First Trimester Abortion
Pocket Book for Health Care Providers

World Health Organization
South-East Asian Region
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The WHO South-East Asia Region (SEARO) continues to accelerate reductions in preventable maternal mortality as one of the eight Flagship Priorities in the Region and a key Sustainable Development Goal (SDG) target. In low- and middle-income countries globally, unsafe abortion is a significant cause of maternal mortality, despite being easily preventable. Between 2015 and 2019, there were an estimated 121 million unintended pregnancies annually, or around 64 unintended pregnancies per 1000 women aged 15–49 years. An estimated 61% of unintended pregnancies ended in abortion, or 39 abortions per 1000 women aged 15–49 years, globally.

Barriers to accessing safe abortion include restrictive laws, poor availability of services, out-of-pocket costs, and stigma. Lack of trained abortion providers is one of the most critical issues. To help fill the gap, this pocketbook aims to support health care providers who are engaged in first-trimester abortion services. It can be used as a quick guide for both surgical and medical methods of abortion. It can be used by all service providers who offer comprehensive abortion care as per national guidelines. It
is aligned with and reflects new WHO guidelines on abortion care, and is an important tool for ensuring all women and girls have access to quality abortion care, delivered by designated health workers with the right skills, resources and information.

I look forward to the impact this pocketbook will have in all countries of the Region, in line with national legal provisions. I urge health leaders to sensitize all stakeholders on their role in providing respectful care and addressing stigma and bias and to ensure this pocketbook is utilized in rural and hard-to-reach areas, helping close the urban-rural divide and reducing the risk of unsafe abortion for every woman everywhere. Towards that outcome, WHO will continue to provide its full support, for a fairer, healthier Region for all.

Dr Poonam Khetrapal Singh
Regional Director
WHO South-East Asia Region
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guidelines and could be adapted for use across various countries.

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## Acronyms and abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>BP</td>
<td>blood pressure</td>
</tr>
<tr>
<td>CAC</td>
<td>comprehensive abortion care</td>
</tr>
<tr>
<td>D&amp;C</td>
<td>dilatation and (sharp) curettage</td>
</tr>
<tr>
<td>EVA</td>
<td>electric vacuum aspiration</td>
</tr>
<tr>
<td>GBV</td>
<td>gender-based violence</td>
</tr>
<tr>
<td>Hb</td>
<td>haemoglobin</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>HLD</td>
<td>high-level disinfection</td>
</tr>
<tr>
<td>HMIS</td>
<td>health management information system</td>
</tr>
<tr>
<td>IUD</td>
<td>intrauterine device</td>
</tr>
<tr>
<td>LMP</td>
<td>last menstrual period</td>
</tr>
<tr>
<td>MMA</td>
<td>medical methods of abortion</td>
</tr>
<tr>
<td>MMR</td>
<td>maternal mortality ratio</td>
</tr>
<tr>
<td>MR</td>
<td>menstrual regulation</td>
</tr>
<tr>
<td>MRM</td>
<td>menstrual regulation with medication</td>
</tr>
<tr>
<td>MTP</td>
<td>medical termination of pregnancy</td>
</tr>
<tr>
<td>MVA</td>
<td>manual vacuum aspiration</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Definition</td>
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<td>--------------</td>
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<tr>
<td>NSAID</td>
<td>non-steroidal anti-inflammatory drug</td>
</tr>
<tr>
<td>OPD</td>
<td>outpatient department</td>
</tr>
<tr>
<td>OT</td>
<td>operation theatre</td>
</tr>
<tr>
<td>PGE1</td>
<td>prostaglandin E1 (misoprostol)</td>
</tr>
<tr>
<td>PAC</td>
<td>post-abortion care</td>
</tr>
<tr>
<td>PAFP</td>
<td>post-abortion family planning</td>
</tr>
<tr>
<td>PGF2</td>
<td>prostaglandin F2</td>
</tr>
<tr>
<td>POC</td>
<td>products of conception</td>
</tr>
<tr>
<td>PPE</td>
<td>personal protective equipment/ attire</td>
</tr>
<tr>
<td>RTI</td>
<td>reproductive tract infection</td>
</tr>
<tr>
<td>SDG</td>
<td>Sustainable Developmental Goal</td>
</tr>
<tr>
<td>SRH</td>
<td>sexual and reproductive health</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</tbody>
</table>
Goal of the pocketbook: Management of first trimester abortion

Strengthening the knowledge and standardizing the skills of health-care providers, enabling them to provide women-centred, comprehensive abortion care (CAC) services, leading to a reduction in the complications of first trimester abortion.

Scope of the pocketbook: Management of first trimester abortion

The document “First trimester abortion – Pocketbook for health-care providers” highlights the key points and standard protocols for providing comprehensive abortion care (CAC) by a trained health-care provider (medical officer/ nursing personnel/ midwife/ primary health-care worker) who is authorized to provide CAC as per the country’s legal framework.
A bortion is defined as spontaneous or induced termination of pregnancy before the period of viability. Viability varies according to a country’s health resources (WHO suggests the period of viability as <28 weeks). First trimester abortion refers to abortion within first 12 weeks of gestation. Abortion can be spontaneous or induced.

1.1 Definitions: Types of abortions

- **Spontaneous abortion**: Abortion is triggered spontaneously, without any external interference. Spontaneous abortion can be in the form of threatened abortion, inevitable abortion, incomplete abortion, complete abortion or missed abortion (Annex 1).

- **Induced abortion**: Termination of pregnancy is done intentionally, before the period of viability by the use of drugs or by surgical procedures.

- **Safe abortion**: Termination of pregnancy is carried out using a method recommended by WHO, appropriate to the duration of pregnancy and by someone with the necessary skills at recommended health facilities. Any abortion can be safe or unsafe.
Unsafe abortion: Termination of pregnancy is done either by an unskilled person or in an environment not conforming to minimal medical standards or both. Unsafe abortion is a leading cause of maternal mortality and morbidity due to sepsis/haemorrhage/uterine perforation/injury to the genital tract. It can lead to physical and mental health complications, social and financial burdens for women, communities and health systems.

Sub-classifications for unsafe abortion (1)
Less safe: Abortion performed by a trained provider who uses an unsafe or outdated method (such as sharp curettage), or by an untrained provider, who uses a safe method (such as misoprostol tablets) but without appropriate information or support from a trained person.

- This is nearly half of all abortions worldwide
- 1 out of 3 unsafe abortion occur in the worst condition (untrained persons using dangerous methods)

Most unsafe abortion occur in the developing world
Least safe: Abortion performed lacks both the criteria: providers are untrained and an unsafe method is used. Methods often involve ingestion of caustic substances, use of traditional concoctions, or insertion of foreign objects.

- Around 45% of all abortions are unsafe, of which 97% occur in developing countries. Of all unsafe abortions, one third are performed under the least safe conditions, i.e. by untrained persons using dangerous and invasive methods (2).

- An important cause of unsafe abortion is unintended pregnancy. The annual global rate of unintended pregnancies is 64 per 1000 women, aged 15–49 years; 61% of unintended pregnancies end in abortion (globally 73.3 million abortions a year).

- One in four women with unsafe abortion is likely to develop temporary or lifelong disability requiring medical care, leading to substantial emotional and financial cost to the woman.

- 8–11% of global maternal deaths are attributed to unsafe abortion. Maternal mortality due to abortion
in countries of the South-East Asia Region ranges between 1% and 13% (less than 1% in Bangladesh to 13% in Timor-Leste (i)).

### 1.2 Key reproductive health indicators in countries of the South-East Asia Region

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<tbody>
<tr>
<td>South-East Asia Region</td>
<td>152</td>
<td>8–11%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Bangladesh</td>
<td>49</td>
<td>60</td>
<td>12</td>
<td>62</td>
<td>173</td>
<td>1%</td>
</tr>
<tr>
<td>Bhutan</td>
<td>43</td>
<td>68</td>
<td>11.7</td>
<td>65.6</td>
<td>183</td>
<td>1.4%</td>
</tr>
<tr>
<td>India</td>
<td>44</td>
<td>77</td>
<td>12.9</td>
<td>53.5</td>
<td>145</td>
<td>8%</td>
</tr>
<tr>
<td>Indonesia</td>
<td>36</td>
<td>63</td>
<td>11</td>
<td>64</td>
<td>177</td>
<td>NA*</td>
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<tr>
<td>Maldives</td>
<td>46</td>
<td>71</td>
<td>31</td>
<td>19</td>
<td>53</td>
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<tr>
<td>Myanmar</td>
<td>35</td>
<td>74</td>
<td>16</td>
<td>52</td>
<td>250</td>
<td>16%</td>
</tr>
<tr>
<td>Nepal</td>
<td>47</td>
<td>69</td>
<td>24</td>
<td>53</td>
<td>186</td>
<td>7%</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>36</td>
<td>72</td>
<td>7.5</td>
<td>64.6</td>
<td>36</td>
<td>NA</td>
</tr>
<tr>
<td>Thailand</td>
<td>51</td>
<td>64</td>
<td>6.2</td>
<td>78.4</td>
<td>37</td>
<td>10%</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>27</td>
<td>68</td>
<td>25</td>
<td>26</td>
<td>142</td>
<td>13%</td>
</tr>
</tbody>
</table>

**Source:**

1. Policies, programme and services for comprehensive abortion care in countries of the WHO South-East Asia Region, 2021


To provide safe abortion care, a health-care provider should focus on women-centred comprehensive abortion care (CAC)

**CAC includes:**
- provision of information;
- abortion management; and
- post-abortion care (PAC).

It encompasses care related to induced and spontaneous abortion.
1.3 Barriers to access abortion services

- Poor availability of services and lack of trained providers
- Restrictive laws and inadequate knowledge of legal status
- Cost to provide/utilize services
- Stigma, making women reluctant to seek services and instead opt for secret, unsafe abortion; stigma can result in providers refusing to perform legal abortions
- Unnecessary requirements, third-party authorization, and instead option and unnecessary tests
- Quality of services

The most doable component of providing safe abortion services is to focus on training the health-care providers.

**Key message**

Health-care workers should provide safe abortion services by following women-centred CAC, to prevent abortion-related complications.
Objective: To understand women’s rights, laws, acts and policies related to abortion

Laws and policies on abortion should protect women’s health and their human rights.

Health-care workers should be well versed with the country’s legal framework related to first trimester abortion so that they can:

- provide accurate information to the woman seeking abortion;
- render advice in line with the provisions of law; and
- protect themselves from any litigation/punishment when providing abortion services.

2.1 Abortion and rights of women

- Safe and legal abortion is a woman’s human right but countries vary in their reproductive health profile and sociopolitical context.
- Reproductive rights rest on the recognition of the basic right of all couples and individuals.
Selected human rights, as specified in international laws and obligation of the countries, are relevant to sexual and reproductive health and rights, and abortion in particular. These are:

- right to the highest attainable standard of physical and mental health, including sexual and reproductive health and rights;
- right to non-discrimination and equality;
- right to life;
- right to privacy;
- right to be free from torture, cruel and degrading treatment and punishment including the right to physical and mental integrity;
- right to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so;
- right to information and education which should also include sexual and reproductive health; and
- right to benefit from scientific progress and its realization.

Awareness of these basic rights by a health-care provider can definitely increase the demand and utilization of safe abortion services by women. A health-care provider can sensitize women regarding these rights.
2.2 Legal grounds for abortion

- When there is a threat to a woman’s life
- When there is a threat to a woman’s health (physical or mental health)
- When pregnancy is the result of rape or incest
- When there is fetal impairment
- For economic and social reasons
- On request

Source: Policies, programme, and services CAC in the South-East Asia Region
Abortion laws generally fall into five categories, from most to least restrictive.

<table>
<thead>
<tr>
<th>Most Restrictive</th>
<th>Least Restrictive</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Prohibited for any reason</td>
<td>Permitted for any reason</td>
</tr>
<tr>
<td>Permitted to save the woman’s life</td>
<td>Permitted to preserve her physical heath</td>
</tr>
<tr>
<td>Permitted on broad socio-economic grounds</td>
<td></td>
</tr>
</tbody>
</table>

Bangladesh, Myanmar, Sri Lanka, Timor-Leste, Bhutan, India, Nepal, Thailand

### 2.3 Country-specific legal framework

All countries permit abortion to save a woman’s life. Post-abortion care (PAC) is unanimously recognized to be an important component of the health delivery system irrespective of the country’s legal status on abortion.

#### Legal provisions for abortions in countries of the South-East Asia Region

<table>
<thead>
<tr>
<th>Country</th>
<th>Conditions permitted</th>
<th>Gestation permitted</th>
<th>Legal provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>To save a woman’s life</td>
<td>Menstrual regulation (MR) up to 12 weeks</td>
<td>A team of two health professionals to certify the need and consent to be approved by the Ministry of Health.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Country</th>
<th>Conditions permitted</th>
<th>Gestation permitted</th>
<th>Legal provisions</th>
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<td></td>
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<td></td>
<td>Though abortions are illegal, but MR (procedure of regulating the menstrual cycle) is allowed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Consent:</strong> By woman herself, or guardian if mentally unstable or of young age.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Provider:</strong> Specialist or non-specialist, and paramedical nurse (nurses can provide MR up to 8 weeks only).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Method:</strong> MR by medication up to 9 weeks, vacuum aspiration (VA) 6–12 weeks.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Place:</strong> All health facilities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Post-abortion care</strong> is an integral part of the MR programme.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Essential medical list:</strong> Medications for abortion not in the list.</td>
</tr>
</tbody>
</table>

Continued
Bhutan

- To save a woman’s life
- Result of rape or incest
- To preserve the woman’s mental health

**Additional conditions approved in the “Management of complications”**

- To preserve the woman’s health
- Fetal impairment

<table>
<thead>
<tr>
<th>Country</th>
<th>Conditions permitted</th>
<th>Gestation permitted</th>
<th>Legal provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bhutan</td>
<td>To save a woman’s life</td>
<td>Up to 180 days</td>
<td>Two medical doctors need to certify that termination is essential.</td>
</tr>
<tr>
<td></td>
<td>Result of rape or incest</td>
<td></td>
<td><strong>Consent:</strong> Compulsory consent of the spouse required.</td>
</tr>
<tr>
<td></td>
<td>To preserve the woman’s mental health</td>
<td></td>
<td><strong>Provider:</strong> General practitioners and specialists can provide treatment of complications.</td>
</tr>
<tr>
<td></td>
<td>To preserve the woman’s health</td>
<td></td>
<td><strong>Method:</strong> Medication with mifepristone and prostaglandin; VA and dilatation and curettage (D&amp;C); illegal abortion, a serious professional misconduct and punishable.</td>
</tr>
<tr>
<td></td>
<td>Fetal impairment</td>
<td></td>
<td><strong>Place:</strong> Facilities where general practitioners and specialists are available.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Essential medical list:</strong> Mifepristone and misoprostol in the list.</td>
</tr>
<tr>
<td>Country</td>
<td>Conditions permitted</td>
<td>Gestation permitted</td>
<td>Legal provisions</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------</td>
<td>---------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Democratic People’s Republic of Korea</td>
<td>–</td>
<td>–</td>
<td>Birth control procedures and abortions banned, to reverse the country’s falling birth rate (October 2015).</td>
</tr>
</tbody>
</table>
| India | ✷ To save a woman’s life  
✷ To preserve a woman’s physical and mental health  
✷ Resulting from rape or incest  
✷ Serious fetal anomaly  
✷ Contraceptive failure | Up to 24 weeks | Up to 20 weeks – opinion of one registered medical practitioner.  
More than 20 weeks up to 24 weeks – opinion of two registered medical practitioners.  
20–24 weeks – is only for “special categories” as defined by MTP Rules 2021.  
No gestation limit in case of serious birth defect (determined by a medical board beyond 24 weeks).  
**Consent:** By the pregnant woman; if minor (<18 years) or mentally ill, consent of the guardian. |

Continued
<table>
<thead>
<tr>
<th>Country</th>
<th>Conditions permitted</th>
<th>Gestation permitted</th>
<th>Legal provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indonesia</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Pregnancy from rape
- Fetus not medically viable

**Provider:** Obstetricians/gynaecologists (specialists) and MBBS doctors (non-specialist physicians who fulfil training qualifications, as specified in the MTP Act and Rules).

