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CHAPTER SEVEN

Comprehensive Abortion Care

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1 Introduction

The World Health Organization (WHO) estimates that 42 million pregnancies end annually in induced abortion; 20 million of these are estimated to be unsafe — performed either by persons lacking the necessary skills or in an environment lacking the minimum medical standards, or both. Deaths and injuries from unsafe abortion continue to be a serious public health problem that affects families and entire communities. Globally, unsafe abortion accounts for 13% of maternal deaths, 99% of which occur in the developing world. Making pregnancy safer includes the provision of or referral for safe abortion services to the full extent allowed by the applicable law and timely and appropriate management of unsafe and spontaneous abortion for all women.

Women and girls in humanitarian settings may be at increased risk of unintended pregnancy and unsafe abortion and require access to safe and legal abortion services:

- Women and adolescents may not be able to continue with their contraceptive method because they lost it during displacement.
- Families may want to delay childbearing until their security and livelihoods are assured, but not have access to contraceptives due to disruption of health services.
- Rape and other forms of sexual violence are increasingly documented in conflict settings.

To help governments, planners and service providers implement their commitments

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to women's health and rights, the WHO issued technical guidance in 2003 to strengthen the capacity of health systems to provide safe abortion care (SAC) and postabortion care (PAC).

PAC is the global strategy to reduce death and suffering from the complications of unsafe and spontaneous abortion and comprises five elements:

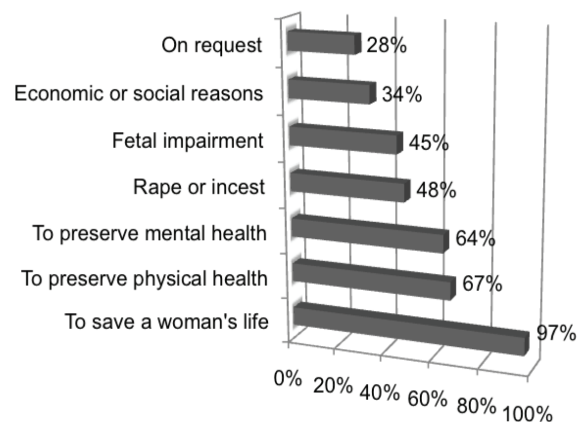
- **Treatment** of incomplete and unsafe abortion and complications that are potentially life-threatening.
- **Counselling** to identify and respond to women's emotional and physical health needs and other concerns.
- **Contraceptive and family planning services** to help women prevent an unwanted pregnancy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

Comprehensive abortion care (CAC) includes all of the elements of PAC as well as safe induced abortion for all legal indications (i.e. as allowed by national law). These elements all contribute to reductions in maternal mortality.

A range of technological options exist to help women prevent or cope with an unwanted pregnancy, including emergency contraception, vacuum aspiration and medical abortion. Also, an increasing number of countries have reformed their abortion laws to expand the legal indications for abortion, including rape and incest.

2 Objectives

Grounds on which abortion is permitted — percentage of countries (n=195)



n=195: 195 countries were included in the study

From: *World Abortion Policies*. New York, UNPD. 2007. www.un.org/esa/population/publications/2007_Abortion_Policies_Chart/2007_WallChart.pdf

The objectives of this chapter are to provide RH officers, programme managers and service providers with:

- programming information on safe and legal abortion services and referral to

such services to the extent allowed by the law;
- basic clinical information to guide service delivery;
- the framework to obtain accurate information and understand the administrative and regulatory boundaries related to abortion in the country where they are working;
- an understanding of the social, cultural and religious norms surrounding safe abortion services;
- the tools to educate communities on their rights.

3 Programming

The following sections outline basic guidelines for ensuring the provision of high-quality comprehensive abortion services.

The addition of safe induced abortion services for all legal indications to the elements of the PAC model results in a comprehensive approach that supports women in exercising their sexual and reproductive rights. Ideally, these services are provided as an integrated, comprehensive package.

Comprehensive abortion care services need not be dependent on the availability of obstetricians/gynaecologists or surgeons. With appropriate training and support, nurses, midwives and other midlevel health workers can safely provide first-line safe abortion and PAC services, even in outpatient settings. (See Table 19.)

3.1 Needs assessment

When planning for abortion services, solicit information and consider community needs and perceptions, including women's preferences for type and sex of the provider and location of services.

High incidence of unsafe abortion is often the result of laws restricting access to abortion. However, even where abortion is legal, women often lack access to safe and legal abortion services. The conditions under which abortion is legally permitted vary from country to country. In some countries, access is highly restricted; in others, pregnancy termination is available on request and on broad medical and social grounds. Virtually every country in the world allows safe and legal abortion in some circumstances.

