CHAPTER 8
COMPREHENSIVE ABORTION CARE

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8.1 INTRODUCTION

The World Health Organization (WHO) estimates that 56 million pregnancies end in induced abortion annually; 22 million of these are estimated to be unsafe, meaning that they are 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 women, girls, families, and entire communities. Globally, unsafe abortion accounts for nearly 10% of maternal deaths, 99% of which occur in the developing world. Making pregnancy safer includes fulfilling women's and girls' right to access comprehensive sexual and reproductive health (SRH) services, including the provision of safe abortion care, 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 abortion care:

- Women and girls may not be able to continue with their contraceptive method because they lost it during displacement and/or lack access to contraceptive services

- Women and girls may want to delay childbearing until their security and livelihoods are assured, but may not have access to contraceptives due to disruptions in health services and supplies
- Many girls reach reproductive age while displaced
- Rape and other forms of sexual violence are often documented in conflict settings

To help governments, planners, and service providers implement their commitments to women's health and rights, the WHO updated their technical guidance in 2012 to strengthen the capacity of health systems to provide safe abortion care (SAC) and post-abortion care (PAC).

PAC is the global strategy to reduce death and suffering from the complications of unsafe and spontaneous abortion and comprises 5 elements:

- Treatment of incomplete and unsafe abortion and complications that are potentially life-threatening
- Counseling to identify and respond to women's and girls' emotional and physical health needs and other concerns
- Contraceptive services to help women and girls prevent unintended pregnancy
- 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 preventing unintended pregnancy, mobilizing resources (to help women and girls receive appropriate and timely care for complications from abortion), and ensuring that health services reflect and meet community expectations and needs

Comprehensive abortion care (CAC) includes all of the elements of PAC as well as safe induced abortion. These elements all contribute to reductions in maternal morbidity and mortality.

A range of technological options exist to help women prevent or cope with an unintended pregnancy, including a range of ongoing and peri-coital contraceptive methods, emergency contraception, medication abortion, and vacuum aspiration. Also, an increasing number of countries have reformed their abortion laws to expand the legal indications for abortion, making abortion legal in nearly all countries in at least some circumstances. Furthermore, multiple international agreements and expert bodies have recognized a women's right to access safe abortion and its links to reducing maternal mortality.

8.2 OBJECTIVES

The objectives of this chapter are to provide SRH Coordinators, health program managers, and service providers with:

- Programming information on comprehensive abortion care and provision of or referral to such services
- Basic clinical information to guide service delivery
- A framework to obtain accurate information and understand the administrative and regulatory context related to abortion in the setting where they are working
- An understanding of the social, cultural, and religious norms surrounding safe abortion care
- Tools to educate communities on their rights and policymakers on their duties

8.3 COMPREHENSIVE ABORTION CARE PROGRAMMING

The addition of safe induced abortion care to the elements of the PAC model results in a comprehensive approach that reduces maternal mortality and morbidity while supporting women in exercising their sexual and reproductive rights. Ideally, these services are provided as an integrated, comprehensive package.

Comprehensive abortion care need not be dependent on the availability of obstetricians/gynecologists or surgeons. With appropriate training and support, nurses, midwives, and other trained health care providers can safely provide first-line safe abortion and PAC services, even in outpatient settings, as is illustrated in Table 8.1.

TABLE 8.1: MANAGEMENT OF ABORTION AND POST ABORTION CARE IN THE FIRST TRIMESTER

	Lay health workers	Pharmacy workers	Pharma-cists	Doctors of comple-mentary systems of medicine	Auxiliary nurses/ ANMs	Nurses	Midwives	Associate/ advanced associate clinicians	Non-specialist doctors	Specialist doctors
Vacuum aspiration for induced abortion	✗ **	✗ **	✗ **	✓	✓	✓	✓	✓	✓ *	✓ *
Vacuum aspiration for management of uncomplicated incomplete abortion/ miscarriage	✗ **	✗ **	✗ **	✓	✓	✓	✓	✓	✓ *	✓ *
Medical abortion in the first trimester	Recom-mendation for subtasks (see below)	✗ **	Recom-mendation for subtasks (see below)	✓	✓	✓	✓	✓	✓ *	✓ *
Management of uncomplicated incomplete abortion/ miscarriage with misoprostol	R✓ **	✗ **	✗ **	✓	✓	✓	✓	✓	✓ *	✓ *

* considered within typical scope of practice; evidence not assessed.

** considered outside of typical scope of practice, evidence not assessed.

8.3.1 Minimum Initial Service Package implementation

Comprehensive abortion care constitutes a life-saving intervention and is therefore incorporated into the Minimum Initial Service Package (MISP), a set of priorities activities to be undertaken at the onset of a crisis. Provision of pregnancy options counseling and safe abortion care and/ or referral to safe abortion care, to the full extent of the law, is included as part of the response to sexual assault survivors. Further, as a signal function in emergency obstetric and newborn care, ensuring the availability of life-saving post-abortion care in health centers and hospitals is a priority activity. In addition, provision of safe abortion care to all women to the full extent of the law is recognized as an "other priority activity." Thus the SRH Coordinator, health program managers, and service providers should ensure that safe abortion care is available at the onset of a crisis when capacity already exists. When existing capacity is not present, SAC should be made available once implementation of the MISP priority activities is underway, ideally within 3 months after the onset of an emergency, if not sooner.