**Method:** Medical methods of abortion and surgical method on clinician’s judgement.

**Place:** All public sector facilities and approved private facilities/clinics.

**Essential medical list:** Mifepristone and misoprostol in the list.

Mostly illegal.

An ethical team of two health professionals (one a medical doctor), at the facility level to

Continued
<table>
<thead>
<tr>
<th>Country</th>
<th>Conditions permitted</th>
<th>Gestation permitted</th>
<th>Legal provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maldives</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Threatens the health of the woman  
- Save life of a pregnant woman  
- Pregnancy from rape (including marital rape)  
- Within 120 days of conception | Consent: By the woman but with spousal authorization; if spouse not available, consent from the paternal father or guardian | legal_provisions: determine eligibility for abortion.  
Consent: By the woman and her husband (except rape victim).  
Provider: Medical doctor (different from the ethical team).  
Method: Not specified.  
Place: Appointed facilities from the Ministry of Health.  
Punishment for providing, assisting in, or supplying information on illegal abortion.  
Essential medical list: Mifepristone and misoprostol not in the list. |
<table>
<thead>
<tr>
<th>Country</th>
<th>Conditions permitted</th>
<th>Gestation permitted</th>
<th>Legal provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pregnancy as a result of rape by incest</td>
<td>Up to 22 weeks of conception</td>
<td>Abortion illegal except when “performed in good faith for the purpose of saving the life of the woman”. Certification/decision of medical board for each case.</td>
</tr>
<tr>
<td></td>
<td>Pregnancy of a minor through rape</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The fetus is a thalassaemia major or a sickle cell major or if the fetus carries a disease that might result in a major permanent disability. Parents must be legally bound by marriage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myanmar</td>
<td>To save the woman’s life</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Myanmar**

- **To save the woman’s life**

- **Up to 22 weeks of conception**

- Abortion illegal except when “performed in good faith for the purpose of saving the life of the woman”.

Certification/decision of medical board for each case.
<table>
<thead>
<tr>
<th>Country</th>
<th>Conditions permitted</th>
<th>Gestation permitted</th>
<th>Legal provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nepal</td>
<td>To preserve physical or mental health of woman</td>
<td>As per indication 12 weeks on request 28 weeks (indications 1–4)</td>
<td>Covered under the Right to Safe Motherhood and Reproductive Health Act, 2018. 12–28 weeks after the opinion of a licensed doctor. Consent up to 12 weeks, with the consent of the woman. Fetus (gestation) up to 28 weeks.</td>
</tr>
</tbody>
</table>

Provider: Under the supervision of an obstetrician and gynaecologist.
Method: Misoprostol only or VA.
Place: Station hospitals, township hospitals, district hospitals and above.
Criminal penalties – against the individual who performs an abortion/ causes a miscarriage.

- To preserve physical or mental health of woman
- Due to rape or incest
- Woman suffering from HIV
- Serious defects in the fetus
- On request up to 12 weeks
<table>
<thead>
<tr>
<th>Country</th>
<th>Conditions permitted</th>
<th>Gestation permitted</th>
<th>Legal provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
<td>✤ To save the mother’s life</td>
<td>No limit</td>
<td>Causing an abortion is a criminal act and a punishable offence.</td>
</tr>
</tbody>
</table>

**Consent:** By pregnant woman; if minor (<18 years) or mentally ill, consent of the guardian.

**Provider:** Specialist, non-specialist MDGP/MBBS, nurses, senior Auxiliary Nursing Midwives (ANMs).

**Method:** Mifepristone + misoprostol up to 10 weeks.

**Place:** Listed facilities (up to 12 weeks) – government, semi-autonomous, non-governmental and private; 12–28 weeks not defined.

**Essential medical list:** Mifepristone and misoprostol in the list.
<table>
<thead>
<tr>
<th>Country</th>
<th>Conditions permitted</th>
<th>Gestation permitted</th>
<th>Legal provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thailand</td>
<td>❖ Save life of a pregnant woman</td>
<td></td>
<td>PAC provided at all health facilities.</td>
</tr>
<tr>
<td></td>
<td>❖ Pregnancy from rape or incest</td>
<td></td>
<td>Incomplete abortions managed by manual vacuum aspiration, dilatation and evacuation, or medication by misoprostol.</td>
</tr>
<tr>
<td></td>
<td>❖ Pregnancy threatens woman’s health</td>
<td></td>
<td>Essential medical list: Misoprostol not in the list.</td>
</tr>
<tr>
<td></td>
<td>❖ Pregnant girl aged under 15 years</td>
<td></td>
<td>Mental health requires certificate/approval.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rape/incest needs evidence.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fetal impairment needs examination and genetic counselling.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Consent:</strong> By the pregnant woman.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Provider:</strong> Medical practitioner is registered and has a licence.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Place:</strong> Medical clinic up to 12 weeks –</td>
</tr>
</tbody>
</table>

Continued
<table>
<thead>
<tr>
<th>Country</th>
<th>Conditions permitted</th>
<th>Gestation permitted</th>
<th>Legal provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>government hospital or government agency or medical infirmary that has overnight facility for stay.Penalties for causing an abortion (with or without the woman’s consent). Essential medical list: Mifepristone and misoprostol in the list.</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>1. To save the woman’s life</td>
<td>Not specified</td>
<td>Requires opinions from three physicians (an exception made by Parliament in 2009). Consent: By the pregnant woman (if possible two days before the abortion). Consent of spouse or partner when possible. In case of minors, consent is given by a legal representative.</td>
</tr>
</tbody>
</table>
FIRST TRIMESTER ABORTION

Continued

<table>
<thead>
<tr>
<th>Country</th>
<th>Conditions permitted</th>
<th>Gestation permitted</th>
<th>Legal provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Delay is suggested where possible, of at least two days between the consent from service providers and the procedure.</td>
</tr>
</tbody>
</table>

Source:

1. Policies, programme and services for comprehensive abortion care in the WHO South-East Asia Region 2021

2. Abortion policy landscape: Bangladesh, Bhutan, Democratic People’s Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste

An enabling regulatory policy and environment is needed to ensure that every woman who can become pregnant and who is legally eligible has access to safe abortion care.

Key message

Laws and policies on abortion should protect women’s reproductive health. It should be ensured that every eligible woman has ready access to safe abortion care. Women-centred CAC should be implemented for providing quality safe abortion. All health-care workers providing CAC should be well versed with the laws of their country concerning CAC. Providers should also make women aware of their human and reproductive rights.
Objective: To provide information to the woman and/or couple for informed decision-making for continuation/termination of pregnancy and post-abortion family planning.

3.1 Definition of counselling
Counselling is a focused, interactive process through which one voluntarily receives support, additional information and guidance from a trained person in an environment that is conducive for sharing thoughts.

It is a two-way communication between a health-care provider and a client, the goal being: facilitating an informed decision-making and addressing concerns of the client.

3.2 Guiding principles of counselling for women seeking first trimester abortion

- Essential elements of counselling are active listening, verbal and non-verbal communication.
- The counsellor should be:
• warm and respectful, communicate in simple language, be a good listener and have a positive non-verbal body language;

• non-judgemental but compassionate without discrimination of the client’s status or reproductive behaviour;

• updated on technical knowledge and skills; and

• aware of national laws and, policies on abortion.

❖ Counselling of a woman should be done at a clean and comfortable place, where confidentiality and privacy is maintained.

❖ Appropriate time for counselling is spent during pre-abortion assessment, during and after the procedure and at the time of discharge.

❖ Local sensitivities regarding gender norms should be considered (e.g. it is appropriate for a male provider who is examining female patients to ensure the presence of female colleagues during examination).

❖ Counselling should be tailored according to the need of the individual.

❖ Clinical communication should be started with issues that are least sensitive and least threatening.

❖ The woman should be encouraged to ask questions. One should rephrase, summarize and clear the doubts and concerns of the woman patiently.
The details of counselling should be recorded in the abortion register and client card.

3.3 Essential components of counselling for first trimester abortion

<table>
<thead>
<tr>
<th>Options of abortion method based on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ Duration of pregnancy</td>
</tr>
<tr>
<td>❖ Woman’s medical condition</td>
</tr>
<tr>
<td>❖ Potential risk factors</td>
</tr>
<tr>
<td>❖ Advantages and disadvantage of each available method</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Option of pain management:</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ Explanation of expected intensity/ duration of pain or menstrual-like cramps</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure details:</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ Details of what will be done before, during and after the procedure</td>
</tr>
<tr>
<td>❖ Any tests that may be performed</td>
</tr>
<tr>
<td>❖ What she is likely to experience (e.g. menstrual-like cramps, pain and bleeding)</td>
</tr>
<tr>
<td>❖ Duration of the process</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk of complications associated with the abortion method:</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ How to recognize potential side-effects and symptoms of pregnancy which may be temporary and where and how to seek help, if required</td>
</tr>
<tr>
<td>❖ Can provide telephonic contact of the facility for emergency</td>
</tr>
<tr>
<td>❖ Failure of abortion</td>
</tr>
</tbody>
</table>
Offer contraceptive choices

- Details of what will be done before, during and after the procedure
- Any tests that may be performed
- When these can be started
- Duration of the process

Provision of additional services:

- Where and how to access services in case of emergency
- Follow-up care including care regarding prevention of unintended pregnancy
- Expected time for return to normal activities including sexual intercourse and follow-up care

3.4 Counselling special groups of women

<table>
<thead>
<tr>
<th>Special group</th>
<th>Challenges</th>
<th>Counselling to be focused</th>
</tr>
</thead>
<tbody>
<tr>
<td>未婚</td>
<td>恐惧缺乏保密性和隐私感</td>
<td>提供信息和教育</td>
</tr>
<tr>
<td>年轻女性</td>
<td>脆弱接受压力</td>
<td>鼓励家长参与通过支持</td>
</tr>
<tr>
<td>年轻女性</td>
<td>第三方授权在青少年中</td>
<td>家长授权不应坚持，除非它是法律要求</td>
</tr>
<tr>
<td>年轻女性</td>
<td>经济限制</td>
<td></td>
</tr>
</tbody>
</table>

Continued
Special group | Challenges | Counselling to be focused
---|---|---
With disadvantage and disabilities | Subjected to coercion and exploitation due to their disability | Information related to support services to be provided and accessibility to those to be facilitated
Living with HIV/AIDS | Stigma and discrimination | Provider to be sensitized about the mode of spread
Facing violence at home | Providers not sensitive enough to the human rights and client’s vulnerability | Referral services for abuse support services to be facilitated

### 3.5 Consent

The informed voluntary consent of an adult woman, or her guardian if minor, should be obtained (Annex 2a and 2b sample information sheet and consent form).

Consent should have documentation regarding the points explained to the woman.

It should be voluntary without any coercion or compulsion.

In case of minors, consent from the guardian is required.
All women seeking abortion services must receive non-judgemental, complete information from a competent provider, to facilitate their decision-making for first trimester abortion. Informed written consent of the adult woman or her guardian if minor, is mandatory for providing abortion services.

Health-care providers should provide empathetic, sensitive, client-centred care ensuring privacy and confidentiality.
Objective: To confirm gestation and location of pregnancy and to evaluate any medical or surgical condition that requires management or may influence the choice of abortion procedure.

4.1 Components of pre-abortion assessment

- Detailed history taking
- General physical and pelvic examination
- Investigations
- Discussion about contraception options
- Informed decision-making by the woman herself informed
### 4.2 Medical history

<table>
<thead>
<tr>
<th>Personal data</th>
<th>◆ Name, age and contact information, if possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons for seeking medical care</td>
<td>◆ Pregnancy symptoms</td>
</tr>
<tr>
<td></td>
<td>◆ Any vaginal bleeding</td>
</tr>
<tr>
<td></td>
<td>◆ Any drug taken for abortion</td>
</tr>
<tr>
<td></td>
<td>◆ If self-abortion was attempted</td>
</tr>
<tr>
<td></td>
<td>◆ Any intervention done for inducing abortion</td>
</tr>
<tr>
<td>Menstrual history</td>
<td>◆ Length and duration of cycle, flow (excessive or normal), regular or irregular</td>
</tr>
<tr>
<td></td>
<td>◆ First date of last menstrual period (LMP) and whether the last period was normal</td>
</tr>
<tr>
<td>Obstetric history</td>
<td>◆ Details of previous pregnancies and their outcomes, including ectopic pregnancy</td>
</tr>
<tr>
<td></td>
<td>◆ Prior miscarriage or abortion, fetal deaths, live births and mode of delivery</td>
</tr>
<tr>
<td>Gynaecological history</td>
<td>◆ Gynaecological issues, including previous gynaecological surgery, history of female genital mutilation, or other known physical abnormalities or conditions</td>
</tr>
<tr>
<td></td>
<td>◆ Contraceptive history:</td>
</tr>
<tr>
<td></td>
<td>• Current contraceptive use</td>
</tr>
<tr>
<td></td>
<td>• Contraceptive methods used in the past and experience (positive or negative) with the methods</td>
</tr>
</tbody>
</table>
### Personal and sexual history
- Any history of smoking, drinking or substance use disorder
- Current partner(s) and whether current partner(s) may have other partner(s)
- History or symptoms of any sexually transmitted infections (STIs) including human immunodeficiency virus/ acquired immunodeficiency syndrome (HIV/ AIDS)

### Surgical/ medical history
- Chronic disease, such as hypertension, seizure disorder, blood-clotting disorders, liver disease, heart disease, diabetes, sickle-cell anaemia, asthma, significant psychiatric disease
- Details of past hospitalizations
- Details of past surgical procedures

### Medications and allergies
- Current and past medication history
- Allergy to medications

### Immunization
- Status of tetanus immunization: last dose received

### Social history
- Marital or partner status
- Family environment: assess family support
- Violence or coercion by partner or family members
- Other social issues that could impact her care
- History and current use of alcohol and illicit drugs
### 4.3 Physical examination (including pelvic examination)

| General health assessment | General appearance  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vital signs</td>
</tr>
<tr>
<td></td>
<td>Signs of weakness, lethargy, anaemia or malnourishment</td>
</tr>
<tr>
<td></td>
<td>Signs or marks of physical violence</td>
</tr>
<tr>
<td></td>
<td>General physical examination (as indicated)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Abdominal examination</th>
<th>Palpate for the uterus, note the size and abdominal tenderness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Note any other abdominal masses</td>
</tr>
<tr>
<td></td>
<td>Note any abdominal scars from previous surgery</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pelvic examination (speculum and bimanual examination)</th>
<th>Explain what she can expect during the pelvic examination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Examine the woman after she has passed urine</td>
</tr>
<tr>
<td></td>
<td>Examine the external genitalia for abnormalities or signs of disease or infection</td>
</tr>
</tbody>
</table>
Speculum examination

- Inspect the cervix and vaginal canal:
  - Look for abnormalities or foreign bodies
  - Look for signs of infection, such as pus or discharge from the cervical os, take sample for culture, if possible and if infection is suspected administer antibiotics
  - Cervical cytology/HPV DNA testing may be performed at this point, if indicated and available

Bimanual examination

- Note the size, shape, position of the uterus – anteverted or retroverted, and mobility of the uterus
- Assessment for adnexal masses
- Assess for tenderness of the uterus on palpation or with cervical movement and/or tenderness of the rectovaginal space (cul-de-sac), which may indicate infection or ectopic pregnancy
Calculation of the gestation period:

**Last normal menstrual period (LMP) known:** One should calculate the number of weeks since the first day of the LMP in a woman with regular cycles.

