Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia

Second edition

Federal Ministry of Health

2013

Foreword

The government of Ethiopia has pursued its commitments to improve the health and wellbeing of women, men and families by adopting and implementing a series of policies and national strategies so as to ensure all Ethiopians have access to basic health services. Apart from strengthening the health system, largely by expanding the health infrastructure, the health sector has been undertaking a number of actions to overcome various forms of reproductive health related problems of the population.

Cognizant of the magnitude of the problem of unsafe abortion, and with due recognition of the need for an integrated approach to reducing maternal morbidity and mortality, the federal ministry of health had developed the first edition of the national technical and procedural guideline for safe abortion services in 2006 based on the authority vested on it by the House of Representatives of the FDRE per Article 552 sub-article 1 of the Penal Code of Ethiopia (promulgated in May 2005).

Following the enactment of a more favorable law and the subsequent introduction of first edition of technical and procedural guideline issued by the federal ministry of health, Ethiopia has become one of the countries that have shown significant reduction in maternal mortality in relation to unsafe abortion. Before 2005, the contribution of unsafe abortion to maternal mortality was estimated at 32% as opposed to the current estimate of 6-9% per documented evidences. In-terms of head count of lives saved and complication averted, this is a significant achievement.

The technical and procedural guideline has been a valuable resource in the last seven years in guiding service organization and service provision. It has also been a guide for ascertaining quality of care. However; there have been evidence based changes in the medical field in rendering provision of safe abortion services with better outcomes. In addition, as the program rolls out some program and system related challenges and issues began to emerge. Hence, these have resulted in the need to develop the second edition of the guideline.

Some of the issues that have been updated and addressed in this second edition of the guideline are:

The first issue is the issue of medication abortion. In the past there was no adequate evidence on the use of medication for gestational age beyond 9 weeks. However, there

is now better and overwhelming evidence on the use of medication abortion that would have positive impact on quality as well as access to safe abortion services as the recourse to surgical method is minimized. These include dosing, route, and gestational age.

The second issue that has been given due attention is second trimester abortion. While the first edition of the guideline addressed first trimester in sufficient detail, the issue of second trimester abortion had been glaringly left out. Second trimester abortion contributes higher morbidity and mortality. In a national study conducted in 2008 and published 2010, 40% of women who seek post abortion care have gestational age beyond 13 weeks and unfortunately live in rural settings. There are also clear grounds for termination of pregnancy associated with congenital malformation which become quite obvious as gestation advances.

The third area that was updated is the issue of task shifting and task sharing particularly the role of the health extension workers and IESO's which has now been better defined in harmony with their existing respective job description. Besides, the roles of private institutions that are not providing comprehensive abortion care have been elucidated in the provision of well defined and quality services.

Lastly, this guideline have been made to be consistent with the current tier and existing HMIS formats of the health system.

Finally, I would like to urge that health care providers at all levels are therefore expected to not only have a good grasp of this guideline, but also prepared to discharge their professional responsibilities as outlined in the document. The FMOH provides unreserved support and guidance to the implementation of the Guideline as an essential component of the strategy to reduce maternal morbidity and mortality.

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Members of the task force that revised the guideline under the leadership of the MOH, whose names and the organizations they represent appears on the last pages of this document, deserve special thanks for their contributions.

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List of Abbreviations

FMHACA:	Food , Medicine and Health care Administration and Control Authority
FDRE:	Federal Democratic Republic of Ethiopia
FP:	Family Planning
GBV:	Gender Based Violence
GP:	General Practitioner
HTC:	HIV counseling and testing
ICPD:	International Conference on Population and Development
IESO:	Integrated Emergency Surgical Officer
IPPF:	International Planned Parenthood Federation
IUCD:	Intrauterine Contraceptive Device
KAP:	Knowledge, Attitude and Practice
LNMP:	Last Normal Menstrual Period
MOH:	Ministry of Health
MVA:	Manual Vacuum Aspiration
PHCU:	Primary Health Care Unit
Po:	Per Os
RH:	Reproductive heath
SMC:	Sharp Metallic Curettage
SNNP:	Southern Nations and Nationalities and peoples
STD:	Sexually Transmitted Diseases
VCT:	Voluntary Counseling and Testing
VIA:	Visual Inspection of Cervix using Aceto-acetic Acid

I. Introduction

Abortion is more than a medical issue, or an ethical issue, or a legal issue. It is, above all, a human issue, involving women and men as individuals, as couples, and as members of societies **(Tietze, 1978).**

Ethiopia has shown a marked improvement in maternal health since the first publication of this guide line in 2006. The maternal mortality ratio in 2011 was 676 per 100,000 live births. Reports indicated the rate of decline of MMR was 4.9% per annum showing that Ethiopia is making substantial progress in reducing maternal mortality but would require to accelerate the pace of decline to be on track of MDG 5.

Prior to 2005 the contribution of unsafe abortion to maternal mortality had been 32% . changing the law to improve access to safe abortion services , introduction of safe and effective methods like MVA and medication abortion , training of both high and mid level workers in CAC and making facilities ready has lead to drastic drop in abortion related morbidity and mortality . A nationwide study on the magnitude of abortion in Ethiopia has estimated the contribution of abortion to MMR in Ethiopia to be 14%.

Following the introduction of the technical and procedural guide line for safe abortion in Ethiopia in June 2006 access to safe services particularly in the first trimester has dramatically improved such that nearly 96%of all abortion in the first trimester are provided in safe condition and only 4%are post abortion care this is in contrast to nearly 100% of post abortion care in the years prior to 2005. Such advances were coupled with an improved up take of medication abortion over surgical methods particularly after 2008.

These developments brought new challenges. These include standardizing medication abortion use in keeping with current evidences, addressing issues of second trimester CAC , improving access to safe services through new public and private out lets .Therefore; this guideline was revised to address these challenges, incorporate new evidences and reflect changes in the reorganization of the health service in three tiers .

