TECHNICAL AND PROCEDURAL GUIDELINE FOR ABORTION CARE SERVICES IN ETHIOPIA

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MINISTRY OF HEALTH-ETHIOPIA

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HEALTHIER CITIZENS FOR PROSPEROUS NATION!

Third Edition

September 2023

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Foreword

Globally, 60% of unintended pregnancies and 30% of all pregnancies or around 73 million are ending in induced abortion each year. It is estimated that 45% of all abortions are unsafe of which 97% take place in developing countries. Sub-Saharan Africans including Ethiopia have the highest maternal mortality ratio estimated at 533 maternal deaths per 100,000 live births. Lack of access to safe, timely, affordable and respectful abortion care is critical public health and human rights problem that is the major contributing factor to increasing maternal death in the developing world. The global community pledged to reduce the global maternal mortality rate to less than 70 per 100,000 live births from the current 210 maternal deaths per 100,000 live births and ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and program by 2030.

The Federal Democratic Republic of Ethiopia (FDRE) constitution stated that women's rights should be protected from harm arising from pregnancy and childbirth and in order to safeguard their health, women have the right of access to family planning information, education and services. Besides, Ethiopia established a favorable policy environment for improving the life and well-being of populations especially improving the most vulnerable segment of the population.

Apart from strengthening the health system, largely by expanding the health infrastructure, the health sector has been undertaking a number of actions to overcome various forms of reproductive health related problems of the population. Indeed, in the last two decades, Ethiopia has made significant improvement in reducing the maternal mortality ratio from 871 per 100,000 live births in 2000 to 267 deaths per 100,000 live births in 2020.

Following the revised abortion law, in 2005, access to abortion care services expanded and substantially decreased abortion related maternal mortality from 32% prior to 2005 which declined overtime with the current estimate of 4.6% which indicates a significant achievement in-terms of lives saved and complications averted. Despite the progressive achievement, Ethiopia

is on of the highest maternal mortalities in Africa which requires more effort in accelerating the pace of decline to be on track SDG-3 through ensuring availability of SRH service including expanding access and quality of family planning and comprehensive abortion care services.

The Technical and Procedural guideline has gone through three developmental phases. The first version was developed in 2006 and after seven years the second version was produce in 2014. The rationale for developing the third version of technical and procedural guideline are to accommodate the progressive changes made in the health system, update with scientific evidence and recommendations made by recent WHO abortion care guideline and align with the second national health sector transformation plan (HSPT-11), health sector investment and development plan, reproductive health (RH) strategies and other national relevant guidelines. The technical and procedural guideline will be a valuable resource for guiding the health system at all levels including health managers, health care professionals working in government or non-governmental organization.

Therefore, I will call upon the Regional Health Bureaus, development partners, and professional association, health managers, providers at all levels to utilize and discharge your professional responsibilities as outlined in the national technical and procedural guideline for safe abortion care.

Dr. Dereje Duguma (M.D, MPH)
State Minister, Ministry of Health

Acknowledgments

Following the endorsement of the national abortion law, the maternal mortality ratio due to unsafe abortion significantly reduced in the country and the national technical and procedural guideline for safe abortion care has played a significant role. Ministry of Health (MoH) extends sincere appreciation to the non-governmental organizations, civil society organizations, professional associations and agencies for their contribution to the development or revision of Technical and Procedural Guideline for Abortion Care Service in Ethiopia. This guideline is updated with the reference of WHO new update on the safe abortion care that would help women and girls to get quality service based on the national abortion law.

The MoH would also like to give special thanks to UNFPA, WHO, Ipas, Pathfinder, and FGAE for their financial support during the guideline development process.

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Contents

List of Abbreviations

CAC:	Comprehensive Abortion Care
FDRE:	Federal Democratic Republic of Ethiopia
FP:	Family Planning
GBV:	Gender Based Violence
GMP:	General Medical Practitioner
GP:	General Practitioner
HEW:	Health Extension Worker
HO:	Health Officer
HSTP	Health Service Transformation Plan
HTC:	HIV counseling and testing
ICPD:	International Conference on Population and Development-
IESO:	Integrated Emergency Surgical Officer
IM:	Intramuscular
IPPF:	International Planned Parenthood Federation
IUCD:	Intrauterine Contraceptive Device
IUFD	Intrauterine Fetal Death
IV:	Intravenous
KAP:	Knowledge, Attitude and Practice
LNMP:	Last Normal Menstrual Period
MOH:	Ministry of Health

MHT:	Mobile Health Team
MISP:	Minimal Initial Service Package
MVA:	Manual Vacuum Aspiration
PHCU:	Primary Health Care Unit
PAFP	Post Abortion Family Planning
Po:	Per Os
RH:	Reproductive heath
SDG:	Sustainable Development Goal
SMC:	Sharp Metallic Curettage
SNNP:	Southern Nations and Nationalities and peoples
SRH:	Sexual and Reproductive Health
STD:	Sexually Transmitted Diseases
VIA:	Visual inspection using acetoacetic acid

1. Introduction

Strengthening access to comprehensive abortion care (CAC) within the health system is fundamental to meeting the Sustainable Development Goals (SDGs). Globally, 60% of unintended pregnancies & 30% of all pregnancies are ending in induced abortion and it is estimated that 45% of all abortions are unsafe. This is a critical public health and human rights issue as unsafe abortion is increasingly concentrated in developing countries (97% of unsafe abortions) and among groups who are vulnerable & marginalized. Sub-Saharan Africans suffer from the highest maternal mortality ratio estimated at 533 maternal deaths per 100,000 live births, or 200,000 maternal deaths a year.