**LMP not known or irregular cycles:** The gestational age should be determined by physical examination and can be confirmed by ultrasound examination.

*The first trimester is generally considered to be the first 12 weeks of pregnancy*

<table>
<thead>
<tr>
<th>Assessment of uterine size</th>
<th>Weeks since the first day of LMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>After 4 weeks of gestation the uterus increases in size by approximately 1 cm per week</td>
<td>2  4  8  12</td>
</tr>
</tbody>
</table>
### Approximate uterine size

- 6 weeks = Hen’s egg
- 8 weeks = Cricket ball size
- 10 weeks = Asian pear
- 12 weeks = Fundus just palpable above symphysis pubis
- After 12 weeks of gestation

### Assessment of the uterine size and position

- The uterus is out of pelvis >12 weeks
- Retroverted uterus

## Limitation of dating by physical examination

<table>
<thead>
<tr>
<th>Uterus smaller in size than the expected period of gestation</th>
<th>Uterus larger in size than the expected period of gestation</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ Wrong dates of LMP</td>
<td>❖ Wrong dates</td>
</tr>
<tr>
<td>❖ Secondary amenorrhoea/ irregular periods</td>
<td>❖ Multiple pregnancy</td>
</tr>
<tr>
<td>❖ Lactational amenorrhoea</td>
<td>❖ Full bladder</td>
</tr>
<tr>
<td>❖ Ectopic pregnancy</td>
<td>❖ Uterine fibroid/ other tumours</td>
</tr>
<tr>
<td>❖ Spontaneous abortion</td>
<td>❖ Uterine malformations</td>
</tr>
<tr>
<td>❖ Missed abortion</td>
<td>❖ Molar pregnancy</td>
</tr>
<tr>
<td>❖ No pregnancy</td>
<td>❖ Gestational trophoblastic disease (molar pregnancy)</td>
</tr>
<tr>
<td></td>
<td>❖ Pregnancy during lactational amenorrhoea</td>
</tr>
</tbody>
</table>
4.4 Laboratory and other investigations

Routine laboratory testing is not a prerequisite for abortion services.

However, the following investigations may be offered:

<table>
<thead>
<tr>
<th>Investigation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy test</td>
<td>✷ To confirm pregnancy</td>
</tr>
<tr>
<td>Haemoglobin % or haematocrit</td>
<td>✷ Required if treating a woman with bleeding</td>
</tr>
<tr>
<td></td>
<td>✷ Haematocrit for suspected anaemia</td>
</tr>
<tr>
<td>Blood group ABO Rh</td>
<td>✷ Testing of blood group including Rh group typing is not mandatory for first trimester abortion services.</td>
</tr>
<tr>
<td></td>
<td>✷ For both medical and surgical abortions at &lt;12 weeks of gestation, the WHO guidance on abortion 2022 recommends against anti-D immunoglobulin administration.</td>
</tr>
<tr>
<td>HIV test</td>
<td>✷ May be done but not required for women to receive induced abortion services. All standard precautions must be taken during the surgical abortion method.</td>
</tr>
</tbody>
</table>

Key message

One should always be alert about the possibility of ectopic pregnancy as it is a life-threatening condition.
Ultrasound* | Ultrasound should not be a prerequisite for providing abortion services.  
| There may be clinical reasons for using ultrasound scanning prior to abortion.

<table>
<thead>
<tr>
<th>Opportunistic screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>STI screening</td>
</tr>
<tr>
<td>Cancer cervix screening</td>
</tr>
<tr>
<td>Other tests may be performed as per individual risk factors on history and examination</td>
</tr>
</tbody>
</table>

*Ultrasound scanning is not routinely required for the provision of abortion. A scan can help:*

- to identify an intrauterine pregnancy and exclude an ectopic pregnancy;
- to determine gestational age;
- to know the viability of pregnancy;
- to diagnose molar pregnancy; and
- to identify any associated pelvic pathology as uterine fibroid, ovarian cyst, etc.
A separate area should be provided where women seeking abortion can be scanned to maintain privacy and confidentiality.

4.5 Evaluation for contraception

Health-care providers should:

- determine the suitability for the contraceptive method chosen by the woman; and

- counsel effectively to choose a suitable method of contraception.

All the findings from history, examinations and investigations are documented in a woman’s case record and she should be apprised of these findings.

**Key message**

Systematic evaluation of a woman seeking abortion takes into consideration her medical history, physical and pelvic examination and investigations, which are the hallmark of providing safe abortion services. Health-care workers should evaluate the woman seeking first trimester abortion in a protocolized manner and identify high-risk cases.
Objective: To provide a woman seeking abortion a choice of abortion methods that are available, appropriate, based on duration of pregnancy and medical condition.

5.1 Recommended methods of first trimester abortion

- Medical methods of abortion (MMA)
- Surgical methods (vacuum aspiration)
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Medical methods of abortion (MMA)</th>
<th>Surgical methods of abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion induced by medications orally/ sublingually/ vaginally or by the buccal route</td>
<td>Abortion performed using suction evacuation (MVA/EVA)</td>
<td></td>
</tr>
<tr>
<td>Effectiveness</td>
<td>95–99%</td>
<td>95–99%</td>
</tr>
<tr>
<td>Products of conception (POC)</td>
<td>Cannot always be examined</td>
<td>Can always be examined</td>
</tr>
<tr>
<td>Duration</td>
<td>8–13 days</td>
<td>15 min</td>
</tr>
</tbody>
</table>
| Advantages                 | • Avoids surgery mimics the process of spontaneous abortion  
                             • Controlled by the woman and may take place at home  
                             • Can be offered at an early stage  
                             • No anaesthesia required  
                             • Limited infrastructure needed | • Quick procedure  
                             • Complete abortion can be easily verified by evaluation of aspirated POC  
                             • Tubal ligation or placement of an intrauterine device (IUD) can be performed at the same time as the procedure  
                             • Post-procedural bleeding minimal |

Continued
<table>
<thead>
<tr>
<th></th>
<th><strong>Medical methods of abortion (MMA)</strong></th>
<th><strong>Surgical methods of abortion</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Limitations</strong></td>
<td>◆ Takes time (hours to days) to complete abortion (timing may not be predictable)</td>
<td>◆ Only a trained health-care provider can do the procedure</td>
</tr>
<tr>
<td></td>
<td>◆ Women experience bleeding and cramping, and potentially some other side-effects (nausea, vomiting)</td>
<td>◆ Takes place in a health-care facility</td>
</tr>
<tr>
<td></td>
<td>◆ Post-procedural bleeding may be prolonged</td>
<td>◆ Requires instrumentation of the uterus</td>
</tr>
<tr>
<td></td>
<td>◆ May require more clinic visits than the surgical method</td>
<td>◆ Small risk of injury to the uterus or cervix</td>
</tr>
<tr>
<td></td>
<td>◆ There may be side-effects of drugs</td>
<td>◆ Timing of abortion is dependent on the facility and provider</td>
</tr>
<tr>
<td></td>
<td>◆ If pregnancy continues after MMA drugs, pregnancy should be terminated as there is a risk of fetal malformation.</td>
<td></td>
</tr>
<tr>
<td><strong>Preferred method</strong></td>
<td>◆ Severely obese women</td>
<td>◆ There are contraindications to medical abortion</td>
</tr>
</tbody>
</table>

Continued
42 FIRST TRIMESTER ABORTION

Continued

<table>
<thead>
<tr>
<th>Medical methods of abortion (MMA)</th>
<th>Surgical methods of abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ Presence of uterine malformations or fibroids or previous cervical surgery</td>
<td>❖ There are constraints for the timing of the abortion</td>
</tr>
</tbody>
</table>

Contraindications

| ❖ Previous allergic haemorrhagic disorder                                                      |
| ❖ Severe anaemia                                                                               |
| ❖ Pre-existing heart disease                                                                   |
| ❖ Reaction to one of the drugs involved                                                        |
| ❖ Inherited porphyria                                                                          |
| ❖ Chronic adrenal failure                                                                      |
| ❖ Known or suspected ectopic pregnancy                                                          |
| ❖ There are no known absolute contraindications                                                |
### 5.2(a) Eligibility of the provider for medical/surgical method of first trimester abortion

<table>
<thead>
<tr>
<th>Cadre of health-care providers</th>
<th>Provide information</th>
<th>Provision of counselling</th>
<th>Medical method &lt;14 weeks</th>
<th>Surgical method VA &lt;14 weeks</th>
<th>Cervical priming with medication prior to surgical abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health worker</td>
<td>Recommend</td>
<td>Recommend</td>
<td>Recommend</td>
<td>–</td>
<td>Suggest</td>
</tr>
<tr>
<td>Pharmacy worker</td>
<td>Suggest</td>
<td>Suggest</td>
<td>Recommend</td>
<td>–</td>
<td>Suggest</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>Recommend</td>
<td>Suggest</td>
<td>Recommend</td>
<td>–</td>
<td>Suggest</td>
</tr>
<tr>
<td>Traditional and complementary medical professional</td>
<td>Recommend</td>
<td>Recommend</td>
<td>Recommend</td>
<td>Recommend*</td>
<td>Recommend</td>
</tr>
<tr>
<td>ANMs</td>
<td>Recommend</td>
<td>Recommend</td>
<td>Recommend</td>
<td>Suggest</td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>Recommend</td>
<td>Recommend</td>
<td>Recommend</td>
<td>Recommend*</td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td>Recommend</td>
<td>Recommend</td>
<td>Recommend</td>
<td>Recommend*</td>
<td>Recommend</td>
</tr>
<tr>
<td>Associated/advance associated clinicians</td>
<td>Recommend</td>
<td>Recommend</td>
<td>Recommend</td>
<td>Recommend</td>
<td></td>
</tr>
<tr>
<td>General medical practitioner (GMP)</td>
<td>Recommend</td>
<td>Recommend</td>
<td>Recommend</td>
<td>Recommend</td>
<td></td>
</tr>
<tr>
<td>Specialty medical practitioner</td>
<td>Recommend</td>
<td>Recommend</td>
<td>Recommend</td>
<td>Recommend</td>
<td></td>
</tr>
</tbody>
</table>

*Only after task-specific training*

Source: WHO Abortion Care Guideline 2022

The country’s policies and guidelines on eligible service providers to provide medical methods/surgical method must be followed.
5.2(b) Eligibility of the site where MMA/ surgical method can be provided

- Services should be available at the primary-care level, with a referral system in place for all requiring higher-level care.

- There should be a place where the woman can be counselled and provided with information, maintaining privacy and confidentiality.

- Surgical abortion should be provided at a place where resuscitation in case of emergencies and provision of sterilization of equipment are available.

- Additional services should be available to individuals seeking abortion as:
  - iron tablets for anaemia;
  - necessary pain medication; and
  - emotional support.

- Referral facility for other services including complications of abortion should be available if required:
  - physical/ sexual abuse support;
  - counselling and testing for sexually transmitted infections (STIs, HIV);
  - psychological or social support; and
  - other medical/ surgical specialties.

A country’s guidelines and protocols for approval of abortion facilities and protocol for MMA/ surgical abortion (VA) should be followed.
### 5.3 Abortion method in pre-existing medical/surgical conditions

<table>
<thead>
<tr>
<th>Pre-existing condition</th>
<th>Medical method</th>
<th>Surgical method</th>
<th>Remarks</th>
</tr>
</thead>
</table>
| Hypertension           | Yes, in controlled, No, in uncontrolled | Yes | - Hypertension should be controlled  
- The usual dose of antihypertensive on the day of the abortion procedure to be taken |
| Anaemia                | Yes            | Yes            | Surgical abortion in severe anaemia can be done only with availability of blood transfusion at the facility |
| Diabetes               | Yes            | Yes            | Morning dose of medication is taken before the procedure |
| Heart disease          | No             | Yes            | Support of cardiologist/physician should be available |
| Asthma                 | Yes            | Yes            | Woman should not have an acute asthmatic attack prior to the procedure |
| Epilepsy               | Yes, in controlled, No, in uncontrolled | Yes | Usual dose of antiepileptic on the day of the abortion procedure to be taken |

Continued
### Key message

Recommended methods of first trimester abortion are either medical or surgical methods. The woman’s decision should be respected regarding the choice of the method and clinical status. Medical methods or surgical methods both should conform to the country’s medicolegal framework.

Health-care providers should inform the woman seeking first trimester abortion about the methods available and the criteria to choose a particular method.

<table>
<thead>
<tr>
<th>Pre-existing condition</th>
<th>Medical method</th>
<th>Surgical method</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood-clotting disorders</td>
<td>No</td>
<td>Yes</td>
<td>❖ At a facility that is equipped to manage severe haemorrhage, anticoagulant to be stopped 48 hours prior to the procedure</td>
</tr>
<tr>
<td>Previous caesarean section/scarred uterus/myomectomy</td>
<td>Yes</td>
<td>Yes</td>
<td>❖ Woman can be admitted on clinician’s advice</td>
</tr>
<tr>
<td>IUD in situ with pregnancy</td>
<td>Yes</td>
<td>Yes</td>
<td>❖ Thread seen – IUD should be removed before the procedure ❖ Thread not seen – IUD should be removed during MVA; otherwise evaluate with USG</td>
</tr>
</tbody>
</table>
Objective: To provide a medical method of abortion (MMA) to a woman seeking first trimester abortion.

MMA using mifepristone + misoprostol or misoprostol alone is one of the non-invasive, safe technologies for abortion care. The method can be used for:

- induced abortion;
- incomplete abortion; and
- missed abortion.

MMA comes under the purview of abortion laws of the country, which should be strictly followed as per the country’s guidelines and protocols.

6.1 Method-specific counselling

Women choosing MMA should be provided the following information:

- The process is similar to a natural miscarriage.
- She should be counselled about different routes of administration.
- She has to follow a definite drug protocol.
If a woman is lactating, she should withhold breastfeeding for 4 hours after misoprostol administration.

Home administration of misoprostol can be allowed (provider’s discretion).

She has to stay within the accessible limits of the appropriate health-care facility. She should not be left unattended at home.

She has to be ready for surgical procedure in case of failure of the method or excessive bleeding.

The symptoms that would be experienced by her should be explained, e.g. pain, expected bleeding pattern, etc.

There could be teratogenic (harmful) effect on the fetus, if pregnancy continues after MMA especially with misoprostol.

A small percentage of women (3%) may expel products with mifepristone alone, but a total drug schedule with misoprostol must be completed.

During the abortion process, it is ideal to avoid intercourse to prevent infection, or use barrier methods.

The woman should have arrangements for transportation to the hospital in case of emergency or she should be admitted for the MMA procedure.

**Voluntary informed consent should be taken for MMA after counselling the woman.**
6.2 Clinical considerations for medical abortion

- Medical abortion is a multi-step process involving two medications (mifepristone and misoprostol) and/or multiple doses of one medication (misoprostol alone).

- Mifepristone with misoprostol is more effective than misoprostol used alone, and is associated with fewer side-effects.

- Vaginal misoprostol is more effective than oral administration, and may have fewer side-effects than sublingual or buccal.

- Allowing home use of misoprostol following the provision of mifepristone at a health-care facility can improve the privacy, convenience and acceptability of services, without compromising on safety.