RH officers, programme managers and service providers must be familiar with national legislation and policies related to safe abortion in the countries in which they work:

- Is there a law/regulation/policy on termination of pregnancy/availability and accessibility of safe abortion services? Pay particular attention to:
  - grounds on which abortion is allowed (e.g. therapeutic, fetal impairment, rape, incest, mental health, personal grounds);
  - time limit within which an abortion can be performed and whether there are situations in which the time limit can be waived;
  - availability of different abortion methods (e.g. surgical, such as electric or manual vacuum aspiration; medical, such as mifepristone and misoprostol) and distribution and provision of medicines for abortion and postabortion care;
  - counselling requirements;
  - settings where abortion can be performed and/or the level of provider who can perform an abortion or provide abortion methods;
  - provisions on the cost of an abortion;
  - regulations or expectations that require others (husbands, parents, guardians) to give permission for the procedure (third-party authorization);
  - mandatory reporting requirements;
  - requirements for health providers who object to performing abortions (conscientious objection) to refer to a colleague who will provide abortion services.
- Is there a law that prohibits/criminalizes abortion?
  - Is there any law and/or regulation concerning the provision of postabortion

Table 19: Comprehensive Abortion Care			
	Community level	**Primary care level**	**Hospital level**
Education and information on prevention and consequences	✓	✓	✓
Recognition of abortion complications	✓	✓	✓
Transportation to safe abortion services and for management of complications of unsafe abortion	✓	✓	✓
Referrals for pregnancy, safe legal abortion care or postabortion care	✓	✓	✓
Referral of survivors of rape or incest to health and/or social services	✓	✓	✓
Vacuum aspiration or medical treatment for incomplete abortion or safe abortion up to 12 weeks of pregnancy		✓	✓
Contraceptive methods, including emergency contraception and postabortion contraception		✓	✓
Emergency treatments, such as IV fluid replacement, oxytocics, haematocrit/haemoglobin testing and antibiotics 24 hours/day		✓	✓
Referral and transport of women with the most severe abortion complications (septicaemia, peritonitis, renal failure)		✓	✓
Second trimester abortion, laparotomy, safe blood transfusion, voluntary sterilization, screening for hepatitis, syphilis and HIV			✓
Management of severe abortion complications			✓

care, including emergency care after an unsafeabortion? Pay particular attention to referral and reporting requirements.
- Is there a law/regulation/policy that states that at least information on safe/unsafe abortion services and postabortion care must be provided?

In addition to the social and legal context, also consider:

- epidemiological context
- staff training, qualifications and capacity
- supplies and equipment
- health facility condition
- emergency transport system
- the capacity of the referral facility.

3.2 Counselling and voluntary informed consent

Service providers must be aware that women seeking abortion care may be under severe emotional stress or physical discomfort. They must ensure privacy, confidentiality and consent for treatment. High-quality counselling provides the woman with emotional support and contributes to the effectiveness of the procedure. Effective counselling is structured completely around the woman's needs and concerns and occurs before, during and after the procedure.

Voluntary informed consent, obtained either by writing or verbally, ensures that the woman understands, and is in agreement with, her proposed treatment plan, including its benefits, risks and alternatives. Informed consent means that the woman makes her decisions freely, without pressure or coercion of any type. Service providers can document this by obtaining the woman's signature on a consent form. In some settings it may be more appropriate to confirm agreement verbally.

3.3 Clinical assessment

Service providers should conduct a complete clinical assessment, consisting of:

- a thorough reproductive health history (including history of sexual violence);
- a careful physical and pelvic examination (ultrasonography (US) and testing for pregnancy are not a precondition or minimum requirement for offering termination of pregnancy services. A pregnancy can be detected during a bimanual pelvic examination as early as 6 to 8 weeks);
- a psychosocial assessment.

Women presenting for treatment of incomplete abortion or abortion complications (postabortion care) should be assessed with particular care, because they may have life-threatening complications. Uterine evacuation is often an important component of case management and once the patient is stabilized, this procedure should not be delayed.

Prompt transfer to a referral hospital may be needed if the woman requires treatment beyond the capability of the health centre where she is seen. Her condition should be stabilized before she is transferred

Ectopic Pregnancy

It is important to consider other potential life-threatening conditions that cause shock, including ectopic (tubal) pregnancy. An ectopic pregnancy can be life-threatening; treat the woman or transfer her as soon as possible to a referral hospital where the diagnosis can be confirmed and the appropriate treatment provided.