Aim of the guideline

The revised guideline is working document on the techniques and procedures that must be observed in providing safe termination of pregnancy as permitted by the penal code of FDRE (May ,2005).

The aim of this guideline is to ensure that women in Ethiopia considering safe termination of pregnancy have access to services of high standard and quality. The guideline is meant to ensure that women obtain standard, consistent, safe termination of pregnancy services regardless of the level of care of the health institution or the qualification of the service provider.

The guideline is for health managers, program coordinators and health care providers – Gynecologists, General Practitioners, health officers , IESO and nurse midwives, nurses and health extension workers. This guideline will be implemented in all health institutions recognized and registered by FMOH.

TYPES OF ABORTION SERVICES

Abortion is the termination of pregnancy before fetal viability, which is conventionally taken to be less than 28 weeks from LNMP. If the LNMP is not known a birth weight of less than 1000gm is considered as an abortion. The abortion may occur either spontaneously or induced. Induced abortion can be safe or unsafe.
There are two types of care related to termination of pregnancy. These are safe abortion care and postabortion care. all abortion care should be women.

Women-centered abortion care is a comprehensive approach to providing abortion services that takes into account the various factors that influence a woman's individual mental and physical health needs as well as her ability to access services and her personal circumstances and her ability to access services.

Women-centered abortion care includes a range of medical and related health services that support women exercising their sexual and reproductive rights. Women-centered

abortion services have three key elements.

- **Choice** that includes the right to determine if and when to become pregnant, to continue or terminate a pregnancy, the right and opportunity to select between options, and having complete and accurate information.

- **Access**, includes having termination of pregnancy service by trained competent providers with up-to-date clinical technologies, easy-to-reach services that are affordable and non-discriminatory.

- **Quality** service, address respectful, confidential services tailored to the woman's needs using accepted standards with appropriate referral procedures.

Safe Abortion care is a comprehensive termination of pregnancy that is offered to clients as permitted by the law

Postabortion care is a comprehensive service to treat women that present to a health care facility after abortion has occurred spontaneously or after attempted termination. Post abortion care has five essential elements. These are:

- **Community-service provider partnership** involving the local community and actors like Health Development Army.,in addition to the formal health personnel to address recognition of symptoms and signs of pregnancy complications, resource mobilization, social and economical issues at the community level.
- **Counseling** where women are provided with accurate and complete information on RH issues including FP, VCT, gender-based violence and other concerns and queries.
- **Emergency treatment** of incomplete abortions and its complications
- **Family Planning** services based on free and informed choice as well as method-mix.
- **Linkage** of the above services with other RH services including STD diagnosis and treatment, information on breast feeding, child nutrition and immunization, screening of reproductive tract cancers, etc.

Several methods of termination of pregnancy are available now. Which method is best for individual institution depend on the duration of pregnancy, the general health status

of the client, availability of method, distance from referral center, knowledge and skill of the provider, and level of care.

Legal Provisions for safe abortion services

Health workers involved in the care of women should be well aware of the provision of this guideline which is the official interpretation of the law on safe abortion services a outlined below. Knowledge of the law is essential so that providers not only know what is expected of them but can also inform and educate women and community at large.

Article 551 of the penal code of the Federal Democratic Republic of Ethiopia allows termination of pregnancy under the following condition

1. Termination of pregnancy by a recognized medical institution within the period permitted by the profession in not punishable where:
    a. The pregnancy is a result of rape or incest ; or
    b. The continuation of the pregnancy endangers the life of the mother or the child or the health of the mother or where the birth of the child a risk to the life or health of the mother; or
    c. The fetus has an incurable and serious deformity ; or
    d. The pregnant woman , owing to a physical or mental deficiency she suffers from or her minority , is physically as well as mentally unfit to bring up the child .
2. In case of grave and imminent danger which can be averted by an immediate intervention , an act of terminating pregnancy in accordance with the provision of Article 75 of this code is not punishable

Timing and place for terminating pregnancy

1. Termination of pregnancy as permitted by the law can be conducted in a public or private facility that fulfills the pre-set criteria**.**

2. A woman who is eligible for pregnancy termination should obtain the service within three working days. This time is used for counseling and diagnostic measures necessary for the procedure

3. All public health facilities at the level of a health center and above and Private facilities starting primary clinics can perform termination of pregnancy as

permitted by law article 551 for pregnancies less than 12 weeks of gestation from the last normal menstrual period**.**

4. Termination of pregnancy between 13-24 weeks should be performed in a primary , General or tertiary Hospital, MCH specialized center and MCH specialized hospitals as permitted by article 551.

5. Termination of pregnancy between 24-28 weeks should be done in a tertiary level of care as permitted by article 551**.**

6. Women who are eligible for pregnancy termination should have the necessary information to seek abortion care as early in pregnancy as possible**.**

Implementation guide for article 551

1. Implementation guide for Article 551 sub article 1-A,

⇒ *Where the pregnancy is a result of rape or incest*

- Termination of pregnancy shall be carried out based upon the disclosure of the woman whether rape or incest has occurred. This fact will be noted in the medical record of the woman.

- Women who request termination of pregnancy after rape and incest are not required to submit evidence of rape and incest and/or identify the offender in order to obtain an abortion services.

2. Implementation guide for Article 551 sub article 1B

⇒ *when the continuation of the pregnancy endangers the life of the mother or the child or the health of the mother or where the birth of the child is a risk to the life or health of the mother*

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

- The woman should not necessarily be in a state of ill health at the time of requesting safe abortion services It is therefore the responsibility of the health provider in charge to assess the woman's conditions and determine in good faith that the continuation of the pregnancy or the birth of the fetus poses a threat to her health or life.

3. Implementation guide for Article 551 sub article 1C

⇒ *when the fetus has an incurable and serious deformity*

- If the physician after conducting the necessary tests diagnoses a physical or genetic abnormality that is incurable, termination of pregnancy can be conducted.