6.3 Drugs for MMA

Regimens recommended can be:

- sequential use of tablet mifepristone followed by misoprostol;

- tablet misoprostol can be used alone; and

- a combination of letrozole plus misoprostol is also suggested.
6.4 Pharmacokinetics of drugs

**Tablet mifepristone**

- Mifepristone is an antiprogestin. It inhibits action of progesterone. It interferes with continuation of pregnancy by withdrawing progesterone support.
- Mifepristone is always administered orally.
- It is available as 200 mg tablet.

**Tablet misoprostol**

- Misoprostol causes cervical softening, uterine contractions, expulsion of products of conception (POC).
- It can be used either in combination with mifepristone or alone.
- It is easy to handle and store in a dry place at or below 25 ºC.
- It is stable at room temperature.
- It can be administered by oral, vaginal, buccal and sublingual routes (side-effects and instructions for use through different routes differ).
- It is available as 25, 100, 200 mcg tablets.

**Key message**

Letrozole is a third-generation aromatase inhibitor and its action is to suppress estrogen production.

The use of letrozole in combination with misoprostol showed higher rates of successful medical abortions.
Buccal and sublingual routes of misoprostol administration

Pharmacokinetics of misoprostol

<table>
<thead>
<tr>
<th>Route</th>
<th>Onset of action</th>
<th>Duration of action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>8 min</td>
<td>2 hours</td>
</tr>
<tr>
<td>Sublingual</td>
<td>11 min</td>
<td>3 hours</td>
</tr>
<tr>
<td>Vaginal</td>
<td>20 min</td>
<td>4 hours</td>
</tr>
<tr>
<td>Rectal</td>
<td>100 min</td>
<td>4 hours</td>
</tr>
</tbody>
</table>

Source: Tang et al., Int J Gynecol Obstet. 2007;99:S160–S167

6.5 Drug regimen for induced first trimester abortion

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Dose</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mifepristone + misoprostol</td>
<td>Mifepristone 200 mg PO 1–2 days later Misoprostol 800 μg B, PV or SL</td>
<td>Minimum interval between mifepristone and misoprostol should be 24 hours.</td>
</tr>
<tr>
<td>Misoprostol</td>
<td>800 μg B, PV or SL</td>
<td>Repeat dose of misoprostol can be considered when needed.</td>
</tr>
<tr>
<td>Mifepristone + letrozole</td>
<td>Letrozole 10 mg daily for three days followed by misoprostol 800 mcg sublingually on the fourth day</td>
<td>Suggested by WHO, further evidence needed.</td>
</tr>
</tbody>
</table>

PO: per oral; B: buccal; PV: vaginal; SL: sublingual
Combination regimen of mifepristone and misoprostol is recommended as it is more effective.

There is no change in dosage of misoprostol as per gestational age of pregnancy, previous guidance advocated different regimens, which varied up to 7 weeks, 9 weeks and 12 weeks.

There is no evidence and guidelines for maximum number of doses of misoprostol. Health-care providers should use caution and clinical judgement.

Moistening of misoprostol tablets is not recommended as it does not improve their efficacy.

**Source:** Abortion Care Guidelines WHO, 2022

### 6.6 Medical management of incomplete abortion

For medical management of incomplete abortion at first trimester, the recommendation is: 600 \( \mu g \) misoprostol administered orally or 400 \( \mu g \) misoprostol administered sublingually.

### 6.7 Medical management of missed abortion

Medical management can be recommended: Dosage and administration of the drug regimen (mifepristone and misoprostol) used is the same as that of first trimester induced abortion.
If using the alternative regimen (misoprostol alone), repeat dosing of misoprostol is more efficacious at >9 weeks of gestation.

Ectopic pregnancy: Mifepristone and misoprostol do not terminate ectopic pregnancy.

6.8 Antibiotic prophylaxis for medical abortion
Antibiotic prophylaxis for medical abortion is not recommended.

6.9 Rh isoimmunization
WHO guidance on abortion, 2022, recommends against anti-D immunoglobulin administration for medical abortions at <12 weeks of gestation.

6.10 Pain management
- During abortion, pain management should be offered routinely and to be provided for the individual to use if and when required.
- Analgesia NSAIDs, e.g., ibuprofen 400–800 mg.
- Acetaminophen can be considered if NSAIDs are not available or not the option.
- Hot water bottle or heating pad can be advocated.
- Verbal support and reassurance and thorough explanation of what to expect is helpful in reducing the perception of pain.
6.11 Expected symptoms after administration of MMA drugs

Expected symptoms are usually self-limiting:

- Bleeding soaking of two thick pads within 1–2 hours after taking misoprostol is normal bleeding; more than this warrants medical attention;
- Pain/ cramps in the abdomen;
- Fever/ chills/ rigors;
- Nausea or vomiting;
- Diarrhoea;
- Headache; and
- Dizziness.

6.12 Success of medical abortion

- Combination of mifepristone and misoprostol has an effectiveness of 95–99% for termination of early pregnancy.

- Success of medical abortion is determined by signs and symptoms as experienced by the individual:
  - bleeding with clots;
  - passage of products of conception (POC); and
  - pain that may be significantly stronger than menstrual pain.
If ongoing symptoms of pregnancy are reported and/or there has been minimal bleeding or no bleeding after taking the medications as directed ongoing pregnancy should be suspected and further evaluation should be done by pelvic examination (demonstrates growing/same size uterus) or by ultrasonography.

6.13 Follow up after first trimester MMA

Routine follow-up not necessary following an uncomplicated medical abortion using mifepristone and misoprostol. Routine follow-up visit is recommended only in case of medical abortion using misoprostol alone to assess the completion of abortion.

Optional follow-up visits at 7–14 days may be provided after the procedure to provide contraceptive counselling and services, emotional support or address any medical concern.

A woman’s recovery and risk for any signs or symptoms of ongoing pregnancy should be explained to her.

Any symptom experienced since the procedure performed should be reviewed and a focused physical examination should be performed for any complaints.

The woman should be informed that fertility may return as early as 8–14 days after medical abortion.

Telephone number of the facility should be provided to the woman to contact in case of any emergency.
6.14 Warning symptoms after first trimester MMA

- Excessive bleeding (soaking two or more pads per hour for two consecutive hours)
- Fever lasting >1 day with or without chills
- Worsening pelvic pain
- Signs of pregnancy as continued nausea and vomiting

6.15 Side-effects and complications of MMA and their management

<table>
<thead>
<tr>
<th>Bleeding</th>
<th>Reassurance if it is within normal limits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If bleeding is more than expected, then evaluation to be done for incomplete abortion</td>
</tr>
<tr>
<td></td>
<td>Vacuum aspiration is advocated for profuse bleeding (incomplete abortion)</td>
</tr>
<tr>
<td></td>
<td>If there is evidence of haemodynamic compromise, intravenous (IV) fluids should be started</td>
</tr>
<tr>
<td></td>
<td>Blood transfusion, if required (rare)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fever</th>
<th>Antipyretic drugs, such as paracetamol</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Repeated doses of misoprostol may cause rise in temperature</td>
</tr>
</tbody>
</table>
6.16 Management of failure of abortion following MMA

- For failure of MMA, one should evaluate if the drugs were taken as directed.
- Either vacuum aspiration or repeat medical method of abortion is advocated.

6.17 Management of incomplete abortion following MMA

- Incomplete abortion can be diagnosed by the clinical presence of open cervical os and bleeding whereby all
POC have not been expelled from the uterus. Common symptoms are:

- vaginal bleeding;
- abdominal pain;
- POC may be visualized or felt at the os; and
- expelled tissue is not consistent with the estimated period of gestation of pregnancy.

The mode of management of incomplete abortion should be based on the individual’s clinical condition and preference of treatment.

For incomplete abortion in first trimester, either vacuum aspiration or medical management is advocated.

The recommended dose for first trimester incomplete abortion is: 600 μg misoprostol administered orally, or 400 μg misoprostol administered sublingually.

Expectant management of incomplete abortion can be tried; however, the possibility of continuous bleeding and pelvis sepsis remains.
Management of failure or incomplete abortion following MMA

![Flowchart illustrating management of failure or incomplete abortion following MMA]

**6.18 Recording and reporting for MMA**

MMA comes under the purview of abortion laws of the country and documentation and reporting should be as per country’s legal provisions.

- Recording of MMA in the hospital abortion records, register for case records, is mandatory.
MMA data should be included in the monthly reporting format with other hospital reports and should be shared with district/province government authorities.

The MMA data should be entered in the government’s health management information system (HMIS) data for inclusion in the global data of MMA and abortions.

**Key message**

MMA can be performed by tablets mifepristone, misoprostol combination or misoprostol alone for less than 12 weeks pregnancy. Counselling and ruling out contraindications is mandatory before initiating MMA. The woman must provide informed voluntary written consent for MMA. For all the regimens, healthcare providers should be aware of the side-effects, expected symptoms, outcome and complications of MMA. Management should be as per country’s protocol and legal framework.
Objective: To provide a surgical method of first trimester abortion.

Vacuum aspiration is the recommended technique of surgical abortion for pregnancies up to 12 weeks. The method can be used for:

- induced abortion;
- incomplete abortion; and
- missed abortion.

Surgical abortion using vacuum aspiration (VA) comes under the purview of abortion laws of the country, which should be strictly followed as per country’s guidelines and protocols.

7.1 Method-specific counselling

- The procedural details of what will be done before, during and after the procedure must be explained to the woman.
- She is likely to experience pain, and pain management options should be provided to her.
Type of anaesthesia – paracervical block – how it will be administered and any complications as anaphylaxis can occur.

Since it is an invasive procedure, there can be complications as perforation, injury to other organs as bladder/ intestine, etc., and laparotomy may be required.

**Voluntary informed consent should be taken for surgical abortion after counselling the woman.**

### 7.2 Clinical considerations for surgical abortion

- Surgical abortion by dilatation and sharp curettage (D&C), including sharp curette checks (i.e. to “complete” the abortion following vacuum aspiration) is not recommended.

- WHO recommends manual vacuum aspiration (MVA) as the safest method for abortion up to 12–14 weeks of size.

- Routine use of general anaesthesia is not recommended for VA in first trimester abortion.
### 7.3 Equipment for vacuum aspiration

<table>
<thead>
<tr>
<th>Manual vacuum aspiration (MVA)</th>
<th>Electric vacuum aspiration (EVA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✷ Hand-held aspirator used to generate vacuum</td>
<td>✷ Electricity used to generate vacuum</td>
</tr>
<tr>
<td>✷ Aspirator is attached to a cannula of 4–12 mm in diameter</td>
<td>✷ Electric vacuum is attached to a cannula of 4–12 mm in diameter</td>
</tr>
</tbody>
</table>

**MVA syringe and cannula**

**EVA**

The procedure of abortion performed is same regardless of the type of vacuum used.
### 7.4 Instruments required for vacuum aspiration

- Sims’ speculum/
  Cusco’s speculum/
  Auvard’s speculum and
  anterior vaginal wall
  retractor

- Tenaculum/ vulsellum

- Dilators

- Manual vacuum aspirator (with a cannula up to 12 mm, electric vacuum aspirator for backup)

- Sponge holding forceps

- Small ovum holding forceps

- Stainless steel bowl for preparing solutions

- Instrument tray

- Clear glass dish/
  light box for tissue
  inspection

- Strainer (metal, glass or gauze)
7.5 Cervical priming prior to surgical procedure

- May be considered to prepare the cervix.
- Some recommended methods of cervical preparation prior to first trimester surgical abortion can be:
  - Oral mifepristone 200 mg (24–48 hours in advance);
  - Misoprostol 400 μg sublingually 1–2 hours before the procedure;
  - Misoprostol 400 μg vaginally or buccally 2–3 hours prior to evacuate procedure; and
  - Use of osmotic dilator for cervical priming in first trimester is not recommended.

7.6 Pain management plan for surgical abortion

<table>
<thead>
<tr>
<th>Non-pharmacological</th>
<th>Pharmacological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respectful, non-judgemental communication</td>
<td>Pain management should be offered routinely and should be provided to those who want it</td>
</tr>
<tr>
<td>Verbal support and reassurance</td>
<td>Analgesia (non-steroidal anti-inflammatory drugs [NSAIDs], e.g. ibuprofen</td>
</tr>
<tr>
<td>Gentle, smooth operative technique</td>
<td></td>
</tr>
</tbody>
</table>

Continued
| Information of each step of the procedure | 400–800 mg) to be given 30–45 minutes prior to the procedure |
| Encouraging deep, controlled breathing | Paracervical block** |
| Encourage listening to music | Conscious sedation+ [S8] paracervical block should be offered wherever conscious sedation is available |
| Use of hot water bottle or heating pad |

+Conscious sedation is a combination of medicines for relaxation (a sedative) and to block pain (an anaesthetic) during a medical procedure. Diazepam or midazolam can be used as they have both the effects.

**Paracervical block**

- A 10 mL syringe, with 22–24 gauge needle, is loaded with 1% plain lignocaine (10 mL).

- There is enough evidence that a sensitivity test before administering local anaesthesia is not mandatory.

- 2 mL of the solution is injected superficially into the cervix at 12 o’clock for placing the tenaculum.

- The cervix is grasped with the vulsellum/ tenaculum and slight traction is applied to expose the area between the smooth cervical epithelium and the vaginal tissue.
The remaining 8 mL is injected in equal amounts at the cervicovaginal junction at 4 and 8 o’clock position at a depth of 2–3 mm. 10 and 2 o’clock positions can be additional optional sites for injection.

One should always aspirate to check, whether inadvertently any vessel is entered into.

The maximum dose of lidocaine in paracervical block is 4.5 mg/kg/dose or generally 200–300 mg (approximately 20 mL of 1% or 40 mL of 0.5%).

Rarely, there can be anaphylaxis to local anaesthetics. Small bolus doses of 0.5 mL of 1:1000 adrenalin should be administered. Dose can be repeated at five-minute intervals.

7.7 Antibiotic prophylaxis

Antibiotic prophylaxis should be provided for first trimester vacuum aspiration.

Single-dose administration of nitroimidazoles, tetracyclines or penicillin has been shown to be effective.

7.8 Anti–D prophylaxis after first trimester abortions

Administration of the immunoglobulin to Rh-negative women is not recommended for medical/ surgical abortion of <12 weeks.
7.9 Infection prevention practices for surgical abortion

All standard precautions for infection prevention should be followed throughout the procedure (see chapter 8 infection prevention).

7.10 Steps of surgical abortion <12 weeks of pregnancy

1. Preparation of the instruments
   - The equipment for MVA should be assembled and charged (Annex 3).
   - One should check that aspirator retains vacuum.
   - If using an EVA, machine should be checked if it is functional.

2. Preparation of the woman for the procedure
   - The woman is asked to empty her bladder and is helped into the dorsal lithotomy position on the procedure table.
   - The provider should wash hands, and put on appropriate barriers, including clean gloves.
The surgical field is prepared with all standard precautions for infection prevention (chapter 8 infection prevention).

3. **Bimanual examination** is performed to:
   - determine the uterine size; and
   - determine the position of the uterus.

4. **Speculum insertion**: The speculum is introduced gently to ensure adequate visualization of the cervix.

5. **Cervical anti-septic preparation**: The cervix is wiped with a non-alcoholic antiseptic solution starting at the cervical os with each new sponge wiping from inward to outward direction circularly until the os has been completely covered by the antiseptic solution.

6. **Paracervical block** is given using 10 mL of 1% lignocaine (or one can proceed to step 7 directly).

7. **Cervical dilatation**: The cervix is stabilized by placing the tenaculum on the anterior cervical lip and continuous traction is applied to straighten the cervical canal.
Dilatation of the cervix is assessed (if cervical priming has been done) to see if cervical os allows a cannula of appropriate size. The dilatation of the cervix should be 1 mm more than the size of the cannula needed for that gestation.

If the cervix is closed or insufficiently dilated, then dilatation is done gently without using force and applying the no-touch technique, with successive mechanical dilators, starting with the smallest.