3.4 Infection prevention

As with any invasive procedure, there is a risk of infection to patients, service providers and

support staff through contact with contaminants. To minimize the risk, standard precautions must be observed at all times. These include using appropriate barriers (such as gloves and masks), handling waste carefully and taking precautions to prevent injuries (see Chapter 2: MISP, paragraph 3.3.2, p. 37). Iatrogenic infection is prevented by following standard precautions, using aseptic techniques and ruling out or treating cervical infection before performing transcervical procedures.

All women undergoing uterine evacuation by vacuum aspiration should be given a prophylactic dose of antibiotics to reduce the risk of infection. The lack of prophylactic antibiotics, however, does not preclude the performance of vacuum aspiration. Routine antibiotics are not necessary or recommended for women who undergo uterine evacuation through medical methods. In this case, antibiotics should be reserved for cases where the woman exhibits signs and symptoms of infection.

3.5 Pain management

Medication should always be offered for pain management. The goal of a pain management plan is to help the woman remain as comfortable as possible. Vacuum aspiration should be conducted with local anaesthesia and/or oral analgesia (such as ibuprofen). General anaesthesia is rarely necessary and puts the woman at greater risk.

3.6 Uterine evacuation

Induced abortion

In the first trimester, the preferred methods of uterine evacuation for induced abortion are:

- Electric vacuum aspiration (EVA) or manual vacuum aspiration (MVA) through 12 completed weeks of pregnancy (12 weeks since the woman's last menstrual period (LMP))
  - Examine the products of conception after the procedure to exclude the possibility of ectopic or molar pregnancy or incomplete abortion.
- Medical methods through nine completed weeks of pregnancy
  - A combination of mifepristone followed by a prostaglandin such as misoprostol is preferred. Where mifepristone is not available, evidence supports use of misoprostol alone, although it is less effective than when used in combination with mifepristone, and less effective than vacuum aspiration. There is not sufficient evidence to recommend these regimens for abortion beyond nine completed weeks.

Women in middle- or late-second trimester should be referred to a hospital with surgical facilities for treatment.

Medical methods for induced abortion up to 9 weeks since LMP

Mifepristone and Misoprostol

200 mg mifepristone orally, followed after 36 - 48 hrs by 800 µg misoprostol vaginally or sublingually

Misoprostol alone

can induce abortion in early pregnancy but repeated doses are needed, such as 800 µg misoprostol vaginally or sublingually repeated every 12 hours up to three doses. Misoprostol alone, however, is less effective than mifepristone and misoprostol combined and generally causes side-effects.

Postabortion Care (PAC)

Both vacuum aspiration and misoprostol are safe, effective and acceptable methods for

evacuation of the uterus for postabortion care.

Misoprostol reduces the cost of PAC services, as it does not require the immediate availability of sterilized equipment, operating theatres or skilled personnel. Misoprostol for the treatment of incomplete abortion is an important option in humanitarian settings where it is difficult to maintain MVA equipment and appropriately trained providers, and where referral for surgical uterine evacuation may be delayed.

Dilatation and curettage (D&C)

Also known as "sharp curettage" with metal instruments, D&C is no longer recommended except in cases where vacuum aspiration or medical methods are not available. Where D&C is currently practised, all possible efforts should be made to replace it with vacuum aspiration or medical methods to improve the safety and quality of care.

The use of misoprostol for obstetric indications is rapidly evolving. RH programme mangers and service providers should stay abreast of the evolving clinical and technical literature. (See Further Reading.)

The use of mifepristone and/or misoprostol for safe abortion and postabortion care requires the back-up of vacuum aspiration services, either on site or through referral, in case of failed or incomplete evacuation of uterine products.

Misoprostol for incomplete abortion up to 12 weeks since LMP

600 microgram misoprostol orally (one dose) is effective and safe.

No published studies have investigated the use of misoprostol to treat women with septic abortion.

3.7 Prevention of tetanus

Women who have had unsafe abortions with non-sterile instruments are at risk of tetanus. Provide or refer the patient for tetanus prophylaxis if this is known or suspected, particularly in communities where tetanus after abortion has been reported. A booster injection of tetanus toxoid (TT) should be given to women who have been previously vaccinated. Tetanus immunoglobulin (TIG) and TT should be administered to women who have not been previously immunized or whose last dose was more than five years ago. If there is any uncertainty regarding the patient's vaccination history, both TIG and TT should be administered. If vaccine and immunoglobulin are given at the same time, use separate needles and syringes and different sites of administration. Patients should be advised to complete the vaccination schedule (second TT dose at four months, third TT dose at six months to one year).