4. Implementation guide for Article 551 sub article 1D

⇒ *when the pregnant woman, owing to a physical or mental deficiency she suffers from or her minority, is physically as well as mentally unfit to bring up the child:*

- The provider will use the stated age on the medical record for age determination to determine whether the person is under 18 or not. No additional proof is required.
- A disabled person is one who has a condition called disability that interferes with his or her ability to perform one or more activities of every day living. Disability can be broadly categorized as mental or physical.
- The provider should assess if the woman is suffering from any form of mental or physical disability.
- Termination of pregnancy Under Article 551 sub article 1D will be done after proper counseling and informed consent.

5. Implementation guide for Article 551-subarticle 2

⇒ In the case of grave and imminent danger, which can be averted only by an immediate intervention, an act of terminating pregnancy in accordance with the provisions of Article 75 of this Code is not punishable.

- **HEALTH PROVIDERS RESPONSIBLE FOR THE PROVISION OF COMPREHENSIVE ABORTION CARE SERVICES ARE AUTHORIZED TO PERFORM ABORTION PROCEDURES ON WOMEN WHOSE MEDICAL CONDITIONS WARRANT THE *IMMEDIATE* TERMINATION OF PREGNANCY.**

Applicable for all sub-articles:

- The provider has to secure an informed consent for the procedure using a standard consent form, which is annexed with this guideline (**Appendix I)**

- The provider shall not be prosecuted if the information provided by the woman is subsequently found to be incorrect

- Minors and mentally disabled women should not be required to sign a consent form to obtain an abortion procedure.

PRE-PROCEDURE CARE

The first steps in providing abortion care are to establish that the woman is pregnant and if she is to determine the duration of pregnancy. taking the woman's history , performing a bimanual pelvic examination , conducting the required laboratory investigations , counseling to help her decide between alternative options and obtaining her consent are all part of the pre-procedure care.

1. Counseling and informed decision making

a. Counseling

- Provide sufficient and accurate information on the method of pregnancy termination and comparative risks of continuing the pregnancy to term with terminating the pregnancy.

- The information provided to and the counseling to women must include a minimum of the following:
    - Options counseling: continuing the pregnancy or terminating the pregnancy'
    - Available methods of pregnancy termination and pain control used, advantages and disadvantages
    - What will be done during and after the procedure
    - Risks associated with the method of termination of pregnancy both short and long term
    - Resumption of menses
    - Follow up care

- The information should be clear, objective, non-coercive and provided in a language understandable to the client and the information should be supplemented with written material**.**

b. Informed decision making

- All women undergoing pregnancy termination should, after having an objective counseling, consent to the procedure of termination in writing.

- The health care institution and the health worker that provides the service has an ethical obligation not to disclose the information provided by the women unless permitted by the client or ordered by a court of law.

2. Diagnosis of pregnancy

Before any procedure to terminate a pregnancy, a detailed medical history and, physical findings should be documented. The presence of pregnancy, the gestational age needs to be confirmed.

1. **The medical history:** Ask and document the following:

    - Age
    - Reproductive history (Number of pregnancies, deliveries, abortions)
    - First date of Last normal menstrual date (LNMP)
    - Gestational age based on LNMP (note that lactating women may not report a missed period)
    - History of drug allergy
    - Any medical or surgical illness: (Note: Assessment of life threatening illnesses as indication for termination and known medical and surgical illnesses that may need special care shall be given due emphasis)

2. **Physical examination:** Undertake the following

    - General physical examination to establish the general health of the woman
    - Bimanual pelvic examination to establish:
        - The diagnosis of intrauterine pregnancy
        - Uterine size and position
        - The presence of other uterine pathology like fibroids

C. **Laboratory investigation:** Do the following laboratory tests if and when available. The absence of such tests should not be reason to prevent safe abortion services.

- Blood group and RH factors
- Urine analysis
- Pregnancy test
- VDRL
- Smear and Gram's stain of vaginal discharge as appropriate
- Cervical cancer screening
- Ultrasound and genetic tests as appropriate

3. Exclude extra-uterine pregnancy

- If a woman presents with amenorrhea, lower abdominal pain and vaginal bleeding consider ectopic pregnancy and /or
- Upon examination there is an adnexal mass
- If a woman with a positive pregnancy test above six weeks of gestation duration has no gestational sac on trans-abdominal ultrasonography

If ectopic pregnancy is suspected, make sure the woman is evaluated by the most senior health provider around or refer to next level of care.

4. Assessment of gestational age

Assess gestational duration based on:

1. The last normal menstrual date
2. Physical finding (Abdominal and pelvic examination)
3. Ultrasound (optional)

2.5. Cervical preparations

The following group of women need cervical preparation regimens:

- Nulliparous women and those aged 18 or below with gestational duration of more than 9 weeks
- All pregnant women with gestations more than 12 weeks.

Pain control in safe abortion setting

All first trimester abortion can be provided out-patient basis. In all second trimester abortion, Procedure should be done in procedure room with facility for general anesthesia. If a general anesthesia has been used ,Observe clients for a minimum of six hours in the recovery room

Options of pain control

- *Non pharmacologic methods*
  1 verbal reassurance with support person
  2 environment …privacy , separate rooms
  3 hot water bottle/heating pad
- *Pharmacologic methods*
  1. narcotic analgesia IM or IV
     Pethidine (meperdine) 50-125 mg IMq3-4hours
     Morphine 10-15 mg IM q 2hours
  2. Anxiolytic (benzodiazepines)

Diazepam 10 mg PO or 2-5 mg IV OR
Midazolam 5 mg IM (or 0.07-0.08 mg/kg IM) OR
Lorazepam 1-2 mm PO or 0.05 mg/kg IM (maximum dose 4 mg)

3. Non steroidal anti inflammatory drugs
   Ibuprofen, Diclofenac or indomethacin PO can be used
4. Anesthesia
   Local anesthesia (paracervical block)
   Regional anesthesia
   General anesthesia

PROCEDURES DURING TERMINATION

All health institutions should provide termination of pregnancy by one of the recommended methods depending on the gestational age.