8. **Suction cannula insertion:** When appropriate cervical dilatation is achieved, the cannula of selected size as per gestational age is inserted just past the internal cervical os and into the uterine cavity, while gently applying traction to the cervix. The cannula should not be inserted forcefully, to avoid trauma to the cervix or uterus.

*The procedure should be stopped if uterine perforation is suspected.*
### Selecting the cannula size

<table>
<thead>
<tr>
<th>Uterine size (week since LMP)</th>
<th>Suggested cannula size (mm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4–6</td>
<td>4–7</td>
</tr>
<tr>
<td>7–9</td>
<td>5–10</td>
</tr>
<tr>
<td>9–12</td>
<td>8–12</td>
</tr>
</tbody>
</table>

Using a too-small cannula may result in incomplete abortion, retained product of conception and frequent clogging of cannula during the procedure.

### Uterine perforation

- There is a feeling of something giving away.
- There is sudden loss of resistance during cervical dilatation or vacuum aspiration.
- The instrument passes well beyond the expected length of the uterus.
- The woman has severe pain or persisting PV bleeding.
- There is an absence of POC in MVA syringe/suction bottle.

---

### 9. Aspiration of uterine contents

The suction cannula is held in one hand and the prepared manual vacuum aspirator/electric vacuum connector is held in other hand and both are connected. The cannula is advanced to mid-uterus and the MVA/EVA are connected.
The suction is initiated by

- MVA – releasing of the valve which leads to the creation of vacuum (Annex 3).
- EVA – after pressure of 60 cmHg is created.

The contents of the uterus are evacuated gently and slowly, rotating the cannula in 180° in each direction. Blood and tissue are visible through the cannula. The opening of the cannula should not be withdrawn beyond the cervical os, otherwise suction gets lost.

If the MVA aspirator becomes full, the aspirator is detached from the cannula, leaving the cannula in the uterus, the aspirator is emptied into an appropriate container, and the vacuum is re-established. This procedure is repeated until the uterus is empty.

Signs of the completion of the procedure:

- red or pink foam appears, and no more tissue is seen passing through the cannula;
- a gritty sensation is felt as the cannula passes along the surface of the evacuated uterus; and
- the uterus contracts around the cannula.
When the procedure is complete, the cannula and cervical tenaculum are removed. The cervix is wiped with a clean swab and bleeding is assessed.

**The practice of dilatation and sharp curettage (D&C), including sharp curette checks (to complete the abortion) following vacuum aspiration is not recommended.**

Disposable cannula should be discarded in the appropriate waste bin for contaminated plastic as per national guidelines.

MVA aspirators and the cannula that will be reused should be kept wet until cleaning. These should be pre-soaked, rinsed or sprayed with water or enzymatic spray. One should not use chlorine or saline.

**10. Inspection of the tissue**

Inspection of the POC is important; to inspect the tissue, the uterine aspirate is emptied into an appropriate container (aspirated contents should not be pushed through the cannula, as it will become contaminated).

The quantity and presence of POC: villi, decidua and sac/membrane should be assessed; after 9 weeks gestation, fetal parts are visible.

One should see for the presence of grape-like hydropic villi, the presence of these may suggest
a molar pregnancy. The tissue must be sent for histopathological examination if molar pregnancy is suspected.

- If the visual inspection is inconclusive, the tissue should be strained, placed in a transparent container, immersed in water, and viewed with light from beneath.

- If no POC are visible or the tissue removed is less than expected for that gestational age, evaluation should be done for incomplete abortion/failed abortion/ectopic pregnancy/uterine anomaly (in a bicornuate or septate uterus, the cannula may have been inserted into the side of the uterus that did not contain the pregnancy).

- Disposal of aspirate: POC and aspirates should be disposed of in the appropriate waste bin for contaminated biological material as per national guidelines.

11. Concurrent procedures

When the aspiration procedure is complete, one should proceed with any concurrent procedure to be conducted such as IUD insertion, tubal ligation or repairing a cervical laceration, as necessary.

12. Recovery and discharge

a) Immediate post-procedure care

- The woman should be reassured that the procedure is finished and that she is no longer pregnant.
Vitals are monitored for any complications and management is provided as needed. In case of tachycardia or hypotension, the woman should be urgently reviewed and managed.

She should be evaluated for bleeding per [S9] vagina and for abdominal pain, which should decrease over time.

The recovery period may last for 30 min to one hour if procedure is done under local anaesthesia or may require longer if sedation or general anaesthesia is used. The woman may leave the facility when she is stable.

Any emotional need of the woman should be assessed. Her anxiety immediately following the abortion should be addressed.

All outcomes of the treatment, including any adverse events should be documented.

b) Before discharge

If the woman has any signs of complications such as fever, excessive bleeding or foul-smelling discharge, evaluation should be done and should be managed at the facility and discharge should be delayed.

The woman should be provided with all the necessary medications before discharge. Pain medications can be provided such as NSAIDs or acetaminophen.

Before the woman leaves the facility, clear, simple oral and written instructions should be provided.
including instructions on diet (normal diet) and sexual intercourse (only after heavy bleeding stops).

- If any concurrent contraception is provided, instructions regarding that should be given.

- The phone number of the facility should be provided so that women may call for questions or concerns and can get appropriate guidance.

7.11 Expected symptoms after discharge

- Nausea and vomiting generally subside within 24 hours after surgical abortion.

- Cramping may occur which may be reduced with NSAIDs such as ibuprofen.

- Light vaginal bleeding or spotting for 2 weeks after completed surgical abortion is normal.

7.12 Warning symptoms

- Heavy vaginal bleeding

- Signs of pregnancy as a continuation of nausea or vomiting

- Increased intensity of cramping or abdominal pain

- Fever >38 °C at least at the interval of 4 hours
7.13 Follow-up visits after first trimester surgical abortion

- Routine follow-up visit after a surgical abortion is not recommended.

- Optional follow-up visits at 7–14 days can be considered for providing psychological support and advice on contraceptive use.

- The woman should be evaluated if:
  - she has continued nausea and vomiting (symptoms of ongoing pregnancy);
  - heavy bleeding;
  - no bleeding at all;
  - pain not relieved by medication;
  - dizziness, fainting attack; and
  - fever.

- Iron tablets should be given with instructions to use in cases of anaemia.

- The woman should be informed that decision to start contraceptives is important as:
• fertility can return as soon as 2 weeks after abortion; and

• emergency contraception should be provided for dual protection.

Referral to other services should be facilitated as per the assessment of her needs:

• STI/ HIV counselling and testing; and

• abuse support services (gender-based violence [GBV]), psychological or social services.

Key message

Vacuum aspiration (VA) is the safest method of first trimester abortions. The procedure should be performed by a trained provider after informed written consent of the woman seeking abortion. Asepsis should be maintained and standard protocol should be followed at every step.

Health-care providers should be well trained in the task of surgical methods of abortion. Providers should explain to the woman undergoing the procedure when to report back to the health-care facility.
Objective: To learn infection prevention measures while caring for the patient in the health-care facility or during a surgical procedure, and also learn how health-care providers should protect themselves while caring for the patient.

8.1 Sources of infection

- **Endogenous source:** Microorganisms present on or within the patient.

- **Exogenous source:** External to the patient such as health workers, visitors, patient-care equipment, medical devices, and the health environment.

8.2 Transmission

Hands, droplet, instruments, blood

8.3 Infection prevention

**Standard precautions:** All patients irrespective of their status are considered as potentially infected. Standard precautions are basic level precautions, when implemented and practised correctly and consistently at all times can reduce hospital-acquired infections (HAIs).
Transmission-based precautions (TBPs) are used in addition to standard precautions when standard precautions alone may be insufficient to prevent transmission of infection.

TBPs are used for patients known or suspected to be infected or colonized with epidemiologically important or highly transmissible pathogens that can transmit or cause infection as global pandemics (COVID-19, SARS-CoV-1, SARS-CoV-2 and MERS-CoV).

8.4 Elements of standard precautions

- Hand hygiene
- Respiratory hygiene (etiquettes)
- Personal protective equipment/attire (PPE) according to the risk
- Safe injection practices, sharp management and injury prevention
- Safe handling, cleaning and disinfection of patient care equipment and instrument processing
- Environmental cleaning
- Safe handling and cleaning of soiled linen
- Waste management
8.4(i) **Hand hygiene (Annex 4a)**

- Hand washing with soap and water (40–60 seconds).
- Hand rubbing with alcohol-based hand rub (20–30 seconds) (Annex 2.2).

**When to perform hand hygiene**

- Before and after examining the woman (or having any direct contact).
- After exposure to blood or any body fluids (secretions or excretions), even if gloves were worn.
- After removing gloves because the gloves may have holes in them.

**Alcohol-based hand rub is the gold standard in all clinical situations (WHO).**

**Hand scrubbing**

The hands should be scrubbed before wearing gloves when performing surgical abortion.

8.4(ii) **Respiratory hygiene (etiquettes)**

- Maintaining at least a 1-metre (3-feet) distance from other individuals in common waiting areas.
- Covering mouth/ nose when sneezing/ coughing.
Performing hand hygiene after soiling hands with respiratory secretions.

Apply additional disease-specific TBPs as needed.

8.4 (iii) **Personal protective equipment/ attire (PPE) (Annex 4b)**

PPE acts as a barrier between the direct contract of the health-care provider and the client.

These are: Cap, mask, goggles, gown, gloves, apron and footwear.

**Country-specific guidelines for PPE during any health emergencies must be followed.**

8.4 (iv) **Processing instruments**

It is important to have clean, germ-free instrument for each client to prevent infection transmission. Therefore, after each procedure and at the end of each day the used instruments must be processed and stored to keep them ready for the next day.

Disposable instruments/ equipment should not be used again.

**Steps of processing** used or contaminated instruments:

- Pre-cleaning soiled instruments before washing.
- Washing with detergent and water.
- High-level disinfection (HLD) or sterilization.
- Storage.

**Pre-cleaning**

- After using instruments, they should be opened if they have lock/ teeth/ hinges (vulsellum, sponge holder). The MVA syringe should be disassembled.
- Instruments should be kept moist till processing so as not to allow contaminants to dry because drying will hinder cleaning of instruments.
- The instruments can be kept moist by putting in water (saline not used), by covering with a moist towel soaked with water or foam, spray or gel specifically intended for this purpose.
- Instruments should be cleaned by wiping with a damp clean cloth before washing.

**Instruments should not be soaked in disinfectant (0.5% chlorine) prior to cleaning because:**

- The instruments get damaged by the action of bleach solution.
- Any blood and body fluid has the potential to inactivate the disinfectant.
- This may contribute to the development of antimicrobial resistance to disinfectants.
Washing with detergent and water

- After pre-cleaning, all surfaces of instruments are washed in running water and with a detergent.
- A soft brush is used; nothing sharp or pointed should be used.
- Cleaning is done until no blood or tissue is visible.
- After washing, instruments are sent for sterilization or HLD.

Sterilization/ high-level disinfection (HLD)

- Sterilization is a process that destroys all microorganisms (such as bacteria, viruses, fungi, and parasite/ protozoa) including bacterial endospores.
  - Technically, there is a reduction $\geq 10^6$ log colony forming units (CFU) of the most resistant spores.
  - It can be done by using steam (autoclaving at 15 lb/sq inch pressure for 20 minutes for unwrapped and 30 minutes for wrapped instruments and linen).
  - It can also be done by soaking in a chemical solution such as 2% glutaraldehyde solution for at least 8 hours.
- HLD is a process that destroys all microorganisms excluding bacterial endospores.
• Technically able to kill 106 log microorganisms except for spores and is acceptable for processing instruments and other items for reuse.

• If sterilization is not possible, HLD can be achieved by boiling.

• It can also be done by soaking in a high-level disinfectant for 20 minutes such as 2% glutaraldehyde solution.

**Storage**

- Autoclaved instruments should be stored in drums with closed lids. If they are not used, they should be autoclaved again after 7 days.

- The date of sterilization should be marked on the tray/drum.

- HLD instruments if not used should be disinfected after 24 hours.

- Instruments should be stored when dry; wet instruments can generate microbial growth.

**8.4 (v) Safe injection practices, sharp management and injury prevention**

- Recapped, bent or broken before disposal, they are made unusable after single use by burning them in a needle destroyer and/or in hub-cutter.
Syringes should never be burnt. They are disposed of in red coloured bins or, if the needle is attached, in a puncture-proof container.

Broken glassware is disposed of in cardboard boxes with a blue-coloured marking.

Do not reuse disposable syringes or needle.

Always wear gloves for sharp disposal.

(Follow national guidelines for segregation of waste and disposal.)

8.4 (vi) Environmental cleanliness

Floors, corridors must be cleaned daily with a wet mop instead of dry sweeping.

The floor should be kept dry.

All examination/operation theatre (OT) tabletops and surface-lamp shades, almirahs, lockers, trollies, etc. should be cleaned with low disinfectant (2% carbolic acid or 0.5% chlorine solution).

Examination tables should be cleaned with low disinfectant after each use.

Soiled areas on floor are cleaned with a mop dampened with a disinfectant cleaning solution (or as per national guidelines).
PoCKETBOOK FOR HEALTH-CARE PROVIDERS

- All cleaning staff should wear PPE.
- At the end of the day, floors, corridors must be cleaned with low disinfectant.

**Blood/ infected spill**

- Spills of infected or potentially infected material on the floor should be covered with paper towel/ blotting paper.
- Disinfectant (5% phenol or freshly prepared 1% hypochlorite solution) is poured on the spill and left for at least 10 minutes.
- The floor is then wiped with gauze or cloth with gloved hands.
- The gauze or cloth used to wipe is discarded as biomedical waste.

**8.4 (vii) Safe handling and cleaning of soiled linen**

- Linen (drapes, sponges, scrub suits, etc. are washed with soap and water and then autoclaved at 15 lb/sq inch for 30 min in a drum.
- The autoclaved linen should be used within one week but if the drum is opened, it should be used within 24 hours.
8.4 (viii) Segregation of waste and disposal

It is important to dispose of all kinds of waste properly as improper disposal of biomedical waste poses a health risk to health-care providers and the community. All waste in a health facility can be divided into:

- General waste: The waste that poses no risk of infections. It is similar to household trash.
- Medical/ biomedical waste: Material generated in the management of clients, including blood, blood products and other body fluids, bandages/ surgical sponges and organic waste such as human tissues, body parts, placenta and POC.
- Sharps: Like needles, blades, broken glass, etc.

There are four steps in the waste management plan:

- Segregation: Segregation of the waste at the point of generation into colour-coded bins in accordance with local regulations is an important step.
- Collection and storage: Waste should be collected in covered bins and not filled more than three fourths. The waste should not be stored for more than 48 hours.
- Transportation: Transportation should be done in closed containers. Dedicated vehicles should be used for offsite transport of waste.
Disposal of waste: Final disposal should be done as per country’s protocols. Sharps should be disposed of into leak-proof, puncture-resistant sharps containers. One should follow the national guidelines on the final disposal of health-care waste (e.g. incineration, burying, and autoclaving).

8.5 Maintaining asepsis and infection prevention for surgical abortion

All standard precautions for infection prevention should be followed throughout the procedure

- Preparation of the skin
  - Pubic hair should not be shaved.
- Cleaning the operative field
- Follow the clinical guidelines of the hospital
  - The vagina should be cleaned with 2.5% betadine.
  - Spirit or alcohol should never be used for the vagina.
- Draping the operative field
  - The perineum and lower abdomen should be draped with sterile drapes, to avoid contact of instrument with body surface.
- During the procedure
• The cervical os to be cleaned from centre to periphery
  • The instruments going inside the uterus should not touch the vagina.