In the last two decades, Ethiopia has made significant inroads in reducing the maternal mortality ratio from 871 per 100,000 live births in 2000 to 401 deaths per 100,000 live births in 2017 which means that about 14,195 maternal deaths were estimated to occur in Ethiopia in 2022. Following the revised abortion law, in 2005, Ethiopian Ministry of Health has developed technical and procedural guideline for safe abortion care and since then access substantial decrease in abortion related maternal mortality from 32% prior to 2005 which decline overtime with current estimate of 4.6 % which indicates a significant achievement in-terms of lives saved and complication averted. Despite the progressive achievement, Ethiopia is one of the highest maternal mortalities in Africa which requires more effort in accelerating the pace of decline to be on track of SDG-3 through ensuring availability of SRH service including expanding access and quality of family planning and comprehensive abortion care services.

The Federal Government of Ethiopia and MOH have made significant commitments to improve the health and right of women and girls as clearly expressed in the constitution of FDRE which states that women have the right to information, education and services, aligning the penal code with the constitution which expanded conditions under which safe services could be accessed and formulating policies and guidelines to facilitate safe access to services. This guideline is therefore the result of this streamlined national effort. Since the development of the guideline, access to quality of comprehensive abortion care service includes the provision of information and delivery of both safe and post abortion care services has expanded with enhanced response of the health system to improve the health need and right of individuals and communities.

The implementation of national technical and procedural guidelines for safe abortion care has been expanding the service including equipping the health workforce and availing the necessary commodities for improving access and quality of comprehensive abortion care services.

Rationale

Unplanned or unintended pregnancies still exist which would be cause for unsafe abortion and subsequently lead to maternal and child mortality and morbidity which requires more effort in accelerating the pace of decline maternal mortality towards achieving sustainable development goal and accessing universal coverage through ensuring availability of SRH service including expanding access and quality of comprehensive abortion care services.

The rationale for revising national technical and procedural safe abortion care guideline are:

- ☐ To enhance the continuity of past success in contributing the redaction of maternal mortality caused by unintended pregnancy and unsafe abortion
- ☐ To address the identified gaps through enhancing the health system
- ☐ To update the guideline with scientific evidence and recommendations made by recent WHO abortion care guideline
- ☐ To align the guideline with the second national health sector transformation plan (HSPT-II), reproductive health (RH) strategies and other national relevant guidelines.
- ☐ Provide guidance for health managers and health care providers during implementation of comprehensive abortion care service at all levels of the health system.

2. Aim of the guideline

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

The revised guideline has incorporated the latest evidence in abortion care and has made it context specific relevant to FDRE and make sure all relevant policy documents, standards and guidelines are seamlessly integrated to make a

coherent document.

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

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

3. Types of Abortion Services

Abortion is the termination of pregnancy before fetal viability, which is conventionally taken to be less than 28 weeks from LNMP. If the LNMP is not known a birth weight of less than 1000gm is considered as an abortion. The abortion may occur either spontaneously or induced. Induced abortion can be safe or unsafe.

There are two types of care related to termination of pregnancy. These are safe abortion care and postabortion care. All abortion care should be women centered and respect the sexual and reproductive right of the woman.

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

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

Abortion services have three key elements.

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

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

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

Quality of care defined as care that is: effective, efficient, accessible, acceptable/ patient centered, equitable and safe. Quality of care: QOC encompasses six dimensions of quality that are required in relation to health care:

- ☐ **Effective**, delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;
- ☐ **Efficient**, delivering health care in a manner which optimizes resource use and avoids waste;
- ☐ **Accessible**, delivering health care that is timely, geographically reachable, and provided in a setting where skills and resources are appropriate to medical need
- ☐ **Acceptable/person-centred**, delivering health care that takes into account the preferences and aspirations of individual service users and the cultures of their communities;
- ☐ **Equitable**, delivering health care that does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location or socioeconomic status;
- ☐ **Safe**, delivering health care that minimizes risks and harm to service users

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

- ☐ **Community-**service provider partnership involving the local community and actors like Health Development Army., in addition to the formal health personnel to address recognition of symptoms and signs of pregnancy complications, resource mobilization, social and economical issues at the community level.

- ☐ **Counseling** where women are provided with accurate and complete information on RH issues including FP, PITC, gender-based violence and other concerns and queries.
- ☐ **Emergency treatment** of incomplete abortions and its complications
- ☐ **Family Planning** services based on free and informed choice as well as method-mix.
- ☐ **Linkage** of the above services with other RH services including STD diagnosis and treatment, information on breast feeding, child nutrition and immunization, screening of reproductive tract cancers, etc.

Several methods of termination of pregnancy are available now. Which method is best for individual client depends on the duration of pregnancy, the general health status of the client, availability of method, distance from referral center, knowledge and skill of the provider, and level of care.

4. Legal Provisions for safe abortion services

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

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

1. Termination of pregnancy by a recognized medical institution within the period permitted by the profession is not punishable where:
   a. The pregnancy is a result of rape or incest; or
   b. The continuation of the pregnancy endangers the life of the mother or the child or the health of the mother or where the birth of the child a risk to the life or health of the mother; or
   c. The fetus has an incurable and serious deformity ; or
   d. The pregnant woman, owing to a physical or mental deficiency she suffers from or her minority, is physically as well as mentally unfit to bring up the child .

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

5. Implementation guide for article 551

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

- Where the pregnancy is a result of rape or incest

- Termination of pregnancy shall be carried out based upon the disclosure of the woman whether rape or incest has occurred. This fact will be noted in the medical record of the woman.
- Women who request termination of pregnancy after rape and incest are not required to submit evidence of rape and incest and/or identify the offender in order to obtain an abortion services.