Medical abortion

Administer the following combination of drugs in the specified dosage:

- Up to 9 completed weeks since LNMP
  - Mifeprestone PO 200 mg followed 48 hours later by
  - Misoprostol 800 µg vaginally. Insert misoprostol deep into the vagina or instruct the woman to do so by herself.

- After 12 till 24 weeks completed weeks since LMP
  - Mifeprestone PO 200 mg followed 48 hours later by
  - Misoprostol 400µg of oral misoprostol every 3 hours up to a maximum of 5 doses if abortion does not occur.

- After 24 till 28 weeks completed weeks since LMP
  - Mifeprestone PO 200 mg followed 48 hours later by
  - Misoprostol 100µg of oral misoprostol every 3 hours up to a maximum of 5 doses if abortion does not occur.

- Depending on the need for pain control, non-narcotic analgesics should be prescribed during and after medical abortion.

In all situation of medication abortion

If there is no fetal expulsion after 24 hours of medication Abortion with last dose of Misoprostol

1. Review the medical history , physical examination and laboratory finding to ascertain indication

2. Perform examination to exclude complications

3. Repeat dose of mifeprostone and misoprostole as recommended regimen

   OR

4. Use alternative techinc in consultation with a specialist in Obstetrics and Gynecology

Contraindications:

Mifepristone:

- Suspected ectopic pregnancy or undiagnosed adnexal mass
- IUD in place (remove before administering medication)
- Chronic adrenal failure
- Concurrent long term corticosteriod therapy
- History of allergy to mifepristone
- Hemorrhagic disorders or concurrent anticoagulant therapy
- Inherited porphyrias

Misoprostol

- History of allergy to prostaglandins including misoprostol

Rule out the above clinical conditions before administering either of the 2 drugs.

After administering mifepristone, advise women to come back 36-48 hours later to take misoprostol. Also inform them to expect bleeding and possible expulsion of products of conception, and whom to contact in complications arise.

Once misoprostol is administered during the second visit, observe for 4 hours during which time up to 90% of women will expel the products of conception. If abortion does not occur during the time of observation, clients should be advised to come back to the health facility about 2 weeks later to confirm that the abortion is completed. If by this time the abortion has failed, use surgical methods to complete the process.

Surgical methods

For pregnancies 12 weeks or less from the first day of LMP the preferred method of termination is vacuum aspiration, manual or electrical. Dilatation and curettage should be used only where vacuum aspiration or medical methods are not available. All efforts should be made to replace SMC with vacuum aspiration at all levels of care.

Vacuum aspiration

Vacuum aspiration is the preferred method of termination of pregnancy for an otherwise uncomplicated pregnancy up to 12 completed weeks of pregnancy from LMP.

Procedure

- Should be done in outpatient procedure room
- Ensure that an assistant is present
- Communication, reassurance and respect is important for building confidence and quality of care.
- Administer prophylactic antibiotics for women considered at high risk for reproductive tract infections; adolescents, single, commercial sex workers, house maids.
- Follow steps for cervical preparation as in section 2.5 above
- Make sure the MVA is functioning properly. Inspect the instruments for optimal use.
- Observe steps to ensure that conceptus tissue is evacuated completely
- Inspect the evacuated tissue for floating villi.
- Staff should protect themselves and clients by applying standard/universal precautions routinely (**appendix II**).
- Staff should follow recommended steps in processing of instruments after abortion (**appendix III**).
- Safely handle and dispose blood, blood soaked materials, sharps and products of conception.

Sharp metallic curettage

Where vacuum aspiration is available, SMC is not recommended. If SMC is to be used for termination of pregnancy, it should be done by a trained health officer, medical doctor or gynecologist. While all general recommendations for vacuum aspiration should be practiced, specific procedures should be followed.

Dilatation and Evacuation

For pregnancies between 13 -18 weeks D and E could be provided particularly if mediation abortion fails or cannot be used because of contraindication

POST PROCEDURE CARE

Post-procedure care is as essential as care during procedure to ensure maximum outcome in abortion care services.

- Follow stability of vital signs; Do abdominal examination for tenderness, fluid accumulation; do pelvic examination for vaginal bleeding:
- Identify, manage, and refer complications as appropriate:
- Inform women that all methods of abortion could have a small risk of failure to terminate the pregnancy, thus necessitating a further procedure:
- Give discharge instructions (using simple language, sequential, and in pace with the level of understanding of the client) on symptoms and signs that indicate complications and the availability of care for any condition 24 hours:
- Give post-procedure counseling, as appropriate, on STDs, VCT, GBV, and contraception and other issues:

- Provide the chosen method of contraception immediately after abortion following the WHO eligibility criteria.
- Administer TT for all eligible women before discharge.
- Inform women about benefits of ANC, breastfeeding, child immunization and nutrition.
- Do Papanicolau smear or VIA for all women.
- STD screening, partner tracing, sexual health counseling should be done
- In the absence of complications women can be discharged as soon as they feel able and their vital signs are stable.
- Give follow up appointment 7-10 days post-procedure (**WHO 2003**).

Special considerations: Anti-D Ig G 250 iu should be given IM for all non-sensitized RhD negative women after termination of pregnancy by any method.

Post abortion family planning(PFAP)

Providing post abortion contraceptive counseling and methods will improve contraceptive acceptance and break the cycle of having unwanted pregnancy. All ranges of contraceptive methods can be used after the first trimester abortions. However, the medical eligibility criteria for each method need to be met.