• After the procedure
  • Disposable consumables should be discarded.
  • Used reusable instruments should be soaked in water till cleaned and should be processed as per protocol.

**Key message**

Sepsis being an important cause of maternal mortality, all steps such as washing hands, wearing PPE, processing instruments and equipment, environment cleaning, handling of sharps and proper waste disposal practices should be followed diligently and as per national guidelines by health-care providers.
Objective: To discuss the diagnosis and management of complications after first trimester abortions either by medical or by surgical method.

9.1 Complications associated with abortion

- Haemorrhage
- Continuation of pregnancy (failed abortion)
- Incomplete abortion
- Infection
- Uterine perforation, cervical injury, vaginal lacerations, abdominal injury, uterine rupture
- Local anaesthesia-related complications
- Drug-related complications
- Long-term sequelae
  - Ashermann syndrome
  - Infertility
9.1(i) Haemorrhage

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>The clinical condition of the patient should be assessed.</td>
<td>If the woman is stable, management is provided according to cause.</td>
</tr>
<tr>
<td>Pulse/ blood pressure (BP)/ respiration and amount of bleeding should be monitored.</td>
<td>If the woman is unstable:</td>
</tr>
<tr>
<td>Assessment is done to see if patient is stable or unstable.</td>
<td>❖ The woman should be stabilized. One should follow principles of ABC (airway, breathing and circulation).</td>
</tr>
<tr>
<td>Unstable woman will have tachycardia, hypotension, increased respiratory rate, cold and clammy skin, low consciousness level, low urine output.</td>
<td>❖ She should be resuscitated before/ while examination.</td>
</tr>
<tr>
<td>Haemorrhage can be due to:</td>
<td>❖ Intravenous fluid replacement with NS or with 18–20 G cannula.</td>
</tr>
<tr>
<td>❖ retained products of conception (POC)</td>
<td>❖ Airway to be ensured.</td>
</tr>
<tr>
<td>❖ trauma or damage to the cervix and/ or uterus</td>
<td>❖ Oxygen 6–8 L/min by mask.</td>
</tr>
<tr>
<td></td>
<td>❖ Blood transfusion to be arranged.</td>
</tr>
<tr>
<td></td>
<td>❖ Response to treatment is assessed. If condition is not improving, the cause should be re-established.</td>
</tr>
</tbody>
</table>
Every service delivery site must be able to stabilize and treat/ refer women with haemorrhage immediately.

Management is provided according to the cause and severity of haemorrhage:

- re-evacuation of the uterus if retained POC
- repair of cervical/ vaginal tear
- uterotonic drugs
- replacement of clotting factors in cases of coagulopathy
- laparoscopy or exploratory laparotomy if perforation suspected.

### Risk factors of continuation of pregnancy

- Early gestational age (<6 weeks)
- Provider’s inexperience
- Uterine anomalies such as bicornuate uterus

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**9.1(ii) Continuation of pregnancy/ failed abortion after medical/surgical abortion**

**Repeat MMA or surgical evacuation**

- Rule out ectopic pregnancy

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Continued
### Diagnosis
Continued signs and symptoms of pregnancy
- Menstrual cycles are not resumed
- Confirm by pelvic examination (demonstrates growing uterus) or by ultrasonography

If suspected, uterine anomaly evacuation may be done under ultrasonography guidance.

### 9.1(iii) Incomplete abortion

#### Diagnosis
- Common symptoms include:
  - vaginal bleeding
  - abdominal pain
  - fever (sign of infection)
- When aspirated tissue not compatible with the estimated period of pregnancy in surgical abortion

#### Management based on
- Clinical condition
- Preference for treatment, which can be either
  - Expectant management: for clinically stable women and when POC are small (efficacy 82–100%)
  - Vacuum aspiration if bleeding is excessive (efficacy 96–100%)
  - Misoprostol 600 μg orally/400 sublingually, 400–800 μg vaginally if bleeding is minimal (efficacy 61–100%)
### 9.1(iv) Post-abortion infections

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signs and symptoms:</td>
<td>Treatment should be started immediately without waiting</td>
</tr>
<tr>
<td>❖ Fever with or without chills, malaise</td>
<td>Depending upon the severity of infection, oral and IV antibiotics can be started</td>
</tr>
<tr>
<td>❖ Foul-smelling vaginal or purulent cervical discharge</td>
<td>Obtaining blood cultures prior to administering antibiotics</td>
</tr>
<tr>
<td>❖ Abdominal or pelvic pain, abdominal or adnexal tenderness</td>
<td>Administration of broad-spectrum antibiotics</td>
</tr>
<tr>
<td>❖ Prolonged vaginal bleeding or spotting</td>
<td><strong>Commonly used regimen:</strong></td>
</tr>
<tr>
<td>❖ Uterine tenderness, cervical motion tenderness</td>
<td>❖ Ampicillin 2 g IV every 6 hours PLUS</td>
</tr>
<tr>
<td>❖ An elevated white blood cell count</td>
<td>❖ Gentamicin 5 mg/kg body weight IV every 24 hours PLUS</td>
</tr>
</tbody>
</table>

Sepsis is defined as life-threatening organ dysfunction caused by a dysregulated host response to infection.

Sepsis causes 20% mortality and can rapidly progress to septic shock.
### Prevention of infection

- Surgical abortion should be performed using the aseptic no-touch technique procedure; prophylactic antibiotics should be provided
- Availability and accessibility of women-centred CAC services
- Provision of well-functioning referral systems of safe abortion

- Rapid fluid administration of 30 mL/kg crystalloid in case of septic shock (presented with hypotension)
- Vasopressors (noradrenaline) started, if hypotensive even after aggressive fluid resuscitation, to maintain a mean arterial pressure ≥ 65 mmHg
- Cause of sepsis should be addressed. If retained POC, evacuation is done as early as possible after loading dose of antibiotics

The woman should be referred to a higher-level facility at the earliest, if facility is not well equipped to manage severe septic shock cases.
### 9.1 (v) Uterine perforation, uterine rupture, cervical and vaginal injury

<table>
<thead>
<tr>
<th><strong>Uterine perforation</strong></th>
<th><strong>Management</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Signs/ symptoms</strong></td>
<td>- When uterine perforation is suspected (not with a suction cannula), observation and antibiotic treatment (conservative management)</td>
</tr>
<tr>
<td>- Nausea, vomiting, shoulder pain</td>
<td></td>
</tr>
<tr>
<td>- Fever</td>
<td>- Laparoscopy is the investigative method of choice</td>
</tr>
<tr>
<td>- Abdominal pain</td>
<td>- If laparoscopy examination and/or the status of patient show suspicion of damage to bowel, blood vessels or other structures, then laparotomy to repair damaged structures should be needed</td>
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<tr>
<td>- Distended abdomen, absent bowel sounds, rigid abdomen, rebound tenderness present</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Cervical and vaginal injury and lacerations</strong></th>
<th><strong>Management</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosis</strong></td>
<td>- Locate the tear/ laceration and repair. Bleeding is controlled by repair under aseptic conditions</td>
</tr>
<tr>
<td>- Bleeding/ pain/ infection</td>
<td>- Pain managed by NSAIDs</td>
</tr>
<tr>
<td>- Bleeding cervical and/ or vaginal tears, lacerations</td>
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Continued
<table>
<thead>
<tr>
<th><strong>FIRST TRIMESTER ABORTION</strong></th>
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<tbody>
<tr>
<td><strong>Continued</strong></td>
</tr>
<tr>
<td><strong>Infection</strong></td>
</tr>
<tr>
<td>- Managed by broad-spectrum antibiotics to be continued after repair until fever/infection-free for 48 hours</td>
</tr>
<tr>
<td>- Specific antibiotics may be provided after cervical/vaginal swab culture and sensitivity test</td>
</tr>
<tr>
<td>- Abstinence advised until wound heals to prevent further laceration or possible infection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Uterine rupture</strong></th>
<th>Management as for uterine perforation</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Rare complication in first trimester abortion</td>
<td></td>
</tr>
<tr>
<td>- It may be associated with unsafe abortions/later gestational ages/previous uterine scar</td>
<td></td>
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</tbody>
</table>
### 9.1(vi) Anaesthesia/drug-related complications

<table>
<thead>
<tr>
<th>Local anaesthesia is safest for vacuum aspiration in the first trimester but can lead to:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Anaphylactic reaction</td>
<td>- Anaphylaxis should be treated immediately with adrenalin</td>
</tr>
<tr>
<td>- Convulsions</td>
<td>- Bolus doses of adrenalin (1 mcg/kg) 0.5 mL of 1:1000, every 10 min if necessary</td>
</tr>
<tr>
<td>- Asthmatic reactions</td>
<td>- Hydrocortisone 100 mg IV</td>
</tr>
<tr>
<td></td>
<td>- Dipheylhydramine 50 mg IM or IV slowly then 50 mg orally every 6 hours when the woman is conscious and stable</td>
</tr>
<tr>
<td></td>
<td>- Repeated dose of hydrocortisone 2 mg/kg body weight IV every 4 hourly may be required</td>
</tr>
<tr>
<td></td>
<td>- Oxygenation should be ensured</td>
</tr>
<tr>
<td></td>
<td>- Convulsions: Benzodiazepines are the drugs of choice for seizure control</td>
</tr>
<tr>
<td></td>
<td>- Collaborative care with a physician required for asthmatic reaction</td>
</tr>
</tbody>
</table>
9.1 (vii) Long-term sequelae and other complications

Most women who have a properly performed induced abortion do not suffer any long-term effects on their general or reproductive health. Some may have:

- Asherman’s syndrome: Women with the condition present with amenorrhea due to formation of adhesions within the uterine cavity.

- Infertility: Infection either during or after the procedure can lead to infertility or increased risk of ectopic pregnancy.

- Psychological symptoms: Early detection of depression or other disorders.

9.2 Referral linkage for post-abortion care

- Well-functioning referral systems are essential for the provision of safe abortion care.

- Need for referral may be required for:
  - management of complications after stabilization;
  - contraception counselling and provision (tubal ligation);
  - reproductive tract infections/ STIs/ HIV; and
  - gender-based violence (GBV).
Timely referrals to appropriate facilities:

- reduce delays in seeking care;
- enhance safety; and
- can mitigate severity of abortion complications.

Key message

Complications of abortions, performed as per standard guidelines and by trained providers, are rare. Incomplete, septic abortion, haemorrhage and trauma to reproductive tract are serious consequences of unsafe abortion and should be treated promptly. Health-care providers should be able to diagnose complications due to first trimester abortion at the earliest and should be able to manage these complications.
Objective: To counsel and provide concurrent contraception to woman seeking first trimester abortion according to her choice.

10.1 Rationale
Post-abortion contraception can avert unintended pregnancies and abortion-associated morbidity and mortality. Since ovulation can occur soon after an abortion, contraception should be provided immediately after the procedure, to help the woman prevent or delay pregnancy.

10.2 Counselling for post-abortion contraception

Timing of contraception counselling

- Contraceptive counselling can be done before or after the abortion process is completed.
- Immediate initiation of post-abortion contraception is advocated as it:
  - improves adherence for use, and
  - reduces the risk of unintended pregnancy.
10.3 Guiding principles of post-abortion contraceptive counselling

Health-care providers at the time of counselling should:

- Provide accurate information to assist in choosing the most appropriate contraceptive methods to meet the client’s needs.

- Inform that fertility can return as early as 2 weeks after abortion with risk of unintended pregnancy unless an effective contraceptive method is used.

- Make available the chosen contraceptive method (or refer her if her chosen method is not available).

- Ensure that the client knows the mode of action, day to start and from where to get the selected contraceptives.

- Identify the cause: whether the woman seeking an abortion is following a contraceptive failure and correct it, if it was due to inappropriate use.

- Respect the decision of the woman to discuss or not to discuss contraceptive option after abortion.

- Understand that the woman’s acceptance of contraceptive must NOT be a pre-condition for providing abortion services.
Support the woman in selecting the contraceptive method best suited to her according to her clinical and personal situation.

Provide method-specific counselling, if the woman chooses a contraceptive method.

### 10.4 Options for post-abortion contraception

All methods of contraception including IUDs and hormonal contraceptives can be initiated immediately following surgical or medical abortion according to medical eligibility criteria.

### 10.5 Medical eligibility recommendations for post-abortion contraceptives

<table>
<thead>
<tr>
<th>Post-abortion contraceptive</th>
<th>First trimester abortion</th>
<th>Immediate post-septic abortion</th>
<th>Definition of categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>COC</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>CIC</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Patch; vaginal ring</td>
<td>1</td>
<td>1</td>
<td>A condition of which there is no restriction for the use of the contraceptive method</td>
</tr>
<tr>
<td>POP</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>DMPA; NET-EN</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Continued
### Post-abortion contraceptive

<table>
<thead>
<tr>
<th>Post-abortion contraceptive</th>
<th>First trimester abortion</th>
<th>Immediate post-septic abortion</th>
<th>Definition of categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>LNG/ ETG implants</td>
<td>1</td>
<td>1</td>
<td>A condition where the advantage of using the methods generally outweigh theoretical or proven risks.</td>
</tr>
<tr>
<td>Copper-bearing IUD</td>
<td>1</td>
<td>4</td>
<td>A condition where theoretical or proven risks usually outweigh advantages of using the methods.</td>
</tr>
<tr>
<td>LNG-releasing IUD</td>
<td>1</td>
<td>4</td>
<td>A condition that represents an unacceptable health risk if the contraceptive method is used</td>
</tr>
<tr>
<td>Condom</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Spermicide</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Diaphragm</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

CIC: combined injectable contraceptive; COC: combined oral contraceptive; DMPA/ NET-EN progestogen-only injectables: depot medroxyprogesterone acetate/norethisterone enanthate; IUD: intrauterine device; LNG/ ETG progestogen-only implants: levonorgestrel/ etonorgestrel; POP: progesterone-only pill
### 10.6 Time of initiation of contraceptive methods after abortion

<table>
<thead>
<tr>
<th>Contraceptive method</th>
<th>Spontaneous abortion or VA (for incomplete/induced abortion)</th>
<th>After medical abortion by mifepristone and misoprostol</th>
</tr>
</thead>
<tbody>
<tr>
<td>COC</td>
<td>Can be started immediately</td>
<td>Can be started after the first pill of medical abortion</td>
</tr>
<tr>
<td>POP</td>
<td>Can be started immediately</td>
<td>Can be started after the first pill of medical abortion</td>
</tr>
<tr>
<td>Injection DMPA</td>
<td>Can be started immediately</td>
<td>Can be started after the first pill of medical abortion</td>
</tr>
<tr>
<td>Contraceptive ring/ implant/patch</td>
<td>Can be started immediately</td>
<td>Can be started after the first pill of medical abortion, but should be instructed to check for expulsion of the ring in the event of heavy bleeding during the medical abortion process [S10]</td>
</tr>
<tr>
<td>Barrier methods</td>
<td>From the first act of sexual intercourse after abortion</td>
<td>From the first act of sexual intercourse after abortion</td>
</tr>
</tbody>
</table>

**Continued**
<table>
<thead>
<tr>
<th>Contraceptive method</th>
<th>Spontaneous abortion or VA (for incomplete/induced abortion)</th>
<th>After medical abortion by mifepristone and misoprostol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fertility awareness-based method (FAB)</td>
<td>Should be delayed until regular menstrual cycles return but should be started with caution</td>
<td>Should be delayed until regular menstrual cycles return but should be started with caution</td>
</tr>
<tr>
<td>IUCD</td>
<td>Can be started immediately but must rule out infection/injury to the genital tract</td>
<td>Can be inserted when the abortion is complete Provider must ensure completion of abortion by physical examination or by USG (around D15) but must rule out infection</td>
</tr>
<tr>
<td>Tubal ligation</td>
<td>Can be performed concurrently or within 7 days</td>
<td>Can be performed after the first menstrual cycle</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>Can be performed at any time</td>
<td>Can be performed at any time</td>
</tr>
<tr>
<td>Emergency contraception</td>
<td>Emergency contraceptive pills or an IUD may be used within 5 days (120 hours) of an act of unprotected sexual intercourse</td>
<td>Emergency contraceptive pills or an IUD may be used within 5 days (120 hours) of an act of unprotected sexual intercourse</td>
</tr>
</tbody>
</table>

Refer to Annex 5: Overview of contraceptive methods
10.7 Post-abortion IUCD

- Assessment: Before the procedure, the woman’s general, medical, reproductive, contraceptive and obstetric history and eligibility for the method is assessed and also a preprocedural assessment is done.