8.3.2 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 as well as stigma. However, even where abortion is less restricted, 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 other countries, pregnancy termination is available on request and on broad medical and social grounds. Virtually every country allows safe and legal abortion in some circumstances.

Understanding the context of abortion in each humanitarian setting is important for identifying entry points for the provision of services. This includes analyzing local laws and policies, understanding where women and girls currently seek induced abortion services, recognizing barriers and facilitators to the provision of CAC, and identifying local

champions of the provision of safe abortion care services. Indeed, working closely with local champions of CAC is critical to identifying the most effective entry points for service provision. These may include representatives of government ministries, civil society actors, health care providers, legal advocates, and others.

Assess clinical capacity to provide comprehensive abortion care, including:

- Skills of a full range of health service providers
- Availability of post-abortion care and basic emergency obstetric care, as CAC can be provided in any setting that also provides these services
- Availability of supplies and equipment for CAC, including manual vacuum aspiration kits, drugs used in medication abortion regimens, and contraceptive methods
- Indicator data centering on contraceptive use and availability and the number of PAC clients
- Availability of referral to higher level care if warranted, including capacity of referral facility and emergency transport system

SRH Coordinators, health program 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, and/or national guideline on termination of pregnancy/availability and accessibility of safe abortion services? Pay particular attention to:
    - o Grounds on which abortion is legally permissible (e.g., threats to the woman's life, physical, or mental health, fetal impairment or disability, rape, incest, socioeconomic or personal circumstances)
    - o Actual enforcement of laws, regulations, policies, and/or national guidelines
    - o Knowledge of laws, regulations, policies, and/or national guidelines among service providers and other local stakeholders
    - o Gestational age limits within which an abortion can be performed and whether there are situations in which these limits can be waived
    - o Availability of different abortion methods (e.g., electric or manual vacuum aspiration, medication abortion regimens with mifepristone/misoprostol, methotrexate/misoprostol, and/or misoprostol alone) and distribution and provision of medications for abortion and post-abortion care
    - o Settings where abortion can be performed and/or the level of provider who can perform an abortion or provide abortion methods
    - o Costs of an abortion
    - o Regulations or expectations that require others (husbands, parents, guardians) to give permission for the procedure (third-party authorization)
    - o Mandatory reporting requirements
    - o Requirements for health providers who object to performing abortions (conscientious objection) to refer to a colleague who will provide abortion care
- The perspectives of women and girls as well as their families, partners, and other community stakeholders are critical to planning CAC including:
    - o Existing women's or other community groups in the local population that could help advocate for and inform the population of available services
    - o Social and cultural norms around unintended pregnancy and abortion, including how decisions are made around access to services and who is involved in decision-making
    - o Women's and girls' current abortion practices and preferences

8.3.3 Programming considerations

There is no one-size-fits-all approach to the provision of CAC in humanitarian settings and it is essential for humanitarian responders to collaborate toward increasing access to services. Promising entry points include, but are not limited to:

- Providing SAC through health facilities run by organizations and/or staffed by willing providers

- Offering technical support to qualified medical personnel already providing abortion services
- Reducing harm from unsafe abortion through the distribution of information and commodities for safe medication abortion

While not all organizations will be able to provide safe abortion care in every setting, there will already be CAC providers to whom organizations can actively refer in some contexts.

PROGRAMMATIC EXAMPLE 8.1: ESTABLISHING AN ABORTION REFERRAL SYSTEM

ORGANIZATION: Adolescent Reproductive Health Zone, Cambridge Reproductive Health Consultants, University of Ottawa

LOCATION: Northern Thailand

INTRODUCTION: For displaced and migrant women in northern Thailand, access to healthcare is often limited, unintended pregnancy is common, and unsafe abortion is a major contributor to maternal death and disability. Although abortion is legally permissible in Thailand for a number of indications, women from Burma have difficulty accessing services even when they meet the eligibility requirements. Based on a pilot project and situational analysis research, in 2015 a multi-national team introduced the Safe Abortion Referral Program (SARP) in Chiang Mai, Thailand to reduce the socio-linguistic, economic, documentation, and transportation barriers women from Burma face in accessing safe and legal abortion care in Thailand.

PROJECT DESCRIPTION: The Adolescent Reproductive Health Zone (ARHZ), a network of five community-based organizations serving refugee and migrant women from Burma, launched the SARP in April 2015. Prior to the launch, ARHZ counselors participated in a three-day training focused on the legal and medical frameworks around abortion in Thailand and Burma, pregnancy options counseling skill-building exercises, and the logistics of the SARP. The training also provided an opportunity for the ARHZ counselors to meet colleagues who were involved in the pilot project in Mae Sot, Thailand, Thai abortion providers, and North American researchers who provided technical assistance and monitoring and evaluation support. In addition to providing women with referrals for care, the SARP offers women financial support, including coverage of both the procedure and travel costs, interpreting services, and accompaniment, as needed and desired.