1. **Elements of PAFP:**

An effective counseling should be used in PAFP. Health providers need to observes the following steps

- Establish rapport:
- Assess the woman's needs:
- Explain human reproduction:
- Ask if the woman desires to delay or prevent future pregnancy:
- Assess the woman's individual situation:
- Explain characteristics of available methods:
- Help the woman choose the method:
- Ensure that the woman understands how the method she selected works: Refer the woman to related community resources as need:
- Methods of choice for PAFP and Medical eligibility criteria:

2. Providing family planning methods

When providing post-abortion contraception the medical eligibility criteria for each method must be considered. All modern contraceptive methods can be used immediately, if

- There are no complications that require further treatment.
- The woman receives proper counseling and informed consent is obtained

- The provider screens for any precautions for using a particular contraceptive method.

a. Family planning In uncomplicated abortions;

All methods contraceptive methods can be used**.**

b. Family planning in abortion with complications:

Infection:

If infection is suspected the woman should be advised not to have sexual intercourse until the infection resolves. If abstinence is not feasible the following contraceptive methods are not recommended in presence of infection:

- Female sterilization or tubal ligation, because this surgical intervention may precipitate pelvic infection or peritonitis.
- Intrauterine contraceptive devices(IUCD): Insertion of foreign body into the uterus in the presence of infection may worsen the condition and treatment will not resolve the infection very easily.

Genital injury:

Genital injury includes uterine perforations, cervical tears, vaginal trauma and lacerations. Contraceptive methods that may temporarily restricted in the presence of genital injury includes: Tubal ligation, IUD, IUS, spermicides and barrier methods other than the male condom. However, the health care provider should assess the location and severity of the injury and choose the appropriate contraceptive method.

Excessive Blood loss:

If the woman has excessive blood loss, female sterilization and IUDs need to be delayed; particularly the hemoglobin level is low.

c. Emergency contraception:

Emergency contraception(EC) can be considered for women who are vulnerable to unprotected sexual intercourse. However, for women receiving abortion care services, provision of other modern contraceptives in advance to prevent future unwanted pregnancies should be made. EC should not be used as a regular contraceptive.

D. Timing of Post Abortion Family planning

Clients served with surgical abortion care:

All modern family planning methods can be used **immediately** after safe induced abortion or uncomplicated post abortion care services

Clients served with Medical Abortion:

- Hormonal methods including pills, injectables or implants may be started on the day of the first pill of medical abortion
- IUD insertion and sterilization can be performed when it is reasonably certain that a woman is **no longer pregnant** or **completed the abortion**.

REFERRAL ARRANGEMNTS

Presence of a well functioning referral system is vital to provide safe and quality abortion services. It is an ethical responsibility to direct clients to appropriate services at any one time. Referral arrangements enable women to access routine care timely, and prompt treatment of complications.

- Refer a woman if the type of care that she needs is beyond the capacity of your institution to manage
- Clearly state the condition at the time of referral, what was done and reason for referral on the referral paper
- Inform the receiving health facility particularly if the woman is suffering from complications and needs immediate care, transport arrangements care during transport including accompanying health personnel, and free service as appropriate.
- Referral should only be made by the most senior health professional on duty.
- The referral center should write a feedback to the referring center on the type of complication ascertained and care provided, outcome of the treatment and plan for subsequent care.
- If HTC services are not provided in your health facility, refer to the nearest center
- Inform victims of rape about and refer for legal and psychological support as needed.
- All women referred to the next level are entitled to care without any precondition.
- Referral arrangement for social support and care is an integral part of the overall abortion care

PROVIDERS SKILLS AND PERFORMANCE

In order to effectively discharge their responsibilities, providers should acquire basic knowledge and skills during their pre-service training and get periodic updates through on the job training. Learning methods should address both knowledge and clinical skills as well as attitudes and beliefs of service providers. A values clarification that helps providers to distinguish between their own values and clients rights to safe reproductive services is an essential component of all training programs. Selection of training sites should take into consideration the volume of flow of patients so that providers will get the opportunity to acquire adequate skills in managing abortion and its complications.

In order to make safe abortion services as permitted by law accessible to all eligible women, the role of midlevel providers such as health officers ,nurses and midwives should be expanded to provide comprehensive abortion services including uterine evacuation using MVA and medical abortion.

The following table illustrates tasks that are required to provide comprehensive abortion care and the role of some categories of reproductive health providers.

Table 1 Task analysis by category of health workers

Task	Professional category				
	GMPs/IESO	Health Officers	Midwives	Nurses	HEW
Patient assessment					
• History taking	✓	✓	✓	✓	✓
• Physical examination	✓	✓	✓	✓	✓
• Bimanual pelvic exam	✓	✓	✓	✓	✓
• Dating gestation	✓	✓	✓	✓	✓
Counseling	+	+	✓	✓	✓
Uterine evacuation in first trimester					
• MVA	✓	✓	✓	✓	X
• SMC	✓	✓	X	X	X
• Medical abortion	✓	✓	✓	✓	X
Uterine evacuation in 2nd trimester					
• Medication abortion	✓	✓	X	X	X
• D and E	X	X	X	X	X
Pain Medications					
• Analgesics/sedatives	✓	✓	✓	✓	✓
• Narcotics/Paracervical block	✓	✓	✓	X	X
Treatment of complications					
• Identification	✓	✓	✓	✓	✓
• Antibiotics	✓	✓	✓	✓	✓
• IV Fluids	✓	✓	✓	✓	✓
• Blood Transfusions[1]	✓	✓	X	X	X
• Maintain airways	✓	✓	✓	✓	X
• Repair of minor injuries	✓	✓	✓	X	X
• Abdominal surgery	✓	✓			
Postprocedure care	✓	✓	✓	✓	✓
Follow up care	✓	✓	✓	✓	✓
Universal precautions	✓	✓	✓	✓	✓
Postabortion contraception	✓	✓	✓	✓	✓
• Information	✓	✓	✓	✓	✓
• Counseling	+	+	✓	✓	✓
• Method choice	✓	✓	✓	✓	✓
• Informed choice/referral	✓	✓	✓	✓	✓
Linkages with other RH services					
• Counseling	✓	✓	✓	✓	✓
• Screening	✓	✓	+	+	+
• Treatment	✓	✓	✓	✓	✓
• Referral	✓	✓	✓	✓	✓
Instrument processing	✓	✓	✓	✓	✓
Education on:					
• Dangers of unsafe abortion	✓	✓	✓	✓	✓
• Prevention of unwanted pregnancy	✓	✓	✓	✓	✓
• Legal provisions for abortion	✓	✓	✓	✓	✓
Training junior health professionals and community health workers	✓	✓	✓	✓	✓
Maintain records and submit reports	✓	✓	✓	✓	✓

Key;

✓ = Roles expected from the category of professionals

X = Roles not expected of the category

+ = May initiate and/or partly perform the task

[1] While decision to transfuse blood shall be made by a senior clinician, all categories of nurses could administer and monitor blood transfusion.