- Assessment is again done immediately before insertion to rule out any current genital tract infection, haemorrhage or genital tract injury.

- Method of insertion after surgical method of abortion: No touch and withdrawal technique
  
  - Use of uterine sound for measuring the length of uterus is not recommended, as it may cause perforation.
  
  - After the confirmation of the completion of evacuation and before withdrawing the cannula, the length of uterine cavity is assessed using the cannula.
  
  - The IUCD is loaded inside the sterile package and the blue guard is fixed at the length, measured by the cannula.
  
  - IUCD is then inserted using the withdrawal technique. Thread is cut 1 cm beyond the external os.
Method of insertion after the medical method of abortion: No touch and withdrawal technique.

- The provider should be very careful while introducing uterine sound.
- Uterine sound should be introduced gently by holding it like a pen/pencil, moving it in the right direction till the resistance is felt without applying any force.
- The technique of insertion is same as that of interval IUCD insertion.

The back-up method is not needed if IUCD is inserted within 12 days of spontaneous or induced abortion and absence of infection.

Follow up: Routine follow up of IUCD may be done after one month preferably after the next menstrual bleeding. At follow up, one must see the presence of string.

10.8 Post-abortion female sterilization

Eligibility criteria

- Woman has received counselling and made an informed choice and has given informed consent.
- Provider is trained in post-abortion female sterilization and requisite equipment are available.
- Post-abortion medical eligibility for female surgical sterilization
### Post-abortion condition

<table>
<thead>
<tr>
<th>Post-abortion condition</th>
<th>Female surgical sterilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncomplicated</td>
<td>A</td>
</tr>
<tr>
<td>Post-aborital sepsis or fever</td>
<td>D</td>
</tr>
<tr>
<td>Severe post-abortal haemorrhage</td>
<td>D</td>
</tr>
<tr>
<td>Severe trauma to genital tract Cervical or vaginal tear at the time of abortion</td>
<td>D</td>
</tr>
<tr>
<td>Uterine perforation</td>
<td>S</td>
</tr>
<tr>
<td>Acute haematometra</td>
<td>D</td>
</tr>
</tbody>
</table>

**Categories:** A Accept; C Caution; D Delay; S Special (experienced surgeon and staff)

- Post-abortion surgical sterilization method: Female surgical sterilization, can be performed either by minilaparotomy or by the laparoscopic method.

### 10.9 Contraception in special situations

- **Anaemia:** All methods are safe including IUCD.
- **Previous scar on uterus:** All methods are safe including IUCD.
- **Hypertension well-controlled:** Progestin-only methods like injectables, implants, LNG, IUCD, POP are all safe; however, COCs patches rings are not to be used.
- **Poorly controlled hypertension:** All hormonal methods can be avoided, preference for IUCD, barrier, non-hormonal pill and natural methods.
- **Well-controlled diabetes mellitus:** All methods are suitable, MEC is category 2 for COC.
With poorly controlled diabetes: COCs and injectable progestins are not suitable, MEC 3, whereas LNG IUS, implants, etc. are MEC 2, copper IUCDs are still category 1.

### 10.10 Myths and misconceptions

<table>
<thead>
<tr>
<th>Myths</th>
<th>Facts</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUCD after abortion may perforate and may go to heart or brain.</td>
<td>There is no passage from the uterus to other organs of the body. Chances of perforation are very low with trained providers.</td>
</tr>
<tr>
<td>Abortion can be used as a method of contraception.</td>
<td>Repeated abortions can lead to increased morbidity.</td>
</tr>
<tr>
<td>Having an abortion will make you infertile.</td>
<td>Chances of infertility are very low with safe abortion practices.</td>
</tr>
<tr>
<td>One will not be able to do heavy physical work if tubal ligation or IUCD insertion is done after abortion.</td>
<td>Any contraception with abortion does not pose any challenge for physical activities. There is no correlation between the performance and the use of IUCD or getting tubal ligation done.</td>
</tr>
</tbody>
</table>

**Key message**

All methods of contraception including intrauterine devices (IUDs) and hormonal contraceptives can be initiated immediately following surgical or medical abortion according to medical eligibility criteria.

**Health-care providers** should be able to counsel women for the contraceptives available in the country and facilitate their acceptability.
Objective: To ensure that the services provided for first trimester CAC are documented and reported.

11.1 Documentation of first trimester CAC services

The aim of documentation is to collect data of first trimester CAC services, to update it for local, regional, national and international review so that trends can be observed to influence policy changes.

- Privacy and confidentiality of the clients to whom abortion services are provided should be ensured when documentation is done.

- Health-care providers should document regularly in the formats as per country’s laws for abortion.

- Documentation should include:
  - demographic information of each client as age, parity, socioeconomic status, marital status, duration of pregnancy, etc.;
  - informed consent in the prescribed format as per country’s rules;
• method advocated;
• provider’s details;
• anaesthesia/ pain medications used;
• cervical priming method if used;
• method used;
• contraception services provided;
• follow-up visits;
• adverse event if any;
• treatment of complications including blood; transfusion if needed
• cases referred to higher centres; and
• log books of medications used;

- Documentation is done in:
  • OPD register;
  • admission register;
  • case record;
  • procedure register at the labour room/ OT;
  • complications of abortion including spontaneous abortion (inevitable, incomplete abortion;
• adverse event register;
• discharge register; and
• any other official record prescribed by the country’s regulatory authorities.

Storage of records
• The abortion and adverse events data need to be stored under safe custody at health facilities as per the country’s legal guidance.
• Confidentiality of data records and reports should be maintained at all levels.

11.2 Reporting of first trimester CAC services
• Every health facility providing abortion services MUST report the data of abortions regularly to each country’s national HMIS.
• The facility must report data to the head of facility who will send it to the district and state authorities for their information and records.
• Communicate with district, state/ province, national government officials regarding:
  • proportion of first trimester abortions out of total abortions;
  • trends over time for seeking abortion or seeking care for complications;
• adverse events during abortion care;
• unmet need of contraception;
• appropriate feedback to facilities; and
• support to strengthen national programmes for contraception and prevent unsafe abortions.

The state/province will share the data monthly/quarterly with concerned:
• national officials;
• regional officials; and
• periodically to the global data recording system.

11.3 Monitoring of first trimester CAC services

The aim of monitoring is to ensure that:
• the services are standardized and evidence-based;
• women are receiving CAC services with respect, dignity, confidentiality and privacy;
• service providers are non-judgemental, empathetic and compassionate, women are satisfied with the services; and
• all the requisite infrastructure and logistics are available.
Process of quality improvement
The monitoring and review process must include all health-care staff involved in first trimester CAC services. This gives the team a sense of ownership of the results. A monitoring tool can be developed (Annex 6a).

- Records are reviewed periodically to help monitor first trimester CAC service provision and trends at the facility.

- Quality of care can be assessed by
  - using checklists for essential infrastructure, logistics, counselling skills of the provider, procedural details, etc. (Annex 6b); and
  - conducting exit interviews, focus groups, or client satisfaction feedback.

- Few simple indicators that provide critical and useful information on first trimester CAC service provision must be identified and reviewed over time.
  - Number of procedures performed
  - Number of women opting for contraception
  - Number of adverse events
Indicators chosen should be such that the measurement helps quantify activities and results, and it also reports on quality component of care.

The overall gaps in terms of quality of abortion care, availability of commodities, logistics, trained human resource, recording mechanism, etc. should be ascertained.

The action plan should address the gaps in service provision, the person responsible to implement the planned actions and the timeline.

The implementation of plan is ensured to improve the quality of service provided.

Review should be done so that the plans implemented improve the services.

If the plan is not giving expected results, it should be suitably modified.

**Key message**

Health-care workers should understand the importance of regular and proper recording of the data for CAC services, which will identify gaps in abortion services to improve the qualities of care.
Objective: To understand what telemedicine is and its role in provision of abortion care services.

12.1 Definition of telemedicine (or telehealth)
A mode of health service delivery where providers and clients, or providers and consultants, are separated by distance (5).

12.2 Types of interactions
- Real-time (synchronously), e.g. by telephone or a video link.
- Store-and-forward (asynchronously) when a query is submitted and an answer provided later, e.g. by email or text/voice/audio message.

12.3 Telemedicine provision models
- Direct to client
- Site to site
- Engaging health-care workers in reaching out to communities
12.4 Advantages of telemedicine

- Provides support for self-management of health care. Nevertheless, it is highly acceptable to women and providers especially for medical abortion.
- Provides privacy and security
- Cost-effective

12.5 Limitations of telemedicine

- Policy barriers limit, especially for abortion

12.6 Technology models for telemedicine services

- Video-conferencing
- Telephone calls
- Text messages
- Internet-based messaging
- Interactive Apps, etc.
- Hotlines

12.7 Telemedicine for MMA

Telehealth can be used for:

- provision of information on abortion care. Scientifically accurate information should be accessible and
understandable, including formats catering to low-literacy and differently abled populations;

- alternative to in-person interactions with the health worker, to deliver medical abortion services in whole or in part;
- assessment of eligibility for medical abortion;
- counselling and/or instruction relating to the abortion process;
- providing instruction for and active facilitation of the administration of medicines;
- follow-up PAC;
- abortion pill prescription, which may be offered as an alternative to in-person appointments. WHO recommends it for improving access to MMA but country’s legal provisions should be followed for providing prescription;
- referrals for medicines (abortion and pain management);
- PAC;
- follow-up care (including emergency care if needed); and
- post-abortion contraceptive services.
12.8 Concerns regarding telemedicine for MMA

- Acceptability: Medical abortion through telemedicine seems to be highly acceptable to women and providers (2).

- Efficacy: Success rate and safety outcomes are similar to those reported in the literature for in-person abortion care (6).

- Danger symptoms: Guidance about the danger symptoms should be clear and accessibility to healthcare services should be facilitated.

- Legal issues: Laws related to telemedicine and abortion laws should be addressed before providing MMA services through telemedicine.

12.9 Self-managed abortion

Self-management of MMA: WHO abortion guidelines (2022) recommend the option of self-management of the medical abortion process at <12 weeks (using the combination of mifepristone plus misoprostol or using misoprostol alone) in whole or any of the three component parts of the process.

- Self-assessment of eligibility (determining pregnancy duration; ruling out contraindications).
Self-administration of abortion medicines outside of a health-care facility and without the direct supervision of a trained health worker, and management of the abortion process.

Self-assessment of the success of the abortion.

**Prerequisite for self-managed abortion**

- Individuals engaging in self-management of medical abortion must also have access to accurate information, quality-assured medicines including for pain management.
- The support of trained health workers and access to a health-care facility and to referral services should be easily available to all women opting for self-managed abortion.

**Self-management of abortion should be within the regulatory framework of the health system of the country.**

- Self-management of contraceptives, injectable contraceptives, over-the-counter combined oral contraceptives, over-the-counter emergency contraceptives and condom usage is also recommended in view of telemedicine, but it has to be under the legal/regulatory framework of the country.
Key message

Telemedicine has a role in assessment of eligibility for medical abortion, counselling and/or instruction relating to the abortion process, active facilitation of the administration of medicines, and follow-up PAC. Telemedicine can play a role in delivering post-abortion contraceptive services, which may apply to both medical and surgical abortion. Health-care workers should be aware of the newer developments in this field.
Spontaneous abortion is when abortion is triggered spontaneously, without any external interference.

### Types of spontaneous abortion

<table>
<thead>
<tr>
<th><strong>Type of spontaneous abortion</strong></th>
<th><strong>Source:</strong> Pocketbook of hospital care for mothers: guidelines for management of common maternal conditions 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Threatened abortion:</strong> Pregnancy is viable and the cervical os is closed. Pregnancy may continue.</td>
<td></td>
</tr>
<tr>
<td><strong>Inevitable abortion:</strong> Process of expulsion of products of conception has started. The cervical os is dilated. Pregnancy will not continue and will proceed to incomplete/complete abortion.</td>
<td></td>
</tr>
<tr>
<td><strong>Incomplete abortion:</strong> Products of conception are partly expelled.</td>
<td></td>
</tr>
<tr>
<td><strong>Complete abortion:</strong> Products of conception are completely expelled.</td>
<td></td>
</tr>
<tr>
<td><strong>Missed abortion:</strong> Products of conception are not expelled but fetal cardiac activity is absent. (Non-viability of intrauterine pregnancy without spontaneous abortion)</td>
<td></td>
</tr>
<tr>
<td><strong>Septic abortion:</strong> Abortion complicated by infection. Sepsis may result from ascending infection from the lower genital tract following spontaneous or unsafe abortion.</td>
<td></td>
</tr>
<tr>
<td>Sepsis may be due to delayed evacuation or due to unsafe abortion involving instrumentation.</td>
<td></td>
</tr>
</tbody>
</table>
Clinical features of various spontaneous abortions

<table>
<thead>
<tr>
<th></th>
<th>Threatened abortion</th>
<th>Inevitable abortion</th>
<th>Incomplete abortion</th>
<th>Complete abortion</th>
<th>Missed abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>Cramping</td>
<td>Cramping</td>
<td>Cramping</td>
<td>Light cramping</td>
<td>May or may not be observed</td>
</tr>
<tr>
<td>Bleeding</td>
<td>Light</td>
<td>Heavy</td>
<td>Heavy</td>
<td>Light</td>
<td>Bleeding altered, coloured blood</td>
</tr>
<tr>
<td>Uterus size</td>
<td>Corresponds to period of gestation</td>
<td>May correspond to period of gestation</td>
<td>Smaller than period of gestation</td>
<td>Smaller than period of gestation</td>
<td>Smaller than period of gestation</td>
</tr>
<tr>
<td>Cervix</td>
<td>Closed</td>
<td>Dilated os</td>
<td>Dilated os</td>
<td>Closed</td>
<td>Closed</td>
</tr>
<tr>
<td>Products of conception</td>
<td>Live fetus and placenta</td>
<td>Fetal parts felt through os or partially extruding</td>
<td>Retained products of conception</td>
<td>None</td>
<td>Fetus and placenta</td>
</tr>
</tbody>
</table>

Continued
<table>
<thead>
<tr>
<th>Threatened abortion</th>
<th>Inevitable abortion</th>
<th>Incomplete abortion</th>
<th>Complete abortion</th>
<th>Missed abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultrasound</td>
<td>Live embryo</td>
<td>Dilated cervical os</td>
<td>Retained products of conception</td>
<td>Empty uterus</td>
</tr>
<tr>
<td></td>
<td>Rarely subchorionic bleed</td>
<td>Sac partially extruding into vagina</td>
<td></td>
<td>Discrepancy between the sonographic gestational age and weeks of pregnancy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Absent fetal heart</td>
</tr>
</tbody>
</table>

*WHO Pocketbook of hospital care for mothers: guidelines for management of common maternal conditions, 2017*
Abortion in first trimester can be conducted by two methods: medical and surgical.