II. Implementation guide for Article 551 sub article 1B

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

- The provider should, in all good faith, follow the knowledge of standard medical indications that necessitate termination of pregnancy to save the life or health of the mother.
- The woman should not necessarily be in a state of ill health at the time of requesting safe abortion services as health is a state of complete physical, mental, and social well-being and not merely an absence of disease or infirmity. It is therefore the responsibility of the health provider in charge to assess the woman's conditions after taking History, doing Physical examination and Investigation, determine that the continuation of the pregnancy or the birth of the fetus poses a threat to her health or life abortion service can be provided.

III. Implementation guide for Article 551 sub article 1C

- when the fetus has an incurable and serious deformity

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

IV. Implementation guide for Article 551 sub article 1D

- Þ when the pregnant woman, owing to a physical or mental deficiency she suffers from or her minority, is physically as well as mentally unfit to bring up the child:
- ☐ The provider will use the stated age on the medical record for age determination to determine whether the person is under 18 or not. No additional proof is required.
- ☐ A disabled person is one who has a condition called disability that
- ☐ interferes with his or her ability to perform one or more activities of every
- ☐ day living. Disability can be broadly categorized as mental or physical.
- ☐ The provider should assess if the woman is suffering from any form of mental or physical disability.

V. Implementation guide for Article 551-subarticle 2

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

  Health providers are responsible for the provision of comprehensive abortion care services are authorized to perform abortion procedures on women whose medical conditions warrant the immediate termination of pregnancy.

6. Applicable for all sub-articles:

- ☐ The provider has to secure an informed consent for the procedure using a standard consent form, which is annexed with this guideline (Appendix).
- ☐ The provider shall not be prosecuted if the information provided by the woman is subsequently found to be incorrect.
- ☐ Minors and mentally disabled women should not be required to sign a consent form to obtain an abortion procedure i.e. parent or guardian consent is not required.

7. Timing and place for terminating pregnancy

1. Termination of pregnancy as permitted by the law can be conducted in a public or private health facility that fulfills the pre-set criteria**.**
2. A woman who is eligible for pregnancy termination should obtain the service within three working days. This time is used for counseling and diagnostic measures necessary for the procedure
3. All public health facilities at the level of a comprehensive Health post and above and Private facilities starting primary clinics can perform termination of pregnancy as permitted by law article 551 for pregnancies less than 12 weeks of gestation from the last normal menstrual period**.**
4. Termination of pregnancy between 13-24 weeks should be performed in a primary , General or tertiary Hospital, MCH specialized center and MCH specialized hospitals as permitted by article 551.
5. Termination of pregnancy between 24-28 weeks should be done in a General or tertiary level of care as permitted by article 551**.**
6. Women who are eligible for pregnancy termination should have the necessary information to seek abortion care as early in pregnancy as possible**.**

8. Provider assisted self-care medical abortion

A woman under 10 weeks of Gestation can access medication for safe termination of Pregnancy provided she has access to a provider who can determine gestational age and provide her complete , objective Information , Education and Counseling for self-administration of medication and assess completeness and complications

9. Mobile Health Team Approach

Mobile Health Team (MHT): can be offered health care service through accessing hard to reach areas or reaching far located individuals or groups of people that are not able access a health-care service for a variety of reasons through facility based approach. The MHT service delivery strategy should also be institutionalized and contextualized as an alternative primary healthcare service delivery strategy to enhance access to primary healthcare service including abortion care services for pastoralist communities and those having difficulties reaching areas with limited and no access to functional health

facilities. Therefore, termination of pregnancy less than 10 weeks of gestation can be provided as part of the health service package for mobile health unit/team with fulfilling the following Legal Provisions for safe abortion services.

- ☐ Appropriate coordination, monitoring and evaluation platform available in the health system.
- ☐ Adequate staffing of health professionals who are allowed to provided facility based comprehensive abortion care service that described in the third version of national technical and procedural guideline for safe abortion
- ☐ At least one members the mobile health team should have in service training on comprehensive abortion care that appropriate to mobile health team
- ☐ The mobile health unit/team should equip with necessary medical abortion drugs and MVA kit and other necessary medication for the services.
- ☐ Referral linkage should be established with nearby facilities ahead for any complications and lifesaving emergency.

10. Safe Abortion Care in Humanitarian Situation

The need for safe abortion services likely increases in humanitarian settings. As sexual violence is associated with war and acute crises, the trauma resulting from sexual violence may be exacerbated if the incident results in a pregnancy. In humanitarian situations, women and girls may also be at increased risk of unintended pregnancy due to loss of or decreased access to family planning. They may want to delay childbearing until security and livelihoods are assured but may not have access to family planning due to disruptions in health supplies and services.

Access to safe abortion care (SAC) can be facilitated from the onset of an emergency by direct service provision or referral to facilities with appropriate settings as permitted by law Article 551 A, B, C and D (Please refer the article above).

Therefore, termination of pregnancy less than 10 weeks of gestation can be provided as part of minimum Initial Service Package (MISP) with fulfilling Legal Provisions and ensuing the following:

- ☐ Safe abortion care can be offered through static facilities or mobile/ outreach services or through referral linkage as permitted by the law.
- ☐ Safe abortion care in humanitarian setting can be offered only by trained professionals who are allowed to provide safe abortion care as indicated in the third version of the national technical and procedural guideline for safe abortion.
- ☐ Appropriate coordination, monitoring and evaluation platforms have to be available in the humanitarian setting in align with the existing health system.
- ☐ Mobile health team platform can be used with adequate health professionals, necessary medical abortion drugs and MVA kit and other necessary medication for save abortion services as indicated in the national technical and procedural guideline for safe abortion.
- ☐ Referral linkage should be established with nearby facilities ahead for any complications and lifesaving emergency.
- ☐ Frequent clinical mentorship / post training follow up are needed to build the skills of health care providers on SRH service including abortion care services.