3.8 Managing complications

While rare, complications are possible with uterine evacuation procedures and they must be dealt with by qualified providers immediately. Serious complications are very rare, but it is important to follow up all patients, as there is a small risk of infection or haemorrhage. Ensure that women have ongoing access to emergency care during their treatment. If the woman requires treatment beyond the capability of the facility where she is seen, stabilize her condition before she is transferred to a higher-level referral service.

3.9 Postprocedure counselling and follow-up

Women should be given instructions on how to take care of themselves after the procedure. Service providers should explain signs of a

Table 20: Gestation Timing and Uterine Evacuation Options																		
	Completed weeks since last menstrual period																	
	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
Preferred methods for induced abortion																		
Vacuum aspiration	✓	✓	✓	✓	✓	✓	✓	✓	Refer women in mid- or late-second trimester to a hospital with surgical and full emergency backup for treatment									
Mifepristone and misoprostol	✓	✓	✓	✓	✓	Under investigation												
Misoprostol alone	✓	✓	✓	✓	✓	Under investigation												
Preferred methods for postabortion care (PAC)																		
Vacuum aspiration	✓	✓	✓	✓	✓	✓	✓	✓	Refer women with incomplete abortions in mid- or late-second trimester to a hospital with surgical and full emergency backup for treatment									
Misoprostol alone	✓	✓	✓	✓	✓	✓	✓	✓										
Adapted from: *Safe abortion: technical and policy guidance for health systems*, WHO, Geneva 2003.																		

normal recovery and signs and symptoms of possible complications that require immediate attention. They should also provide detailed information about postabortion contraception and protection from sexually transmitted infections. A return visit should be scheduled for 10 to 14 days later.

Postabortion contraception

Lack of access to adequate family planning services is a major contributor to the problem of unsafe abortion. Conversely, unwanted pregnancy and, in many cases, unsafe abortion are prime indicators of the unmet need for safe and effective family planning services. Contraceptive acceptance and continuation rates are higher when offered at the site of initial treatment. Ensure that all staff providing PAC know how to counsel on and provide family planning methods.

At a minimum, all women receiving abortion care must understand that:

- ovulation can occur as early as 10 days after an abortion, resulting in pregnancy even before menses returns;
- contraception, including an IUD or hormonal methods, may be started immediately after uterine evacuation;
- sexual intercourse should be avoided for a few days after bleeding has stopped because of the risk of infection.

(Refer to Chapter 5: Family Planning for further details on family planning services.)

3.10 Integration of services

Service providers must identify other RH needs each woman may have and refer her or offer information on relevant services, such as management of reproductive tract infections (see Chapter 9: Sexually Transmitted Infections) or post-rape care (see Chapter 2: MISP and Chapter 8: Gender-based Violence).

4 Human rights and legal issues

A systematic lack of access by crisis-affected persons to comprehensive abortion care is a denial of their equal rights and protection as mandated under international human rights law. The following statement from the International Conference on Population and Development (ICPD) underpins the guidance given in this chapter:

"All Governments and relevant intergovernmental and nongovernmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancy must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling....[W]here abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion."

Programme of Action of the ICPD, paragraph 8.25, Cairo, 1994,

The respect, protection and fulfilment of human rights related to abortion include:

- taking positive steps to reduce maternal mortality, which can be caused by unsafe abortion;
- ensuring that States give information to help women prevent unintended pregnancies;
- making safe abortion services available (in circumstances where abortion is legal);
- removing punitive provisions for women who undergo abortion, because criminalizing abortion may lead women to seek unsafe procedures with subsequent risks to their life and health.

The following are circumstances in which human rights abuses occur:

- Forcing a woman to carry an unwanted or unviable pregnancy to term is considered degrading and causes mental suffering (especially in cases of rape or incest).
- Denying medical treatment to a woman suffering from complications of unsafe abortion unless she provides information on the person who performed the unsafe abortion constitutes cruel and degrading treatment.
- Laws that require service providers to report women who have had an abortion or needed treatment for unsafe abortion violate women's right to privacy.
- Lack of confidentiality in the health system or requirements for third party consent to the procedure may deter women or girls from seeking health services.
- Forcing women (of ethnic minorities or with disabilities) to undergo abortions is discriminatory.
- Forced pregnancy is a human rights violation and, in some situations, a war crime.