**Medical method** is advocated by ingestion of drugs which are taken orally or sublingually, by vaginal or buccal route. These drugs may lead to side-effects as nausea, vomiting, fever, shivering and allergy reaction. Expected outcome and likelihood of success is very high. If this method fails for termination of pregnancy, there may be chance of some defect in the baby if pregnancy is continued.

**Surgical method** will be performed using local anaesthesia, the cervix is carefully dilated until there is enough room to pass a suction cannula/ curette/ instrument into the womb. The products in the uterine cavity will be sucked out with suction cannula. The tissue may be sent to pathology laboratory for examination.

The expected outcome and likelihood of success is similar for both methods and as high as 95 – 99%.
One can resume their routine activities a day after the abortion.

One will be required to report to the provider if there are warning signs as excessive bleeding, pain, fever or continued nausea and vomiting.

There are risks and complications with this procedure. These include but are not limited to the following:

- Bleeding that can be so heavy that a blood transfusion may be needed. It may also need further surgery.
- Damage may occur to the uterus with rupture or perforation. This may require a laparoscopy and/or laparotomy, there is a risk of damage to other organs such as bowel or bladder, which may require further corrective surgery.
- This being a blind procedure, rarely evacuation may remain incomplete.
- Rarely the procedure may not be able to be completed, due to narrowing of the inside of the cervix. If the condition continues, further surgery will be necessary.
- Widening of the mouth of the uterus may lead to cervical incompetence (Uterus unable to hold pregnancy in future).
Rarely adhesions may develop in uterus leading to amenorrhea/sub-fertility.

Infection can occur in the uterus. This can cause heavy bleeding or discharge, worsening cramps or high fever. The infection may affect the fallopian tubes and cause problems with getting pregnant in the future. Antibiotics are used to treat the infection.

Allergic reaction can occur from medicines or due to blood transfusion.

Excessive bleeding can occur.

Option of choosing the Contraception during/after the procedure are oral contraceptive pills, POP, DMPA, IUCD, tubal ligation, vasectomy for husband, etc.
Name of patient:

...........................................................................................................................................................................

Sex:.........................Age.............. Registration no. : .........................

Address: ..........................................................................................................................................................

..........................................................................................................................................................

Diagnosis ..........................................................................................................................................................

..........................................................................................................................................................

Operation title....................................................................................................................................................

I, ......................................................................................................................................................................the undersigned give 
consent for MY OWN/AFOREMENTIONED PATIENTS operation and/or medication/investigation/anaesthesia/therapy, etc.
I acknowledge that the doctor has explained.

- My medical condition and the proposed procedure, including additional treatment if the doctor finds something unexpected. I understand the risks, including the risks that are specific to me.

- The anaesthetic required for this procedure. I understand the risks, including the risks that are specific to me.

- Other relevant treatment options and their associated risks.

- My prognosis and the risks of not having the procedure.

- That tissues and blood may be removed and could be used for diagnosis or management of my conditions, stored and disposed of sensitively by the hospital.

- I have been explained that excessive bleeding, infection, cardiac arrest, pulmonary embolism and complications like this can arise suddenly and unexpectedly while undergoing medication/investigation/operation/therapy/procedure or anaesthesia.

- I give consent for any change in the anaesthesia or operative procedure as well as for removal of any organ as deemed necessary by the doctors at the time of medication/investigation/therapy/surgical procedure.
I have been made aware that after the above procedure/medication/investigation/therapy and anaesthesia, some complication may arise and laparotomy may be required.

I was able to ask questions and raise concern with the doctor about my condition, the proposed procedure and its risks and my treatment options. My questions and concerns have been discussed and answered to my satisfaction.

I understand I have the right to change my mind at any time, including after I have signed this form but, preferably following a discussion with my doctor.

I understand that image/s or video footage may be recorded as a part of and during my procedure.

I accept that medicine is not an exact science and understand that no guarantees can be given to the result and understand these limitations.

I have read the above writing/ the above writing has been read out to me, and it explained to me in the ........................................ language by .................................. (interpreter) which I understand.

I have understood the aforesaid and I am giving my consent willingly with sound mental state without any coercion, undue influence, fraud, misrepresentation or mistake of fact.
I request Dr .............................................................. to perform upon me the above-mentioned procedure.

<table>
<thead>
<tr>
<th><strong>Doctor</strong></th>
<th><strong>Patient/Guardian</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sign:</td>
<td>Sign /Thumb impression:</td>
</tr>
<tr>
<td>Name:</td>
<td>...........................................</td>
</tr>
<tr>
<td>Address:</td>
<td>Name: ..........................................................</td>
</tr>
<tr>
<td></td>
<td>Address: ..................................................</td>
</tr>
<tr>
<td></td>
<td>..................................................</td>
</tr>
<tr>
<td>Age........Date........</td>
<td>Age........Date...............</td>
</tr>
</tbody>
</table>
WHO recommends Manual Vacuum Aspiration (MVA) as the safest method for abortion up to 12–14 weeks of size.

Components of MVA kit are:
1. MVA aspirator
2. Suction cannula

1. **MVA aspirator**

<table>
<thead>
<tr>
<th>Parts of MVA syringe (assembled)</th>
<th>Creating a vacuum</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="Parts of MVA syringe" /></td>
<td><img src="image2" alt="Creating a vacuum" /></td>
</tr>
</tbody>
</table>
2. **Suction cannulas** are available in different sizes (4 – 12 mm) and have permanently affixed base with wings. Healthcare worker should know how to assemble, disassemble and charge the MVA.

- **Disassembling the MVA aspirator**
  - Cylinder and plunger are pulled apart from the valve assembly.
  - Cap release tab is pressed, and the cap is removed in the valve assembly unit.
  - Hinged valve is opened by pulling open the clasp.
  - Valve liner is removed.
- Collar stop is disengaged by sliding under retaining clip. Plunger is pulled completely out of cylinder.
- O-Ring is displaced by pressing its sides and rolling it down into groove below.
- Sharp objects should never be used for removing the O-ring as it can damage the O-ring.

**Reassembling the MVA aspirator**

- Valve liner is placed in the valve by aligning ridges.
- The valve is closed ensuring it snaps into place.
- The cap is put onto end of valve assembly unit.
- Cylinder is pushed straight up to the base of the valve.
- O-ring is placed into groove near tip of plunger.
- One drop of sterile lubricant (silicon gel) is applied around O-ring with finger.
- Plunger arms are pressed and pushed straight into cylinder.
- Collar stop tabs are inserted into holes in cylinder.
- Plunger is moved in and out to lubricate (step 6 and 9 not required if it is a single use disposable MVA syringe).
charging the aspirator

- With open valve buttons plunger is pushed up to the base of valve.
- Valve buttons are pushed down and forward until they lock.
- Plunger is pulled back until both its arms catch up on the wide sides of cylinder.
- Charged aspirator should never be grasped by the plunger arms as this can eject the contents.
- Aspirator should be checked for vacuum by pressing the valve buttons a rush of air indicates vacuum was created. Aspirator retains vacuum until it is 80% full after which the contents should be emptied and vacuum recreated.

sterilization/high-level disinfection of aspirator.
Any of these methods can be used for sterilization of vacuum aspirator:

autoclave

- The instrument is disassembled fully.
- Parts of the aspirator and cannula are wrapped separately in paper/linen.
- The pressure autoclave is set at 121 °C/250 °F for 30 minutes with pressure of 106 kPa/15 lbs/in2.
Boiling

- Boiling the submerged aspirator, cannula for 20 minutes with boiler lid closed. Time should be counted after water has started boiling. No fresh instrument to be added after water is boiling.

- One should wait for the water to cool before removing cannula and handle only by the adaptor/base.

Glutaraldehyde

- Instruments should be fully submerged in 2% solution for 20 minutes.

- Instruments must be thoroughly rinsed with sterile water before use.

- Solution should be changed as per recommendations.

*Aspirator should be thoroughly rinsed with sterile water after *processing*

- **Sterilization/high-level disinfection of suction cannula:** Each disposable cannula is presterilized (before packaging) with ethylene oxide (ETO) which remains sterile for three years.

Cannula that can be reused should be sterilized as sterilization/HLD is done for MVA. Cannula should be replaced if it is cracked or bent, especially near the tip.
**Annexure 4(a)**

**Hand hygiene by washing**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Wet hands with water;</td>
</tr>
<tr>
<td>1</td>
<td>Apply enough soap to cover all hand surfaces;</td>
</tr>
<tr>
<td>2</td>
<td>Rub hands palm to palm;</td>
</tr>
<tr>
<td>3</td>
<td>Right palm over left dorsum with interlaced fingers and vice versa;</td>
</tr>
<tr>
<td>4</td>
<td>Palm to palm with fingers interlaced;</td>
</tr>
<tr>
<td>5</td>
<td>Backs of fingers to opposing palms with fingers interlocked;</td>
</tr>
<tr>
<td>6</td>
<td>Rotational rubbing of left thumb clasped in right palm and vice versa;</td>
</tr>
<tr>
<td>7</td>
<td>Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;</td>
</tr>
<tr>
<td>8</td>
<td>Rinse hands with water;</td>
</tr>
<tr>
<td>9</td>
<td>Dry hands thoroughly with a single use towel;</td>
</tr>
<tr>
<td>10</td>
<td>Use towel to turn off faucet;</td>
</tr>
<tr>
<td>11</td>
<td>Your hands are now safe.</td>
</tr>
</tbody>
</table>
Annexure 4(b)

PERSONAL PROTECTIVE

- Cap
- Mask
- Goggles
- Gown
- Gloves
- Apron
- Footwear
## Overview of contraceptive methods after first trimester abortion

<table>
<thead>
<tr>
<th>Name</th>
<th>Time of starting</th>
<th>Advantage</th>
<th>Side effects / limitations</th>
<th>Failure rates per 100 women year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male condom</td>
<td>At resumption of sexual activity</td>
<td>Autonomy to start Safe Prevents STI/RTI</td>
<td>Irritation May slip or break</td>
<td>2</td>
</tr>
<tr>
<td>Female condom</td>
<td>At resumption of sexual activity</td>
<td>Autonomy to start Safe Prevents STI/RTI</td>
<td>Expensive Difficult to insert May make sex less enjoyable</td>
<td>5</td>
</tr>
<tr>
<td>COCP</td>
<td>Immediately after VA</td>
<td>Highly effective</td>
<td>Daily dose No protection against RTI/STI</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Continued
<table>
<thead>
<tr>
<th>Name</th>
<th>Time of starting</th>
<th>Advantage</th>
<th>Side effects / limitations</th>
<th>Failure rates per 100 women year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1 of MMA</td>
<td></td>
<td>No interference with sexual activity</td>
<td>Not suitable while breastfeeding Interaction with certain drugs (Rifampicin, Phenytoin, etc.) reduces effectiveness</td>
<td>&lt;1</td>
</tr>
<tr>
<td>POP</td>
<td>Immediately after VA</td>
<td>Highly effective</td>
<td>Daily dose No protection against RTI/STI may cause changes in menstrual pattern as irregular bleeding, spotting</td>
<td>0.3</td>
</tr>
<tr>
<td>Day 1 of MMA</td>
<td></td>
<td>No interference with sexual activity Fast reversibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Progestin-only injectable DMPA, NET-EN</td>
<td>Immediately after VA</td>
<td>Highly effective</td>
<td>Must return for injections every two or three months</td>
<td></td>
</tr>
<tr>
<td>Day 1 of MMA</td>
<td></td>
<td>No interference with sexual activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Time of starting</td>
<td>Advantage</td>
<td>Side effects / limitations</td>
<td>Failure rates per 100 women year</td>
</tr>
<tr>
<td>------</td>
<td>------------------</td>
<td>-----------</td>
<td>----------------------------</td>
<td>----------------------------------</td>
</tr>
</tbody>
</table>
| IUD  | Immediately after VA if no excessive bleeding or infection | Highly effective  
No interference with sexual activity  
Long-term contraception, effective for 5 – 10 years.  
Immediate return to fertility following removal | May cause irregular bleeding, spotting, amenorrhea  
Delayed and unpredictable return to fertility after stopping use  
No protection against STIs/HIV/HBV | 0.6 |
|      | After surety of complete abortion after MMA | Trained provider required | May increase menstrual bleeding and cramping during the first few months  
No protection against STIs/HIV/HBV | |
<table>
<thead>
<tr>
<th>Name</th>
<th>Time of starting</th>
<th>Advantage</th>
<th>Side effects / limitations</th>
<th>Failure rates per 100 women year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female sterilization</td>
<td>Immediately after VA if there is no infection or severe bleeding</td>
<td>Permanent method</td>
<td>Requires trained staff</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Highly effective immediately</td>
<td>Slight risk of surgical complication</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No interference with sexual activity</td>
<td>No protection against STIs/HIV/HBV</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No long-term side effects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male sterilization</td>
<td>Independent of abortion procedure</td>
<td>Permanent method</td>
<td>Alternate methods till azoospermia confirmed after 3 months</td>
<td>0.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No interference with sexual activity</td>
<td>No apparent long-term health risks</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No apparent long-term health risks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural family planning</td>
<td>Only after next menstrual cycle</td>
<td>No supplies required</td>
<td>No protection against STIs/HIV/HBV</td>
<td></td>
</tr>
<tr>
<td>methods</td>
<td></td>
<td>Under control of couple</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fertility awareness based/</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>standard days method</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Monitoring tool for first trimester CAC service facility

- Date
- Name of facility
- Name of the provider
- Name of Programme Manager visiting the site number of procedures performed
- No. of abortion care procedures provided at the facility in the last three months
  - Methods/technology used for the procedures
  - Contraception given (numbers)
- If NO service provide reason for non-provision/
- Does the examination and treatment area have visual and auditory privacy?
- Does the facility have the necessary instruments and supplies for infection control and procedures?
Are the following available at the facility:

- MVA kits;
- MMA drugs;
- all contraceptive methods;
- IEC material on abortion care;
- existing protocol and logistics for waste disposal; and
- documentation forms.

Have the healthcare workers attached to the facility been trained in the specific tasks?

Gaps identified for quality improvement in the facility

Action plan for quality improvement – Person Responsible – Timeline
Check Lists for First Trimester CAC Services

1. Check List Infrastructure and Logistics
   - Examination room available
   - Place for counselling where privacy can be maintained
   - Procedure room with infection control practices exists
   - Instruments needed available
   - Resuscitation equipment available
   - Sterilization facilities available
   - Drugs & parenteral fluid available
   - Supplies for infection control practice

2. Check List for Procedural Competency
   - Counselling
     - Privacy and confidentiality maintained
     - Comfortable place to sit for the client
     - Abortion- specific content, methods/complications, etc. explained
• Contraceptive counselling done
• Referral facilities facilitated if needed
• Enough time given to ask questions

❖ Pre-Procedural Evaluation
• History taken in detail
• Estimation of gestational age done
• Indicated investigations done
• Informed consent obtained
• Contraception chosen is available

❖ Procedural Competency Medical Method of Abortion (MMA)
• MMA drugs provided
• MMA drugs regime explained
• Expected symptoms, danger signs & complications explained
• Follow up instructions provided

❖ Surgical Abortion
• Instruments prepared
• Woman cleaned and draped
• Cervical antiseptic preparation performed
- Paracervical block administered
- Appropriate cervical dilatation assessed
- Suction cannula inserted with no touch technique
- Suction pressure checked in MVA /EVA
- Uterine contents aspirated inspected
- Concurrent procedure: IUD insertion, if opted, done
- Instruments processed as per guidelines

❖ Documentation

Documentation done

- Procedure specific contents of counselling
- Consent
- Anesthesia/pain medications
- Procedure details
- Concurrent procedure if done
- Adverse event if any
- Advice at discharge
- Follow up instructions
- Entries in all relevant registers / HMIS
References