11. Provider Obligation

All health facilities which are recognized by MOH shall provide the full range of Sexual and reproductive health services including comprehensive abortion care.

A health professional may not refuse on grounds of personal belief to provide services such as contraceptive, legal abortion and blood transfusion (article 84, Reg no. 299/2013)

12. Pre-Abortion Care

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

I. Counseling and informed decision making

a. Counseling

- ☐ Provide sufficient and accurate information on the methods of pregnancy terminations and comparative risks of continuing the pregnancy to term .
- ☐ The information provided to and the counseling o f f e r e d to the women must include a minimum of the following:
  - provision of complete information about the associated benefits, risks and alternatives;
  - Options counseling: continuing the pregnancy or terminating the pregnancy'
  - Available methods of pregnancy termination , tests that would be performed and pain control used, advantages and disadvantages
  - What will be done before, during and after the procedure of Abortion
  - Risks associated with the method of termination of pregnancy both short and long term
  - how to recognize potential side-effects and symptoms of ongoing pregnancy
  - Resumption of normal activities including menses , sexual activity
  - Availability of and return to Follow-up Care
- ☐ The information should be clear, objective, non-coercive and provided in a language understandable to the client and the information should be supplemented with written material**.**

b. Informed decision making

- ☐ All women undergoing pregnancy termination should, after having an objective counseling, consent to the procedure of termination in writing.
- ☐ The health care institution and the health worker that provides the service has an ethical obligation not to disclose the information provided by the women unless permitted by the client or ordered by a court of law.

II. Diagnosis of pregnancy

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

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

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

2. Physical examination: Undertake the following

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

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

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

III. Exclude extra-uterine pregnancy

- ☐ If a woman presents with amenorrhea, lower abdominal pain and vaginal bleeding consider ectopic pregnancy and /or
- ☐ Upon examination there is an adnexal mass
- ☐ If a woman with a positive pregnancy test above six weeks of gestation duration has no gestational sac on trans-abdominal ultrasonography If ectopic pregnancy is suspected, make sure the woman is evaluated by the most senior health provider around or refer to next level of care.

IV. Assessment of gestational age

Assess gestational duration based on:

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

V. Cervical Preparation

The following group of women need cervical preparation regimens:

- ☐ Nulliparous women
- ☐ Young aged (18 or below) with gestational duration of more than 9 weeks
- ☐ All pregnant women with gestations more than 12 weeks if they undergo a surgical procedure

5.1 Cervical preparation steps: cervical preparation can be done either by osmotic dilators or using medication.

The regimens for cervical preparation are:

For Surgical Procedure under 12 weeks

- ☐ Mifepristone 200 mg orally 24–48 hours prior to the procedure
- ☐ Misoprostol 400 µg sublingually 1–2 hours prior to the procedure
- ☐ Misoprostol 400 µg vaginally or buccally 2–3 hours prior to the procedure

NB Do not Use Laminaria under 12 weeks

For surgical abortion between 12 and 19 weeks:

a combination of mifepristone plus misoprostol is preferred or with an osmotic dilator plus medication (mifepristone, misoprostol, or a combination of both).

For surgical abortion between 12 and 19 weeks, when using an osmotic dilator for cervical priming: the period between osmotic dilator placement and the procedure should not extend beyond two days.

For surgical abortion at ≥ 19 weeks: Recommend cervical priming with an osmotic dilator plus medication (mifepristone, misoprostol, or a combination of both)

13. Pain control for safe abortion

All first trimester abortion can be provided in out-patient basis. In all second trimester abortion, Procedure should be done in procedure room with facility for conscious sedation, Epidural or general anesthesia. If a Conscious sedation, Epidural or general anesthesia has been used , observe clients for a minimum of four to six hours in the recovery room until the effect of medication has completely worn off.

Options of pain control

- ☐ use Non pharmacologic methods in combination with
  - 1 verbal reassurance with support person
  - 2 environment ...privacy , separate rooms
  - 3 hot water bottle/heating pad
- ☐ Pharmacologic methods

For all medical abortion pain control should be used **Under 12 weeks of Gestation use**

1 . Non steroidal anti inflammatory drugs: Ibuprofen, Diclofenac or indomethacin PO can be used

2 . If MVA is the method o f choice, Use para cervical block. Above 12 weeks of gestation

2. use NSAIDs together with anxiolytics, Antiemetics or Epidural if available

For all surgical abortion

1. Use NSAIDs together with paracervical block narcotic analgesia IM or IV Pethidine (meperdine) 50-100 mg stat
2. Anxiolytic (benzodiazepines) Diazepam 10 mg PO or 2-5 mg IV ORMidazolam 5 mg IM (or 0.07-0.08 mg/kg IM) OR Lorazepam 1-2 mm PO or 0.05 mg/kg IM Stat
3. Anesthesia Local anesthesia (paracervical block) Regional anesthesia-Epidural if available. General anesthesia rarely or if there is a complication

14. Procedures During Termination

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

Medical abortion

Administer the following combination of drugs in the specified dosage:

- ☐ Up to 9 completed weeks since LNMP
  - Mifeprestone PO 200 mg followed by in one to two days by
  - Misoprostol 800 µg buccal , sublingual or vaginal, Insert misoprostol deep into the vagina or instruct the woman to do so by herself.
- ☐ Between 9 weeks to 12 weeks same as above but the dose of Mifepristone and Misoprostol may be repeated
- ☐ After 12 till 24 weeks completed weeks since LMP
  - Mifepristone PO 200 mg followed in one to two days by
  - Misoprostol 400µg of Buccal , sub lingual or vaginal misoprostol every 3 hours up to a maximum of 5 doses if abortion does not occur.
- ☐ After 24 till 28 weeks completed weeks since LMP
  - Mifepristone PO 200 mg followed in one to two days by
  - Misoprostol 100µg of Buccal , Sublingual, or vaginal misoprostol every 3 hours up to a maximum of 5 doses if abortion does not occur.