RESULTS: Over the first 2 years of the program, 81 women from Burmese communities in northern Thailand accessed the SARP; 52 women (64%) were successfully referred for care and received safe and legal abortions in either a Thai public hospital or a Thai private clinic. Both providers and women were overwhelmingly positive about their experiences with the SARP. Women reported lack of costs, friendly program staff, accompaniment to and interpretation at the providing facility, and safety of services as key features. After accessing the SARP and receiving support, women became community advocates for reproductive health.

LESSONS LEARNED: This experience suggests that referral programs for safe and legal abortion can be successful in settings with large displaced, migrant, and refugee populations. Identifying ways to work within legal constraints to expand access to safe services has the potential to reduce harm from unsafe abortion in humanitarian settings and facilitate women's access to high quality abortion care.

When services are provided it is important that they are offered in an equitable manner. This means that providers should not withhold services based on a client's age, marital status, disability, or religious affiliation and that all clients are treated in a respectful, non-judgmental manner. Organizations should have and disseminate a policy clearly stating these expectations and addressing attitudes of staff at all levels that may not be favorable to equitable provision of safe abortion services. One effective approach to improving staff attitudes is conducting values clarification and attitudes transformation (VCAT). Evidence demonstrates that VCAT participants hold more favorable attitudes toward access to safe abortion care upon completion of the curriculum.

CAC with manual vacuum aspiration is a safe and relatively simple procedure. As described in the task-sharing recommendations by the WHO, CAC can be safely and effectively provided by a range of health service professionals, including nurses and midwives, at any facility that provides basic emergency obstetric care. As with any clinical service, it is important to ensure the availability of sufficient, qualified health care personnel. The clinical competency of providers should be assessed before beginning the provision of services in order to develop a plan for competency-based training and supportive supervision.

BOX 8.1: VALUES CLARIFICATION AND ATTITUDES TRANSFORMATION

Evidence suggests that stigmatizing attitudes held from the individual to the national leadership level—including by key players in the humanitarian community such as health care providers, program and technical staff, and senior leadership within humanitarian assistance agencies—play a powerful role in restricting women's access to safe abortion care in crisis and fragile settings. A global evaluation led by the Inter-agency Working Group on Reproductive Health in Crises (IAWG), and an internal survey among IAWG members, discovered that:

- **Discomfort or personal objection to providing SAC based on religious and moral grounds influenced some humanitarian staff's professional conduct**
- **Negative attitudes towards abortion and fear of reprisal from their community due to real or perceived involvement in SAC influenced health care providers' willingness to provide services**

This underscores that even with clinical skills and proper knowledge of the legal framework, providers' negative attitudes and fears related to the provision of contraception and safe abortion care continue to act as underlying barriers that restrict women's access to care in fragile and crisis-affected settings.

This is a very real challenge in abortion care, but one that can be addressed through adaptation and use of existing resources, such as values clarification and attitude transformation or "VCAT" materials and approaches, which have proven successful with abortion care in other settings. VCAT work is almost always necessary and is best done as pre-work to technical training and/or service implementation. Recent VCAT trainings within several humanitarian agencies have created momentum towards incorporating and/or strengthening SAC in some of their country programs and existing VCAT materials are currently being adapted for humanitarian contexts (see www.ipas.org).

COUNSELING AND 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, access to adequate information, and informed consent for treatment. High-quality counseling provides the woman with emotional support and contributes to the effectiveness of the procedure. Effective and unbiased counseling is structured completely around the woman's needs and concerns and occurs before, during, and after the procedure.

Informed consent 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, based on scientifically accurate, non-biased information, without pressure or coercion of any kind.

CLINICAL ASSESSMENT

Before performing a uterine evacuation, it is essential to assess a woman's clinical status and eligibility for medication methods or vacuum aspiration. This allows

the provider to assist the woman in making an informed choice about her preferred method of uterine evacuation. The assessment should be conducted in private.

The components of a complete clinical assessment are:

- A pertinent health history (including history of sexual violence)
- A careful physical and pelvic examination including a bimanual exam
- Collection of specimens and ordering of any lab tests, as warranted by the circumstances

An important part of the clinical assessment is an evaluation of the woman's emotional state, relevant relationship and family circumstances, and support systems, as they have a direct bearing on her clinical experience. Open, supportive communication and a gentle, reassuring manner help ensure that the provider obtains the relevant information needed to offer the best possible care for the woman.

Women presenting for treatment of incomplete abortion or abortion complications (post-abortion 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 center where she is seen. Her condition should be stabilized before she is transferred.

INFECTION PREVENTION

As with any medical 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. Iatrogenic infection is prevented by following standard precautions, using aseptic techniques and ruling out or treating cervical infection before performing transcervical procedures.