4.1 Challenges and opportunities

RH programme managers and service providers may face difficult decisions or dilemmas regarding abortion. They may find that their ability to provide comprehensive abortion care is restricted by national legislation, social or cultural norms or medical misconceptions.

For example, even where it is legally permitted, safe abortion may not be easily accessible; there may be additional requirements regarding consent and counselling, and countries often impose a limit on the period during which abortion may be performed. Other challenges may include judgmental or discouraging attitudes of health-care providers, insufficient service capacity to meet the demand or unevenly distributed or poor-quality services. Also, women themselves may be unaware of the availability of abortion services or their right to access them within the legal framework.

As an RH programme manager or service provider, you are likely to find yourself facing such challenges. You must be aware of your agency/organization position on these issues and include it as part of your analysis of the situation and possible next steps.

Train and equip all RH service providers to provide CAC information and services or refer to safe and legal abortion services within the framework of the law. It is essential that RH officers, programme managers and service providers understand clearly what is allowed under the law in the country where they are working. Efforts by policy-makers must address administrative and regulatory barriers to safe abortion and postabortion care.

When faced with a difficult situation, your first priority must be the best interest of your client, focusing on her/his safety and health. It is also important to consider your own safety and the safety of your colleagues. Then, you may wish to:

- discuss options with your client (e.g. if you are unable to provide certain methods of abortion, you can counsel her where she can obtain services);
- explore linkages with and referrals to local organizations that might be able to help your client further;
- while respecting the confidentiality of your client, identify with colleagues and other RH providers how to avoid and manage such situations in the future;
- raise these concerns in health coordination meetings;
- talk to your supervisor.

5 Monitoring

Continuously monitor and evaluate safe abortion and PAC services. Assess the level of use of these services and review clients' records, the availability and proper use of equipment and supplies and specific indicators of the quality of care. Identify changes or problems that occur, provide feedback to staff and intervene to correct any problems identified.

For more information on monitoring see Chapter 3: Assessment, Monitoring and Evaluation.

6 Further reading

Essential reading

Safe abortion: technical and policy guidance for health systems. WHO, Geneva, 2003. http://www.who.int/reproductive-health/publications/safe_abortion/safe_abortion.pdf

Managing complications in pregnancy and childbirth: a guide for midwives and doctors. WHO, Geneva, 2003. http://www.who.int/reproductive-health/impac/index.html

Additional reading

Herrick J et al. *Woman-centered postabortion care (trainer's and reference manuals).* Ipas,

Table 21: Indicators to Monitor Availability and Effectiveness of Safe Abortion and PAC Services					
Name	**Definition**	**Formula**	**Type**	**Data Source**	**Remarks**
		Numerator and Denominator	**Process, outcome or impact**		
Abortion services* performed with appropriate technology	Proportion of abortion services* performed with appropriate technology (vacuum aspiration or medical methods)	Number of abortion services* performed with appropriate technology/total number of abortions x 100	Outcome	Facility records	"Abortion services"* include treatment of abortion complications (resulting from both spontaneous or induced/ unsafe abortion) as well as provision of induced abortion procedures.
Women accessing abortion services* who receive contraception prior to discharge from the facility	Proportion of women receiving abortion services* who receive contraception prior to discharge from the facility	Number of women who received contraceptive services prior to discharge from the facility/number of women who were treated for abortion x 100	Outcome	Facility records	**Recommendation:** At least 60% of all women receiving abortion services* will receive a contraceptive of their choice before discharge from the facility
Extent to which induced abortions are being provided	Proportion of women who receive abortion services* that receive induced procedures	Number of women receiving induced abortion procedures at facility in a given period/number of all women receiving abortion services* in facility in the same time period x 100	Outcome	Health service records — but potential problems with underreporting (i.e. omission of cases not admitted to facilities) and misclassification	Over time, a shift toward a higher proportion of women receiving induced abortion as a part of all abortion services* in facility **Recommendation:** approaching 100%

Chapel Hill, NC, 2004. http://www.ipas.org/Publications/Woman-centered_postabortion_care_Trainers_manual.aspx

Hyman A et al. *Woman-centered abortion care (trainer's manual).* Ipas. Chapel Hill, NC, 2005. http://www.ipas.org/Publications/Woman-centered_abortion_care_Trainers_manual.aspx

Misoprostol in Obstetrics and Gynecology. www.misoprostol.org

Frequently asked clinical questions about medical abortion. World Health Organization, 2006. http://www.who.int/reproductivehealth/publications/en/