In all situation of medication abortion

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

1. Review the medical history , physical examination and laboratory finding to ascertain indication
2. Perform examination to exclude complications
3. Repeat dose of mifepristone and misoprostol as recommended regimen

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

Contraindications:

Mifepristone and Misoprostol

- Suspected ectopic pregnancy or undiagnosed adnexal mass
- IUCD in place (remove before administering medication)
- Chronic adrenal failure
- Concurrent long term corticosteroid therapy
- History of allergy to mifepristone
- Hemorrhagic disorders or concurrent anticoagulant therapy
- Inherited porphyria
- History of allergy to prostaglandins including misoprostol Rule out the above clinical conditions before administering either of the 2 drugs.

Surgical methods

For pregnancies 12 weeks or less from the first day of LMP the preferred method of termination is vacuum aspiration, manual or electrical. between 12 -14 weeks MVA can be used by trained and Skilled provider

Vacuum aspiration

Vacuum aspiration is the preferred method of termination of pregnancy for an otherwise uncomplicated pregnancy up to 12 -14 completed weeks of pregnancy from LMP.

The provision of vacuum aspiration includes the assessment of gestational age, cervical priming (if needed), the actual procedure, pain management including the provision of a paracervical block and the assessment of completeness of abortion through the visual inspection of products of conception.

Procedure

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

Dilatation and Evacuation

For pregnancies between 14 -24 weeks D and E could be provided particularly if mediction abortion fails or cannot be used because of contraindication or if the woman choses as a method

15. Management of IUFD at ≥ 14 to ≤ 28 weeks

Fetal demise (fetal death) refers to situations in which the fetus is no longer alive, but the uterus has not yet started to expel its contents and the cervical os remains closed . The diagnosis is made by ultrasound scan following the clinical findings, which can include vaginal bleeding, absent fetal heart sounds on electronic auscultation, a failure to feel fetal movements or a uterus that is significantly smaller than the expected size . IUFD may be managed expectantly, or treated surgically (D&E) or medically.

For medical management of IUFD at ≥ 14 to ≤ 28 weeks: Suggest the use of combination mifepristone plus misoprostol over misoprostol alone.

- ☐ Suggested regimen: 200 mg mifepristone administered orally, followed 1–2 days later by repeat doses of 400 jig misoprostol administered sublingually or vaginally every 4–6 hours. The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.
- ☐ Alternative regimens: repeat doses of 400 jig misoprostol administered sublingually or vaginally every 4–6 hours.

16. Management of Incomplete Abortion

Incomplete abortion is defined by clinical presence of an open cervical os and bleeding, whereby all products of conception have not been expelled from the uterus, or the expelled products are not consistent with the estimated duration of pregnancy.

For the management of incomplete abortion <14 weeks either vacuum aspiration or medical management is recommended. The decision about the mode of management of incomplete abortion should be based on the individual's clinical condition and preference for treatment.

- ☐ For the medical management of incomplete abortion at <14 weeks the use of 600 jig misoprostol administered orally or 400 jig misoprostol administered sublingually.
- ☐ For the medical management of incomplete abortion at ≥ 14 weeks uterine size: WHO Suggest the use of repeat doses of 400 jig misoprostol administered sublingually, vaginally or buccally every 3 hour

17. Post Procedure Care

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

- ☐ Follow stability of vital signs; Do abdominal examination for tenderness, fluid
- ☐ accumulation; do pelvic examination for vaginal bleeding:
- ☐ Identify, manage, and refer complications as appropriate:
- ☐ Inform women that all methods of abortion could have a small risk of failure to terminate the pregnancy, thus necessitating a further procedure:

- ☐ Give discharge instructions (using simple language, sequential, and in pace with the level of understanding of the client) on symptoms and signs that indicate complications and the availability of care for any condition 24 hours:
- ☐ Give post-procedure counseling, as appropriate, on STDs, VCT, GBV, and contraception and other issues:
- ☐ Provide the chosen method of contraception immediately after abortion following the WHO eligibility criteria.
- ☐ Administer TT for all eligible women before discharge.
- ☐ Inform women about benefits of ANC, breastfeeding, child immunization and nutrition.
- ☐ Do Papanicolau smear or VIA for all women.
- ☐ STD screening, partner tracing, sexual health counseling should be done
- ☐ In the absence of complications women can be discharged as soon as they feel able and their vital signs are stable.
- ☐ Routine post procedure appointment is not recommended unless the woman have a specific health issues

18. Post abortion family planning(PAFP)

Providing post abortion contraceptive counseling and methods will improve contraceptive acceptance and break the cycle of having unwanted pregnancy. All ranges of contraceptive methods can be used after the first trimester abortions. However, the Medical Eligibility Criteria (MEC) for each method need to be met.

1. Elements of PAFP:

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

- ☐ Establish rapport:
- ☐ Assess the woman's needs:
- ☐ Explain human reproduction:
- ☐ Ask if the woman desires to delay or prevent future pregnancy:
- ☐ Assess the woman's individual situation:

- ☐ Explain characteristics of available methods:
- ☐ Help the woman choose the method:
- ☐ Ensure that the woman understands how the method she selected works: Refer the woman to related community resources as need:
- ☐ Methods of choice for PAFP and Medical eligibility criteria:

2. Providing family planning methods

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

- ☐ There are no complications that require further treatment.
- ☐ The woman receives proper counseling and informed oral consent is obtained (no need written consent for receiving contraceptive method except permanent method of contraception)
- ☐ The provider screens for any precautions for using a particular contraceptive method.

a. Family planning In uncomplicated abortions;

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

b. Family planning in abortion with complications: Infection:

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

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

Genital injury:

Genital injury includes uterine perforations, cervical tears, vaginal trauma and lacerations. Contraceptive methods that may temporarily restricted in the presence of genital injury includes: Tubal ligation, IUCD, IUS, spermicides and

barrier methods other than the male condom. However, the health care provider should assess the location and severity of the injury and choose the appropriate contraceptive method.