Administer prophylactic antibiotics, 200 mg of oral doxycycline or 500 mg of oral metronidazole, for all women prior to vacuum aspiration. Where antibiotics are unavailable, uterine aspiration may still be offered. Therapeutic antibiotics should be administered to all women who are suspected of or who have been diagnosed with an infection. Women who show no signs of infection do not need to continue antibiotics after the procedure.

Routine use of antibiotics is not recommended for women undergoing medication abortion. Women who have signs or symptoms of a sexually transmitted infection (STI) at the time of medication abortion should be treated appropriately and medication abortion can be provided without delay.

Immediately after use, all reusable surgical instruments used in abortion care should be sent for cleaning and sterilization. Medical equipment and supplies intended for single use should not be reused. Follow standard instrument processing guidance and manufacturers' instructions. Some manufacturers produce aspirators and cannulae made of high-grade plastics that are engineered to be sterilized in an autoclave, while other plastic instruments will crack and melt when exposed to high heat. Health care workers should always refer to the instructions for use of all items being disinfected, to ensure they are using the appropriate form of disinfection.

PAIN MANAGEMENT

Women undergoing first trimester vacuum aspiration should receive a combination of pain medications (such as oral ibuprofen or diclofenac), local anesthesia in the form of a paracervical block, and non-pharmacologic approaches to treat pain. Medications should be supplemented with supportive techniques to decrease pain and anxiety. Some techniques that may be helpful include respectful staff, a clean, secure, and private setting, counseling, verbal support, gentle surgical technique, and a heating pad or hot water bottle in the recovery room. General anesthesia is rarely necessary and puts the woman at greater risk. Paracetamol is not effective for pain relief during vacuum aspiration.

All women undergoing medication abortion in the first trimester should also be offered pain management with non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen or diclofenac. In addition to medications, other methods that may help women manage pain during a medication abortion are thorough counseling, a supportive environment, and applying a heating pad or hot water bottle

to the lower abdomen. These methods are complementary but not adequate substitutes for pain management with medications.

Studies have shown that NSAIDS do not reduce the effectiveness of misoprostol. Additionally, studies have shown paracetamol and acetaminophen to be ineffective for pain relief for uterine evacuation.

UTERINE EVACUATION INDICATIONS AND METHODS

Induced abortion: First trimester

The recommended abortion methods in the first trimester are manual or electric vacuum aspiration or medication methods using a combination of mifepristone followed by misoprostol. 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. The use of mifepristone and/or misoprostol for safe abortion and post-abortion 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. Sharp curettage/dilation and curettage is an outdated surgical abortion technique and should be replaced by medication or aspiration methods.

BOX 8.2: DISPOSAL OF PRODUCTS OF CONCEPTION

Any disposable material that has come in contact with body fluids should be considered infectious waste and disposed of properly; this includes human tissue such as products of conception (POC).

Some local protocols dictate that a health facility's infectious waste be removed by a second party, such as a private company or government organization, and disposed of off-site. Wherever infectious waste is deposited, it must always be contained and, ideally, incinerated. To dispose of infectious waste, including POC:

- **Burning solid infectious waste in an incinerator or oil drum is the best option**
- **Open burning in a secured area is an acceptable alternative**
- **Bury solid infectious waste on-site, as long as it is secured behind a fence or wall away from any water source. Initial depth should be 2 to 5 meters deep. As waste is added, cover it with 10 to 30cm (4 to 10 inches) of soil. When the level of waste reaches to within 30 to 50 cm of the ground surface, fill the pit with dirt, seal it with concrete, and dig another pit. Burying waste is the next best option after burning**
- **Pour liquid infectious waste down a sink or drain connected to an adequately treated sewer or pit latrine. Burial of infectious liquid with other infectious waste is an acceptable alternative**

Products of conception resulting from medication abortion should be disposed of in the same way as other infectious waste. If a woman passes the POC at home, she should be advised to dispose of them by whatever appropriate means are available to her, such as pouring them down a toilet that is used for feces or by burying them away from a water source.

Vacuum aspiration

- Manual vacuum aspiration (MVA) or electric vacuum aspiration (EVA) are recommended for pregnancies up to 12-14 weeks (12-14 weeks since the first day of the woman's last menstrual period (LMP))
- Vacuum aspiration is extremely effective and safe and is successful in 98%-100% of cases
- The procedure should not be completed by sharp curettage
- Examine the products of conception after the procedure to exclude the possibility of ectopic or molar pregnancy or incomplete abortion

Medication methods

- Medication abortion methods can be used up to 12 weeks of pregnancy
- A combination of mifepristone followed by a prostaglandin such as misoprostol is the gold standard
- Research protocols for pregnancies up to 12 weeks report success rates of over 95%
- Misoprostol only for induced abortion, using the recommended regimen, is successful in approximately 85% of cases

TABLE 8.2: MIFEPRISTONE AND MISOPROSTOL REGIMENS FOR ABORTION UP TO 12 WEEKS

GESTATIONAL AGE	MIFEPRISTONE DOSE	MISOPROSTOL DOSE, ROUTE AND TIMING
Up to 10 weeks	200 mg orally	After 24-48 hours, 800 µg buccally, sublingually, or vaginally for one dose
10-12 weeks	200 mg orally	After 36-48 hours, 800 µg vaginally followed by 400 µg vaginally or sublingually every 3 hours for a maximum of 5 doses of misoprostol