2 obstetricians and Gynecologists can perform all the tasks listed including Dilation and Evacuation and termination of pregnancy 24-28 weeks of gestation

Category of health workers and their role in SAC

Training curricula on abortion care should enable health providers competently perform the tasks described in the above table. The following categories of health workers are authorized to perform abortion procedures fort first trimester pregnancy using medical abortion and/or MVA:

- Nurses (both clinical or Public Health)
- Midwives
- Health Officers, and IESO
- General medical practitioners, and
- Specialists in Obstetrics and Gynecology

Specialists in Obstetrics and Gynecology, general medical practitioners and health officers with adequate training on the specific skills are authorized to perform second trimester abortion procedures.

ABORTION SERVICES BY LEVEL OF CARE

In organizing abortion care services, program planners and facility managers should take the following two issues in consideration:

- Organizing emergency abortion services to provide life saving procedures on a 24 hours basis, and
- Elective abortion, performed at the request of the woman or the recommendations of health provider.
- All facilities providing 2 trimester abortion services should have functioning operation theater , person skilled in life saving skills offering CEMoC and be trainind in 2 nd trimester abortion services

The following table is a summary of the elements of recommended abortion services to be provided and staffing patterns at different levels of care.

Abortion services by level of health care

Level of Care	Type of health personnel available	Abortion services
Community/ Health posts	Health Extension Workers(HEW)	• Recognition of signs and symptoms of pregnancy • Recognition of signs and symptoms of abortion and its complications • Education on RH including FP and abortion • Inform communities and women on the legal provisions for safe abortion • Distribution of appropriate contraceptives, including emergency contraceptives • Checking vital signs • Pain medication
Health Centers	Health Officers (HOs) Midwives, Clinical Nurses, Public Health Nurses,	The above activities plus, • Counseling • General physical and pelvic examination • Vacuum aspiration up to 12 completed weeks of pregnancy • Medical abortion up to 9 completed weeks of pregnancy • Administration of antibiotics and IV fluids • Training of Community level workers and junior health

		professionals in abortion service provision
Primary Hospital	Same as above, plus general medical practitioners (GMPs), IESO, and anesthetist	The above activities plus: • Uterine evacuation for second trimester abortion 13-24 weeks • Treatment of most complications • Blood X-matching and transfusion • Local and general anesthesia • Laparatomy and indicated surgery • Diagnosis and referral for serious complications such as peritonitis and renal failure. • Referral for all abortions above 24 weeks • Training of all cadres of health professionals (preservice and inservice)
General Hospital	Same as above plus; Obstetrician & Gynecologist	The above activities plus: • Uterine evacuation for second trimester abortion upto 28 weeks • Treatment of most complications • Blood X-matching and transfusion • Local and general anesthesia • Laparatomy and indicated surgery • Diagnosis and referral for serious complications such as peritonitis and renal failure. • Training of all cadres of health professionals (preservice and inservice)
Referral hospitals	Same as above plus; Obstetrician & Gynecologist and or Specialist	The above activities plus: • Treatment of severe complications (including bowel injury, tetanus, renal failure, gas gangrene, severe sepsis) • Treatment of coagulopathy
Private facilities		

PRIMARY CLINICS	Staffed by Nurses and assistants	• Counseling • General physical and pelvic examination • Vacuum aspiration up to 12 completed weeks of pregnancy • Medical abortion up to 9 completed weeks of pregnancy • Administration of antibiotics and IV fluids
MEDIUM CLINICS	Staffed by HO or GMP and a team of other health workers, nurses and midwives	• Counseling • General physical and pelvic examination • Vacuum aspiration up to 12 completed weeks of pregnancy • Medical abortion up to 9 completed weeks of pregnancy • Administration of antibiotics and IV fluids
MCH SPECILAITY CENTERS, AND SPECIALIZED HOSPITLAS STAFFED BY OBSTETRICIAN AND GYNECOLOGIST	Staffed by Specialists (ob/gy), GMP and a team of other health workers	• Counseling • General physical and pelvic examination • Vacuum aspiration up to 12 completed weeks of pregnancy • Medical abortion up to 9 completed weeks of pregnancy • Administration of antibiotics and IV fluids ▪ Same as primary hospital

ESSENTIAL EQUIPMENT AND SUPPLIES

Health facilities providing safe abortion services should be supplied with basic minimum equipment, instruments and supplies that have to be replenished regularly such as pain medications, antibiotics, IV fluids, disinfectants, etc. Following is a list of basic supplies, instruments and equipment that should always be available in sufficient amounts in all health facilities rendering services. Program managers, facility directors and those responsible should include these items in the routine budgeting, procurement and distribution systems.