Excessive Blood loss:

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

c. Emergency contraception:

Emergency contraception (EC) can be considered for women who are vulnerable to unprotected sexual intercourse. However, for women receiving abortion care

services, provision of other modern contraceptives in advance to prevent future unwanted pregnancies should be made. EC should not be used as a regular contraceptive.

D. Timing of Post Abortion Family planning

Clients served with surgical abortion care:

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

Clients served with Medical Abortion:

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

19. Referral Arrangemnts

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

- ☐ Refer a woman if the type of care that she needs is beyond the capacity of your institution to manage

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

20. Providers Skills and Performance

In order to effectively discharge their responsibilities, providers should acquire basic knowledge and skills during their pre-service training and get periodic updates through on the job training. Learning methods should address both knowledge and clinical skills as well as attitudes and beliefs of service providers.

A values clarification that helps providers to distinguish between their own values and clients rights to safe reproductive services is an essential component of all training programs. Selection of training sites should take into consideration the volume of flow of patients so that providers will get the opportunity to acquire adequate skills in managing abortion and its complications.

In order to make safe abortion services as permitted by law accessible to all eligible women, the role of midlevel providers such as health officers ,nurses

and midwives should be expanded to provide comprehensive abortion services including uterine evacuation using MVA and medical abortion.

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

Table 1 Task analysis by category of health workers

Task	Professional Category						
	OBGYN	GMPs/I ESO	Health Officers	Midwives	Nurses	HEW level IV	HEW
☐ Patient assessment							
☐ History taking	☐	☐	☐	☐	☐	☐	☐
☐ Physical examination	☐	☐	☐	☐	☐	☐	☐
☐ Bimanual pelvic exam	☐	☐	☐	☐	☐	☐	X
☐ Dating gestation	☐	☐	☐	☐	☐	☐	☐
☐ Counseling	☐	+	+	☐	☐	☐	☐
☐ Uterine evacuation in first taste							
☐ MVA	☐	☐	☐	☐	☐	☐	X
☐ Medical abortion	☐	☐	☐	☐	☐	☐	X
☐ Uterine evacuation in 2nd taste	☐						
☐ Medication abortion	☐	☐	☐	X	X	X	X
☐ D and E	☐	X	X	X	X	X	X
☐ Pain Medications							
☐ Analgesics/sedatives	☐	☐	☐	☐	☐	☐	☐
☐ Narcotics/Paracervical block	☐	☐	☐	☐	☐	X	X
☐ Treatment of complications							
☐ Identification	☐	☐	☐	☐	☐	☐	☐
☐ Antibiotics	☐	☐	☐	☐	☐	X	x
☐ IV Fluids	☐	☐	☐	☐	☐	X	x
☐ Blood Transfusions[1]	☐	☐	☐	X	X	X	X

☐ Maintain airways	☐	☐	☐	☐	☐	X	X
☐ Repair of minor injuries	☐	☐	☐	☐	☐	X	X
☐ Abdominal surgery	☐	☐	X	X	X	X	x
☐ Post procedure care	☐	☐	☐	☐	☐		x
☐ Follow up care	☐	☐	☐	☐	☐	☐	x
☐ Universal precautions	☐	☐	☐	☐	☐	☐	☐
☐ Postabortion contraception	☐	☐	☐	☐	☐	☐	☐
☐ Information	☐	☐	☐	☐	☐	☐	☐
☐ Counseling	☐	☐	☐	☐	☐	☐	☐
☐ Method choice	☐	☐	☐	☐	☐	☐	☐
☐ Informed choice/referral	☐	☐	☐	☐	☐	☐	☐
☐ Linkages with other RH sces							
☐ Counseling	☐	☐	☐	☐	☐	☐	☐
☐ Screening	☐	☐	☐	+	+	☐	+
☐ Treatment	☐	☐	☐	☐	☐	☐	☐
☐ Referral	☐	☐	☐	☐	☐	☐	☐
☐ Instrument processing		☐	☐	☐	☐	☐	x
☐ Education on:							
☐ Dangers of unsafe action	☐	☐	☐	☐	☐	☐	☐
☐ Prevention of unwanted pregnancy	☐	☐	☐	☐	☐	☐	☐
☐ Legal provisions for abortion	☐	☐	☐	☐	☐	☐	☐
☐ Training junior health professionals and community health	☐	☐	☐	☐	☐	☐	x
☐ Maintai records and submit	☐	☐	☐	☐	☐	☐	x

Key;

✓ = Roles expected from the category of professionals

X = Roles not expected of the category

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

2 The role of the Pharmacy professional is to dispense medication that has been prescribed by other professional

21. Category of health workers and their role in SAC

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

- ☐ level IV health Extension workers
- ☐ Nurses (both clinical or Public Health)
- ☐ Midwives
- ☐ Health Officers, and IESO
- ☐ General medical practitioners, and
- ☐ Specialists in Obstetrics and Gynecology Specialists in Obstetrics and Gynecology, general medical practitioners and health officers with adequate training on the specific skills are authorized to perform second trimester abortion procedures.