TABLE 8.3: MISOPROSTOL-ONLY REGIMENS FOR ABORTION UP TO 12 WEEKS

DOSE	ROUTE	TIMING
Misoprostol 800 µg (four 200 µg pills) OR	Vaginal	Every 3 -12 hours for a maximum of 3 doses
Misoprostol 800 µg (four 200 µg pills)	Sublingual	Every 3 hours for a maximum of 3 doses

Misoprostol may reduce the cost of CAC services. The cost of a uterine evacuation depends on the clinical regimen, the technology, and the cost of providing backup in case re-evacuation is needed. Uterine evacuation with misoprostol is considered a low-cost treatment and, as with MVA, can be provided by a range of health service providers.

Induced abortion: Second trimester

Women in the second trimester and beyond should be referred to a hospital with facilities, supplies, and trained providers for management. Two types of abortion procedures are recommended in the second trimester: dilatation and evacuation (D&E) and misoprostol-based methods (mifepristone plus misoprostol or misoprostol alone). D&E involves preparing the cervix and then evacuating the uterus with a combination of vacuum aspiration and forceps. This procedure

PROGRAMMATIC EXAMPLE 8.2: COMMUNITY-BASED DISTRIBUTION OF MISOPROSTOL FOR EARLY ABORTION

ORGANIZATION: Community-based organizations, Cambridge Reproductive Health Consultants, Ibis Reproductive Health, University of Ottawa

LOCATION: Northern Thailand

INTRODUCTION: Although abortion is legal in Thailand for a number of indications, women from Burma residing in Thailand are rarely able to access safe services. However, misoprostol is widely available in clinics, pharmacies, and drug shops throughout northern Thailand.

PROJECT DESCRIPTION: In 2011, a multi-disciplinary team at Ibis Reproductive Health partnered with individuals associated with several local community-based organizations in Tak Province, Thailand to establish a misoprostol distribution network. Using a train-the-trainer model, Network leaders received a five-day training in the medical and legal aspects of misoprostol use for early pregnancy termination (defined as ≤ 9 weeks' gestation), contact information for an on-call expert who could discuss complicated cases or review protocols, the indications for referral to post-abortion care services, and the logistical issues surrounding medication distribution and case documentation. After determination of eligibility based on self-report and counseling, trained Network members instructed women who desired an abortion to vaginally administer 800 mcg of misoprostol, a second 800 mcg dose 24 hours later, and a third 800 mcg dose one week later, if needed. Network providers gave women quality-verified misoprostol.

RESULTS: Over the first 3 years, 918 women received early abortion care using misoprostol through the community-based distribution program. Of these, 885 women (96.4%) were not pregnant at follow-up, 29 were pregnant at follow-up (3.2%), and four women were lost to follow-up (0.4%). Interviews revealed that providers are motivated

to participate due to concerns surrounding unsafe abortion in the community and frame their work as a public health intervention and women felt positively about their abortion experiences and the initiative. All providers and women that we interviewed, including those women who remained pregnant after taking the misoprostol, would recommend the initiative to others and felt expanding the reach of the Network was warranted.

LESSONS LEARNED: Global efforts to provide women with medically accurate information about medication abortion, including misoprostol-alone regimens for early abortion, have inspired harm reduction programming, dissemination of medically accurate information through telemedicine services and websites, and the establishment of call centers in contexts where access to safe services is limited, or unavailable. Findings from this initiative demonstrate that community-based distribution of misoprostol can be a safe, effective, and culturally resonant strategy for increasing access to safe abortion, even in a legally restricted, low-resource, conflict-affected setting. The findings and project model may be relevant for replication in similar settings where continued maternal morbidity and mortality resulting from unsafe abortion and restrictive abortion laws exist.

requires skilled clinicians, specialized instruments, and more intensive clinical care than aspiration in early pregnancy. D&E provision is appropriate for higher-volume sites, as the experience level of providers is directly related to complication rates. Medication-based regimens with mifepristone plus misoprostol or misoprostol alone are used to both prepare the cervix and induce uterine contractions and eventual pregnancy expulsion. When both instrumentation and medication methods are available, women should have the option to choose their preferred method. Second trimester abortion with medications requires fewer technical skills and resources and can be offered in facilities where D&E cannot be provided. Generally, second trimester medication abortion can be offered wherever obstetrical services are available.

Post-abortion care

Both vacuum aspiration and misoprostol alone are safe, effective, and acceptable methods for evacuation of the uterus for post-abortion care in the first trimester. Misoprostol for the treatment of incomplete abortion is an important option in humanitarian settings where it may be difficult to maintain MVA equipment and appropriately trained providers and where referral for surgical uterine evacuation may be delayed. The use of misoprostol for obstetric indications is rapidly evolving. SRH Coordinators, health program managers, and service providers should stay abreast of the evolving clinical and technical literature.