A. Basic Supplies

- IV equipment and fluids
- Syringes and needles
- Sterile gloves, different size
- Cotton balls or gauze sponges
- Antiseptic solutions
- Long needle holders

B. Instruments and equipment for first trimester uterine evacuation

1) Basic Uterine Evacuation
    - Tenaculum
    - Sponge forceps or uterine packing forceps
    - Malleable metal sound
    - Pratt or Denniston dilators: sizes 13-27 French
    - Medium speculum, self retaining
    - local anesthesia 1% with out adrenalin
    - Plastic strainer
    - Clear glass dish for tissue inspection
    - Long dressing forceps
    - Container for cleansing solution
    - Single tooth tenaculum forceps

2) Vacuum aspiration with electric pump
    - Basic uterine evacuation instruments plus:
    - Vacuum pump with extra glass bottles
    - Connecting tubing
    - Cannulae (any of the following)
        - Flexible: 4, 5,6,7,8,9,10,12mm
        - Curved rigid: 7,8,9,10,12,14mm
        - Straight rigid: 7,8,9,10,12mm

3) Manual vacuum aspiration
    - Basic uterine evacuation instruments plus:
    - Vacuum aspirators
    - Adapters

- Flexible or semi rigid cannulae, size 4-12mm

C. Instruments and equipments for second trimester Safe abortion service

1 Medication abortion

- Mifepristone tablets..200mg oral
- Misoprostol tablet ….400micro gram tablets

2 surgical methods (D&E) up to 18 weeks

- A traumatic Tenacullem or Volsellum
- Wide specullem (Klopher or Sims), Sponge(Ringed) forceps and Scissors
- Lidocaine and 22 gauge spinal needle for paracervical block
- Cervical dilators (Misoprostol tablet or Osmotic dilators)
- Electrical or manual Vacuum aspirator with 12,14 and 16 mm cannula
- Tapered Cervical dilators Pratts up to 51mm
- Small and large Sopher & Bierer uterine evacuation forceps
- Large postpartum flexible curette
- Bowel or container for examining evacuated tissue

3 Second trimester Safe abortion service needs

- Proper fetal /tissue disposal IE disposal pit , incinerator
- Emergency surgical backup
- Basic life support …oxygen Ambu bag
- Ultrasound is optional Blood bank is optional
- Clear referral mechanism to higher level facility , when needed
- pain control medication
- utertonic agents (oxytocin 10 IU or Ergometrine 0.2 mg
- in-patient bed for Misoprostol Administration
- bowl or container for fetal disposal

MONITORING AND EVALUATION

Health facilities and clinical providers should maintain data on abortion services into regular systems of recording such as logbooks, clinical records, and daily activity records. The logbook for registration of clients receiving abortion services as shown in **Appendix IV** should be used by all health facilities providing abortion services. Data from the logbook shall be regularly reported to the next higher level, following the reporting format attached as **Appendix V**.

Program managers should be bale to monitor services to assess if they are being provided as per standards and take corrective measures as appropriate. Among others monitoring abortion services should include:

- Analyses of patterns or problems using service statistics
- Proportion of women seeking repeat abortions
- Observation of counseling and clinical services
- Ensuring regular and continuous supply of equipment and supplies
- Aggregation of data from health facility upwards
- Review of measures to improve services
- Proportion of women seeking second trimester abortion

Evaluation of abortion programs should provide data on the impact that they had brought about on reducing maternal mortality from unsafe abortion. However, since the gathering of such data requires a vital events registration system or a study on a very large population, it is may not be a feasible alternative in the Ethiopian setting. Instead, as many maternal mortality reduction programs do, it is imperative to focus on process or output indicators. In accordance, the following indicators could be used for evaluation of abortion programs:

- Number type and percentage of facilities providing abortion services by geographic area, i.e. Woreda, Zone, Region, Country wide
- Increase in the use of legal abortion services (access)
- Changes in patterns and rate of (hospital admissions) abortion complications
- Number and category of providers trained on abortion care
- Assessment of the quality of training
- Number and percentage of eligible providers performing abortion by level of facility and geographic distribution
- Costs of abortion services and treating complications of abortion by procedure and fees for services
- Providers' KAP, needs and ideas to improve services
- Serous adverse event including Deaths from abortion

Some aspects of abortion care services to be included in monitoring plans

Types of Services to be monitored	*Indicators to measure activities*	*Sources of information*	*What type of question should we ask?*
Infection prevention	Percentage of cases in which infection prevention practices were fully adhered to	Observation of services using checklists	• Was no-touch technique used? • Were MVA instruments properly processed?
Management and organization of services	• Average amount of time clients receiving abortion care spend in the facility • Average amount of time from arrival to procedure • Hours during which service are available	• Observe & evaluate patient flow • Review client records and conduct interview with staff	During which time of the day does client waiting time increase?
Counseling	• Number and percentage of clients receiving counseling	• Observing counseling sessions using performance checklist • Review cases from logbook	Were women with special needs given referrals?
Contraceptive counseling and services	• Number and type of contraceptives dispensed on site • Number and percentage of women who received contraceptive counseling • Number and percentage of women desiring contraception who received a method	• Observe counseling • Conduct exit interviews • Review logbooks	• How well was the woman counseled about available contraceptive methods? • Did the woman leave with desired method or information? • Did the woman have to go to another facility to receive a contraceptive method?
Client satisfaction	• Percentage of women who indicate that they received respectful care • Percentage of women who agree that services fees are reasonable	• Conduct exit interview • Review service fee charges	• Did you feel that you were treated respectfully? • Do you think the amount that you had to pay for services was reasonable?

Examples shown in the above table could serve as a useful tool to monitor quality of care at the facility levels. Facility directors and program managers are encouraged to develop and apply such tools as part of their monitoring plans

Appendix I: **Consent form**

Consent form for uterine Evacuation
Draft

After having consulted with my health service provider of my health conditions, I hereby consent to a procedure for safe termination of pregnancy. I have been counseled and informed of the alternative methods, possible side effects and outcomes of the procedure.

In the event of complications arising during the procedure I request and authorize the responsible health professional to do whatever is necessary to protect my health and well-being.

I confirm that the information that I provided to my health service provider is accurate.