22. Abortion Services by Level of Care

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

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

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

Table 2: Abortion services by level of health care

A. Public Health facilities

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

Primary Hospital	Same as above, plus general medical practitioners (GMPs), IESO's, and anesthetists	☐ The above activities plus: ☐ Uterine evacuation for ☐ second trimester abortion 13-24 weeks ☐ Treatment of most complications ☐ Blood X-matching and transfusion ☐ Local and general anesthesia ☐ Laparotomy and indicated surgery ☐ Diagnosis and referral for serious complications such as peritonitis and renal failure. ☐ Referral for all abortions above 24 weeks ☐ Training of all cadres of health professionals (pre-service and in-service)
General Hospital and Referral hospitals	Same as above plus; Obstetricians &gynecologists anesthesiologists and other specialists	**The above activities plus:** ☐ Uterine evacuation for ☐ second trimester ☐ abortion upto 28 weeks ☐ Treatment of severe complications ☐ (including bowel injury, tetanus, renal failure, gas gangrene, severe sepsis) ☐ Treatment of coagulopathy

B. Private Health Facilities

PRIMARY CLINICS	Staffed by Nurses and Assistants	☐ Counseling ☐ General physical and pelvic examination ☐ Medical abortion up to 12 completed weeks of pregnancy ☐ Administration of antibiotics and IV fluids ☐ Referral
MEDIUM CLINICS	Staffed by HO or GMP and a team of other health workers, nurses and midwives	☐ Counseling ☐ General physical and pelvic examination ☐ Vacuum aspiration up to 12 completed weeks of pregnancy ☐ Medical abortion up to 12 completed weeks of pregnancy ☐ Administration of antibiotics and IV fluids ☐ Referral
MCH SPECILAITY CENTERS, AND SPECIALIZED HOSPITLAS STAFFED BY OBSTETRICIAN AND GYNECOLOGIST	Staffed by Specialists (ob/gyn), GMP and a team of other health workers	**The medium clinic activities plus:** ☐ Uterine evacuation for second ☐ trimester abortion 13-24 weeks ☐ Treatment of most complications ☐ Blood X-matching and transfusion ☐ Local and general anesthesia ☐ Laparatomy and indicated surgery ☐ Diagnosis and referral for serious complications such as peritonitis and renal failure. ☐ Referral for all abortions above ☐ 24 weeks

23. Essential Equipment and Supplies

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

A. Basic Supplies

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

B. Instruments and equipment for first trimester uterine evacuation

1. Basic Uterine Evacuation

- ☐ Tenaculum
- ☐ Sponge forceps or uterine packing forceps
- ☐ Malleable metal sound
- ☐ Pratt or Denniston dilators: sizes 13-27 French
- ☐ Medium speculum, self retaining
- ☐ local anesthesia 1% with out adrenalin
- ☐ Plastic strainer
- ☐ Clear glass dish for tissue inspection
- ☐ Long dressing forceps
- ☐ Container for cleansing solution
- ☐ Single tooth tenaculum forceps 2)

2. Vacuum aspiration with electric pump

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

3. Manual vacuum

- ☐ aspiration
- ☐ Basic uterine evacuation instruments plus:
- ☐ Vacuum aspirators
- ☐ Adapters
- ☐ Flexible or semi rigid cannulae, size 4-12mm

C. Instruments and equipments for second trimester Safe abortion service

1. Medication abortion

- ☐ Mifepristone tablets..200mg oral
- ☐ Misoprostol tablet ....200 micro gram tablets

2. Surgical methods (D&E) up to 24 weeks

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

- ☐ Large postpartum flexible curette
- ☐ Bowel or container for examining evacuated tissue

3 Second trimester Safe abortion service needs

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

24. Monitoring and Evaluation

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

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

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

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

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

Table 3: Some aspects of abortion care services to be included in monitoring plans

Types of Services to be monitored	Indicators to measure activities	Sources of information	What type of question should we ask?
Infection prevention	Percentage of cases in which infection prevention practices were fully adhered to	Observation of services using checklists	☐ Was no-touch technique used? ☐ Were MVA instruments properly processed?
Management and organization of services	☐ Average amount of time clients receiving abortion care spend in the facility ☐ Average amount of time from arrival to procedure ☐ Hours during which service are available	☐ Observe & evaluate patient flow ☐ Review client records and conduct interview with staff	During which time of the day does client waiting time increase?
Counseling	☐ Number and percentage of clients receiving counseling	☐ Observing counseling sessions using performance checklist ☐ Review cases from logbook	Were women with special needs given referrals?

Contraceptive counseling and services	☐ Number and type of contraceptives dispensed on site ☐ Number and percentage of women who received contraceptive counseling ☐ Number and percentage of women desiring contraception who received a method	☐ Observe counseling ☐ Conduct exit interviews ☐ Review logbooks	☐ How well was the woman counseled about available contraceptive methods? ☐ Did the woman leave with desired method or information? ☐ Did the woman have to go to another facility to receive a contraceptive method?
Client satisfaction	☐ Percentage of women who indicate that they received respectful care ☐ Percentage of women who agree that services fees are reasonable	☐ Conduct exit interview ☐ Review service fee charges	☐ Did you feel that you were treated respectfully? ☐ Do you think the amount that you had to pay for services was reasonable?

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

Appendices

Appendix I: Consent form

Consent form for comprehensive abortion care raft

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

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

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

Signature _____

Date _____

Appendix II: Universal Precautions

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

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

Appendix III: Instrument Processing

Follow specific instructions for processing medical instrument as appropriate. For detailed guidance please refer to National IPC ref Manaul MOH Third Edition 2019 Guidance For instruments and equipment that could be reprocessed through high-level disinfection, follow the steps described below:

Immediately following the procedure, all MVA Syringes and Cannulae that will be reused should be kept wet until cleaning. therefore Pre soak in water Do not use chlorine or saline.