Both D&E and medication abortion methods are used for post-abortion care in the second trimester and beyond (see previous sub-subsection). Determination of method is based on the specific clinical indications as well as provider and patient preference.

TABLE 8.4: MISOPROSTOL FOR INCOMPLETE ABORTION UP TO 13 WEEKS UTERINE SIZE

DOSE	ROUTE	TIMING
Misoprostol 600 µg (three 200 µg pills) OR	Oral	Single dose
Misoprostol 400 µg (two 200 µg pills)	Sublingual	Single dose

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.

BOX 8.3: SAFETY OF INDUCED ABORTION

"When performed by skilled providers using correct medical techniques and drugs, and under hygienic conditions, induced abortion is a very safe medical procedure." World Health Organization, 2012.

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. 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 service.

Typically, women presenting for post-abortion care are ambulatory and complaining of vaginal bleeding and pain and fever or chills and need treatment for incomplete abortion. Women who have suffered more severe complications may present with shock, hemorrhage, sepsis, and intra-abdominal injury. Severe complications are more likely in settings where unsafe abortion is common.

A rapid, initial assessment should be performed on all women presenting for care. If a woman shows signs and symptoms of shock or has heavy vaginal bleeding, she needs immediate stabilization.

Once the initial assessment and stabilization are underway, a more complete clinical assessment may be done to determine the cause and begin treatment. Shock in PAC clients is usually either hemorrhagic or septic. Hemorrhagic shock is the result of severe blood loss, which may be caused by an incomplete abortion, uterine atony, or vaginal, cervical, uterine, or intraabdominal injury. Septic shock is the end result of infection, which may come from incomplete abortion, endometritis, or intra-abdominal injury. A history and directed physical exam with concurrent treatment should be done urgently for definitive management of underlying causes. Treatment may require immediate uterine evacuation. 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 service.

Post-procedure counseling 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 normal recovery and signs and symptoms of possible complications that require immediate attention. They should also provide detailed information about post-abortion contraception and protection from sexually transmitted infections (STIs). Routine follow-up after uterine evacuation using MVA, medication abortion with mifepristone followed by misoprostol, or treatment of incomplete abortion (PAC) with misoprostol is not necessary. However, because of lower efficacy, routine follow-up after induced abortion with misoprostol-only is recommended. In all cases, if there are complications, the woman should return to the facility immediately. If the woman desires follow-up care, she may be scheduled approximately two weeks after the procedure to confirm the process was successful, or to receive additional desired services.

Post-abortion contraception

Lack of access to adequate contraceptive services is an important contributor to the need for safe abortion. Conversely, unintended pregnancy and, in many cases, unsafe abortion are prime indicators of the unmet need for safe and effective contraceptive services. Ensure that all staff providing comprehensive abortion services know how to counsel on and provide contraceptive methods following SAC or PAC. Contraceptive acceptance and continuation rates are higher when offered at the site of initial treatment and when a wide range of short-acting, long-acting and permanent methods are available.

At a minimum, all women receiving abortion care must be counseled on post-abortion contraception and understand that:

- Ovulation can occur as early as 10 days after an

abortion, resulting in pregnancy even before menses returns

- All methods, including an intrauterine device (IUD) or hormonal methods, may be started immediately after uncomplicated uterine evacuation with vacuum aspiration
- Hormonal methods, including implants, oral contraceptive pills, and injectables, may be started on the same day as the first dose of the medication abortion drug
- IUDs can be used as soon as the provider is reasonably sure the woman is no longer pregnant

BOX 8.4: WORKING WITH EXISTING PROVIDERS TO IMPROVE THE QUALITY OF ABORTION CARE

A humanitarian organization responding to a crisis in Asia identified unsafe abortion as an important cause of maternal morbidity and mortality. Although abortion is permitted in this country under some circumstances, it remains legally restricted and culturally taboo. Discussions with key informants revealed that women and girls prefer to seek abortion services from private providers because of their perceived discretion and confidentiality. However, further interviews demonstrated that the quality of abortion services was variable and international standards of safe abortion care were not followed.

Despite issues with service quality, the humanitarian organization identified these private providers as an important entry point for increasing access to safe abortion care in a legally restricted crisis setting. The humanitarian organization believed it could reach more women and girls through improving the quality of services already offered by these providers than by introducing services through new providers with whom women and girls were unfamiliar. This humanitarian organization mapped all the private providers of abortion services in the area and selected willing providers with necessary medical qualifications to receive technical support. The humanitarian organization provides clinical training and mentorship, supportive supervision, and essential supplies and equipment to ensure the private providers meet international standards in voluntary informed choice, counseling, uterine evacuation, and provision of contraception.

One challenge faced by the humanitarian organization was ensuring equitable access to safe abortion services, since these private providers charge safe abortion clients user fees. While unable to eliminate user fees, the humanitarian organization also supports willing midwives on its own staff to provide safe abortion care free of charge in the government facilities they support. Women and girls who cannot afford the private providers can seek safe abortion care from these midwives. (See Programmatic Example 8.3).