Signature_____ Date_____

Appendix II: ***UNIVERSAL PRECAUTIONS***

Health care workers involved in providing abortion should follow the following universal precaution measures in order to prevent the transmission of infection form providers to patients, from patients to providers and to the community:

- Wash hands thoroughly with soap and water immediately before and after contact with each patient
- Use high level disinfected or sterile gloves and replace same between patients and procedures
- Never use gloved hands to open and close doors or to process instruments
- Wear sterile or high level disinfected gowns
- Clean floors, beds, toilets, walls and rubber draw sheets with detergents and hot water.
- Wear heavy-duty gloves during cleaning surfaces and washing bed sheets spilled with blood and body fluids and processing equipment for reuse.
- Dispose waste contaminated with blood, body fluids, laboratory specimens or body tissues safely following facility protocols
- Avoid recapping of needles whenever possible: I f this is a must use the scoop method.
- Dispose sharps in puncture resistant containers and bury or incinerate
- All reusable instruments shall be soaked in a 0.5% chlorine solution and cleaned with soap and water immediately after use and sterilized or high level disinfected.

Appendix III: *INSTRUMENT PROCESSING*

Follow specific instructions for processing medical instrument as appropriate. For instruments and equipment that could be reprocessed through high-level disinfection, follow the steps described below:

- Decontamination: Soak instruments in a 0.5% chlorine solution for 10 minutes
- Cleaning: Clean instruments with warm water and detergents, do not use soap. Wear masks and heavy-duty gloves during cleaning. Disassemble parts of the instrument and make sure that they are cleaned thoroughly.
- High level disinfection: There are two options:
    - Soak in 0.5% chlorine solution for 20 minutes, or
    - Boil for 20 minutes

  NB: rinse with sterile water if processed with chemicals. Dry with sterile towel.
- Store or use immediately: After instruments are processed they should be kept in a dry sterile or high-level disinfected containers protected from dust and other contaminants. Instruments processed with boiling or using solutions should be reprocessed every two days unless used.

Logbook for Abortion Procedures

Federal Ministry of Health

Health Center/Hospital Safe/Post Abortion Care Register

Region	Sub-city/Woreda	Health Facility Name	Begin date	End date

Federal Ministry of Health

INSTRUCTIONS FOR SAFE/POST ABORTION CARE REGISTRATION AT HEALTH CENTER / HOSPITAL

The abortion register is completed from Women's card by care provider.

Location information to be completed at front of register:

Region	Write the region where the facility is located
Zone	Write the zone where the facility is located
Woreda/subcity	Write the woreda/subcity where the facility is located
Health Facility	Write the name the health facility where abortion care is provided
Register begin Date	Enter the date of the first entry in the register/write as (EC) Day/Month/Year (DD/MM/YY)
Register End Date	Enter the date of the last entry in the register/write as (EC) Day/Month/Year (DD/MM/YY)

SN	Datum	Comments
	Identification: Personal Information	
1	Serial number	Sequential serial number in registration book; to entered on client's registration book for later identification in register
2	Date of visit	Date of service provision for post abortion care, DD/MM/YY
3	Medical Record Number (MRN)	Unique individual identifier used on medical information folder, for HC & Hosp
4	Age of the women	Age in years
5	Gestational age	Complete gestational age in weeks
6	No of previous abortion	No of abortion a women had other than the current one
7	Post abortion care	Tick if post abortion care is provided
8	Safe abortion care	Tick if safe abortion is performed
9	DX/ Reason for safe/post abortion care	Enter a corresponding code from the foot note of the register
	Type of procedure (√)	
10	MVA	Manual Vacuum Aspiration
11	E&C	Evacuation and curettage
12	MA	Medical Abortion
13	D&C	Dilatation and curettage
14	MP	Mixed procedures
15	Other	Other procedure than listed above
16	PITC counseling offered	Tick if HIV test offered under provider initiated HIV counseling and testing
17	PITC test performed	Tick if client tested for HIV/AIDS.
18	Test result (R,NR,I)	Write R in red per if the result is reactive, NR in normal pen if the result is negative, and I in normal pen if the result is indeterminate
	Complication (√)	
19	Minor	if complication is easily managed (manageable) How minor is defined by care provider
20	Serious	if complication is catastrophic and required major intervention
21	Death	If a woman died of abortion process
22	None	if no complication resulting from the abortion
23	Post abortion counseling	tick if any counseling is provided following abortion care service
24	Managed by	Full name and signature of the person provided the service
25	Remark/Linkage to services etc	Any note/linkage that provider requires to document

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Logbook for comprehensive Abortion Care Services

Serial No.	Date	MRN	Age of Woman (Yrs)	Gestation (wks)	Gravida	Para	No. of previous abortions	Diagnosis	Type of uterine evacuation Procedure					Managed as		Analegsic, Anesthesia, Sedation: drugs given & dose	Postabortion Contraception						outcome			Other treatment provided	Counseling, screening diagnosis &/or treatment for other reproductive health needs		Remarks	Name & Signature of service provider
																	Counseled		Expressed desire		Type of contraceptive Method/s supplied	Referred	complications		Death					
									MVA	E&C	MA	D&C	Other	Out-pt	In-pt		Yes	No	Yes	No			yes (specify)	no			Yes, list	No		

Count	
<=19	
20-24	
>=25	

Appendix V

Quarterly/Monthly Reporting Format for Abortion Services

Region: _____	Name of Health Facility_____
Zone: _____	Year (Eth. Cal)_____
Woreda: _____	Quarter/Month_____

	Total	Safe Abortion	Postabortion
1. Number of women who received abortion care			
2. Completed gestation (weeks)			
• Less than 8weeks			
• 8-12 weeks			
• **GREATER THAN 12 WEEKS**			
3. Type of procedure/method			
• MVA			
• SMC			
• Medical abortion			
• Other, Specify			
4. Women who expressed desire to delay further pregnancy			
5. Women who received a contraceptive method			
6. Referred for contraceptive method			
7. Number of women referred to other facility for abortion care by reason			
8. Number of women with major complications			
9. Number of women who have died from complications of abortion			

Prepared by: _____

Approved by: _____

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