Point-of-Use Preparation

Clean and Disassemble Instruments

Wear gloves and face protection. Clean all instrument surfaces thoroughly in warm water Disassemble the aspirator by pulling the cylinder out of the valve. Remove the cap by pressing down the cap-release tabs with one hand and pulling off the cap with the other hand.

Open the hinged valve by pulling open the clasp. Place the right thumb alongside the right valve button and theleft thumb on the valve latch. With the left thumb, pull up and to the left on the valve latch whilepushing down and out on the valve body with the right thumb. Remove the valve liner.

Disengage the collar stop by sliding it sideways under the retaining clip, or remove the collar stop completely.

Pull the plunger completely out of the cylinder. Displace plunger O-ring by squeezing its sides and rolling it into the groove below.

Instruments must be completely clean before further processing. If tissue is trapped in the tip of a cannula, flush water through the cannulae repeatedly or use a cotton- tipped probe, soft brush or soft cloth to gently remove material. If unable to remove blood or tissue during cleaning despite repeated attempts, discard the instrument.

Caution:

Do not use any pointed or sharp objects to clean the valve parts or to move the O-ring. This could cause damage and prevent the aspirator from maintaining a vacuum.

Processing Options

The MVA syringe does not directly touch the woman's body. However, when it is used, the cylinder fills with blood. There is the potential risk that some contaminants from a previous woman could be introduced to another woman if the MVA aspirator is not fully processed (soaked, cleaned and sterilized or high-level disinfected) between each use. Therefore, after cleaning, the MVA Plus must undergo high-level disinfection or sterilization between patients to remove contaminants. Once processed, the aspirator maybe kept in a clean container. MVA Syringes must be completely disassembled for all processing methods.

The MVA Cannulae require high-level disinfection or sterilization before re-use and must be high-level disinfected or sterile when inserted into the uterus. Chemical processing agents are hazardous substances. When processing instruments, take necessary precautions, such as using personal protective equipment. Refer to the manufacturer's safety instructions to establish safe use.

For optimal infection prevention, items should be processed using a method that provides the highest level of effectiveness. Use one of the following methods, listed in order of decreasing

Effectiveness:

Sterilize

Steam autoclave in linen or paper for 30 minutes at 121°C (250°F) and 106kPa (15lbs./in2

- ☐ Soak completely immersed in 2% glutaraldehyde solution (Cidex® or equivalent) for the time recommended by the manufacturer—most recommend 10 hours.
- ☐ Boil in water for 20 minutes. Grasping hot cannulae may cause flattening. Let water cool before removing cannulae and handle by the adapter/base.

- ☐ Soak completely immersed in a 0.5% chlorine solution for 20 minutes. Change chlorine solution daily or sooner if solution becomes cloudy. Soak completely immersed in 2% glutaraldehyde solution (Cidex® or equivalent) for the time recommended by the manufacturer—recommendations range from 20–90 minutes.
- ☐ If chemical agents were used in processing, the Cannulae are to be thoroughly rinsed with either boiled water (for instruments that were high-level disinfected) or sterile water (if instrument was sterilized) after processing.
- ☐ Ipas MVA Plus Aspirator parts can be thoroughly rinsed in clean potable water (drinking water).

Storage

MVA Syringes and adapters may be dried, the O-ring lubricated and the device reassembled and stored in a clean, dry area until use.

The aspirator does not need to remain high-level disinfected or sterilized at the time of use and can be placed in a clean area .

Cannulae must remain sterile or high-level disinfected until next use. Store cannulae in either sterile or high-level disinfected containers to preserve the level at which they were processed. Handle cannulae by the base ends.

Assembly and Use

Before use, reassemble, lubricate and check vacuum capability of the aspirator.

Place the valve liner in position inside the valve by aligning the internal ridges. Close the valve until it snaps in place. Snap the cap onto the end of the valve. Push the cylinder into the base of the valve without twisting.

Place the plunger O-ring in the groove at the end of the plunger and lubricate it by spreading one drop of lubricant around the O-ring with a fingertip. Silicone or other non-petroleum-based

Appendix IV. Waste Disposal

Dispose of waste contaminated with blood, body fluids, laboratory specimens, or body tissues safely, following facility protocols.

Health facilities should have a clear policy about how staff should respond to women's requests to take the fetus with them for private burial. If the woman is given the fetus (and placenta, if desired), it should be placed in a sealed, wrapped container. The woman and her family should be informed that to prevent any possible infection risk, the container should remain unopened and should be carefully buried as soon as possible where it will be undisturbed.

Waste disposal needs

- ✓ Handling
- ✓ Sorting
- ✓ Interim storage
- ✓ Transport

Disposal methods could be

- ✓ Placental pit
- ✓ Open air burial
- ✓ Incineration

Appendix V: Logbook for Abortion Procedures

Federal Ministry of Health

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

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

Location information to be completed at front of register:

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

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

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Serial No.	Date	MRN	Age of women (Yrs)	Gestational age (Wks)	Gravida	Para	No. of Previous abortions	Diagnosis	Type of Uterine Evacuation Procedure					Managed as		Analgesic, Anesthesia, sedation drugs given & dose
									MVA	E&C	MA	D&C	Other	Out-pt	In-pt	

Count
2D-2,1 s25

Abortion Care Services														
Post Abortion Contraception						Outcome			Other Treatment Provided	Counseling, screening diagnosis &/or treatment for other reproductive health needs		Remarks	Name & signature of service provider
Counseled		Expressed Desire		Type of contraceptive methods supplied	Referred	Complications		Death					
Yes	No	Yes	No			Yes (Specify)	No			Yes, List	No		

Appendix VI: Quarterly/Monthly Reporting Format for Abortion Services

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

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

Prepared by: _____

Approved by: _____