8.3.4 Implementing comprehensive abortion care in the acute through recovery phases

As is outlined in Chapter 3, provision of safe abortion care contributes to reducing excess maternal morbidity and mortality. Comprehensive abortion care, including post-abortion contraception, should be provided during the acute through recovery phases of a crisis using the clinical guidance described in this chapter.

However, competency-based clinical training and values clarification activities may not be possible during an acute emergency. Where possible, services should be provided by those already skilled in the provision of comprehensive abortion care. In many cases, rapid, on-the-job training can be provided to qualified health care workers to build their skills when previously trained providers are not available. When transitioning to comprehensive services, organizations should plan for competency-based training, ongoing clinical mentorship, and continued improvement of staff attitudes to support high-quality service provision.

8.3.5 Working with specific populations

ADOLESCENTS

The extremely high number of young women who continue to resort to unsafe abortion makes it critical to ensure that young women, regardless of marital status, have access to safe abortion as part of comprehensive health care services.

There are many social, economic, logistical, policy, and health system barriers to safe abortion care for young women, including stigma and negative attitudes towards adolescent sexuality, fear of negative repercussions, lack of access to comprehensive sexuality education, limited financial resources, cost of care, transportation, third-party involvement laws, and concerns over privacy and confidentiality. These dynamics explain why young women often find no alternative than to resort to unsafe abortion, even in settings where safe abortion is legal. These dynamics also shed light on why young women who obtain abortion care tend to access it later in the pregnancy and are more likely to delay seeking help for abortion-related complications than adults.

PROGRAMMATIC EXAMPLE 8.3: PROVIDING COMPREHENSIVE ABORTION CARE

ORGANIZATION: Confidential

LOCATION: Crisis-affected Asian country where abortion is restricted to only a few circumstances

INTRODUCTION: According to the World Health Organization, 25 million unsafe abortions (45% of all abortions) occurred every year between 2010 and 2014. The overwhelming majority of unsafe abortions occurred in developing countries in Africa, Asia, and Latin America. In one crisis-affected country in Asia, this humanitarian organization has made great strides in increasing access to contraceptive and post-abortion care services. Despite this progress, the number of unsafe abortions remained high, putting women's health and lives at risk.

PROJECT DESCRIPTION: The organization recognized the need for greater access to safe abortion care (SAC) and decided to introduce comprehensive abortion services (CAC) into its programming. In doing so, CAC was integrated into the services already offered by nurses and midwives in government health facilities and support was provided to improve the quality of abortion services offered by private providers. Values clarification and attitude transformation (VCAT) activities were important first steps to fostering an environment conducive to high quality, unbiased care. The organization conducted on-the-job training on misoprostol and manual vacuum aspiration for CAC and provided all necessary supplies and equipment. In order to maintain client privacy and confidentiality, a system was devised to record SAC clients in the post-abortion care (PAC) register with a confidential mark. Women were informed of CAC services during one-on-one community outreach sessions to maintain a low profile within the community. When working with private providers, the organization developed a Memorandum of Understanding, facilitated competency-based trainings on contraception, MVA, and infection prevention, and provided all necessary supplies and equipment in exchange for the price reduction of contraceptive and CAC services.

RESULTS: In the first year of the initiative, 3,411 women and girls received CAC services. Of these, 3,086 were PAC clients and 325 were SAC clients. From July to December of 2017, the 59 public facilities supported by the organization received 206 SAC and 1,064 PAC clients. At the 11 supported private providers, 25 SAC and 715 PAC clients accessed services. As a result of facilitated trainings, these private providers are now using MVA and misoprostol in lieu of dilation and curettage (D&C) for CAC clients.

LESSONS LEARNED: VCAT workshops are key to improving attitudes among health providers as well as organizational staff. Maintaining a low profile, ensuring client confidentiality, working with nurses and midwives, and conducting one-on-one CAC information sessions were particularly helpful strategies for integrating SAC at the government facilities. Implementing CAC through a network of private providers has proved challenging due to their reluctance in recording and sharing data and higher costs for services remains a barrier for women and girls. Measuring the quality of care of private providers is also challenging without direct observation.

BOX 8.5: GUIDING PRINCIPLES OF ABORTION CARE FOR YOUNG WOMEN

- Young women have the right to decide whether, when, and with whom to have sex
- Young women have the right to decide whether, when, and with whom to have a child
- Young women have a right to high-quality health care which includes comprehensive abortion care and contraceptive services
- Young women have a right to confidential care that protects their privacy and safety
- Young women are the most important stakeholders in their SRH care
- Young women have perspectives and experiences that older people do not, which can help improve service provision
- By voluntarily seeking safe abortion care, young women can be presumed capable of informed consent to such care

Clinical provision of abortion care for young women is generally the same as for adult women. However, a few clinical differences should be considered.

