**Lunch**
01:30-02:30 pm	Certificate Distribution and Closing

Reference

1. World Health Organization. (2012). Safe abortion: Technical and policy guidance for health systems (second ed.). Geneva: World Health Organization (WHO)
2. Ipas. (2013) Medical abortion study guide (second ed.) K.Turner (Ed), Chapel Hill, NC: Ipas.
3. World Health Organization.(2014). Clinical practice handbook for safe abortion. Geneva:World Health Organization Press.
4. World Health Organization. (2015). Medical eligibility criteria for contraceptive use (5th ed.). Geneva: World Health Organization Press.
5. World Health Organization. (2018). Medical management of abortion. Geneva: World Health Organization Press
6. Postabortion Care Consortium. (2013). Postabortion Care (PAC) Consortium. From http://www.pac-consortium.org/
7. Unsafe abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2008. Sixth edition. Geneva, World Health Organization, 2011.
8. Hossain, A., Maddow-Zimet, I., Ingerick, M., Bhuiyan, H. U., Vlassoff, M., & Singh, S. (2017). Access to and Quality of Menstrual Regulation and Postabortion Care in Bangladesh: Evidence from a Survey Of Health Facilities, 2014. March, 1–18. https://www.guttmacher.org/sites/default/files/report_pdf/menstrual-regulation-postabortion-care-bangladesh_0.pdf
7. National Institute of Population Research and Training, International Centre for Diarrhoeal Disease Research, Bangladesh, and M. E. (2016). Bangladesh: Maternal Mortality and Health Care Survey 2016: Preliminary Report.
8. Shah, I. H., & Åhman, E. (2012). Unsafe abortion differentials in 2008 by age and developing country region: High burden among young women. Reproductive Health Matters, 20 (39), 169–173. https://doi.org/10.1016/S0968-8080(12)39598-0
9. Ipas. (2020) Clinical Updates in Reproductive Health. L.Castleman & N.Kapp (Eds.). Chapel Hill, NC: Ipas.
10. FIGO. (2011). Consensus statement on uterine evacuation. Retrieved from https://www.figo.org/news/new-down- load-uterine-evacuation-figo-consensus-statement-0014150
11. Hossain A et al., Access to and Quality of Menstrual Regulation and Postabortion Care in Bangladesh: Evidence from a Survey of Health Facilities, 2014, New York:

Guttmacher Institute, 2017, https://www.guttmacher.org/report/menstrual-regulation-postabortion-care-bangladesh.

12. Ipas. (2013). Women -centered, comprehensive abortion care: Reference Manual (second ed.) K.L.Turner &A.Huber (Eds.), Chapel Hill, NC: Ipas.

13. Government of the People's Republic of Bangladesh, Penal Code, 1860, as adopted by the Bangladesh Laws Revision and Declaration Act of 1973.

14. Population Control and Family Planning Division, Government of the People's Republic of Bangladesh, Memo No. 5-14/MCH-FP/Trg.79, Dhaka, Bangladesh: Population Control and Family Planning Division, 1979.

15. Proceedings of the 62nd Meeting of the National Technical Committee of Directorate General of Family Planning, June 30, 2014.

16. Directorate General of Family Planning, Government of the People's Republic of Bangladesh, Memo No. DGFP/MCH-S/

17. NTC-4/138/95 (Part-05)/34: Agenda - 4, Dhaka, Bangladesh: Directorate General of Family Planning, 2014