- Counseling: Young women may have had little opportunity to learn about SRH and may consequently need more information than many adult women
- First pelvic exam: It is possible that this will be a young woman's first pelvic exam and she may be nervous or afraid. Ensure auditory and visual privacy, offer a female health worker, or a relative, friend or partner, stand near her and talk to and support her during the pelvic examination if the young woman wants, explain what will be done, do not begin to examine her until receiving her consent even if an adult has legally consented on her behalf, and perform the examination as gently and smoothly as possible to minimize discomfort and anxiety
- Vacuum aspiration: Although no studies have been done on the subject, providers may find that a young, nulliparous woman's cervix may be more difficult to dilate than that of an older, parous woman and thus may require a slower dilation process. This can be accomplished either by starting with a smaller dilator than is required by women with one or more children, or by priming the cervix with misoprostol. The latter may constitute clinical protocol for all uterine evacuations in some facilities. Anesthesia dosages remain the same as for older women
- Medication abortion: Early medication abortion has been proven to be safe, effective, and acceptable for young women, as for adult women. Dosage regimens are the same for both populations

BOX 8.6: ABORTION CARE FOR HIV POSITIVE WOMEN

Women living with HIV have the same rights as other women to decide whether to carry a pregnancy to term or have an abortion.

Women receiving abortion care who are HIV-positive need specific information, support, counseling, and medical care. If counselors have not undergone extensive HIV training, they should refer HIV-positive women to appropriate services, where available. HIV-positive women should be offered information that can help them better understand their condition and improve their own health, as well as the health of their sexual partners and children.

Women living with HIV and AIDS may use all currently available abortion procedures, including medication abortion regimens. Women living with HIV or AIDS may be at risk for anemia, especially if they have malaria or are taking certain antiretroviral therapies. As with any woman, if heavy bleeding occurs after the initiation of medication abortion care, treat promptly with vacuum aspiration.

Health-care workers should treat the blood and body fluids of all persons as potential sources of infection, independent of diagnosis or perceived risk. Standard precautions should be followed with all clients and all workers, regardless of their presumed infection status or diagnosis, and there is no reason to treat individuals with known blood borne diseases differently.

WOMEN WHO HAVE EXPERIENCED VIOLENCE

It is likely that providers will encounter women who have experienced sexual violence. Women who have experienced such violence, which includes rape, sexual

assault, coercive sex, incest and involuntary sex work, will often experience related health conditions, such as physical injury, STIs, psychological distress, or unplanned pregnancy. Physical or psychological violence during pregnancy may also contribute to miscarriage or the desire for an abortion.

Abortion care visits may be the only contact that women who have experienced violence have with the healthcare system. Counselors should develop a standard method for asking all clients about violence in their lives and incorporate those questions into routine counseling. Health workers must be cognizant of their own limitations in assisting women experiencing violence, be aware of any existing gender-based violence (GBV) referral pathways and, whenever possible, refer women to others specialized in addressing these women's needs.

Special violence-related counseling considerations include:

- An unintended pregnancy may be the result of rape or incest
- A spontaneous abortion could have been caused by physical abuse
- A woman may face further violence if her abortion or use of contraception is not kept confidential
- A woman may have been forced or coerced into having an abortion
- The pregnancy could have been wanted

8.3.6 Coordinating and making linkages

It is critical that all women and girls who have received comprehensive abortion care be counseled on contraception and provided with their method of choice on the same day as the procedure. Service providers should also identify other SRH needs each woman or girl may have and refer her or offer information on relevant services, such as management of reproductive tract infections or post-rape care. Women and girls presenting for post-rape care with a pregnancy should be offered a safe abortion or a referral, if they wish.

All health care workers should have basic skills on and favorable attitudes toward safe abortion care so they can identify those women who may want the service, refer them to the appropriate provider, and treat them with respect. Health care providers who claim conscientious objection to providing abortion must refer the woman or girl to another willing and trained provider in the same or another easily accessible health facility. In places where referral is not possible, the objecting provider must provide the abortion to save the woman's life or to prevent damage to her health.

PROGRAMMATIC EXAMPLE 8.4: PROVIDING MENSTRUAL REGULATION AND POST-ABORTION CARE IN AN ACUTE CRISIS

ORGANIZATION: Ipas with implementing partners

LOCATION: Bangladesh

INTRODUCTION: An eruption of violence triggered an exodus of refugees to Bangladesh. There were nearly 626,000 newly arrived refugees to Bangladesh in the 3 months since August 2017, joining about 400,000 that had arrived before that escalation. It is known that in crisis settings women face significant hardships when trying to prevent unintended pregnancy due to loss of livelihoods, assets, and family and social structures; disrupted access to contraception and other SRH services; and increased risk of exploitation, sexual violence, and transactional sex. In February 2017, a report from the United Nations stated that more than half of the 101 refugee women interviewed by UN investigators across the border in Bangladesh said they had suffered rape or other forms of sexual violence at the hands of security forces.

PROJECT DESCRIPTION: Ipas-Bangladesh responded to a request from UNFPA to establish menstrual regulation (MR)* and post-abortion care (PAC) services in 8 strategically located facilities serving refugees. The implementation rapidly included the following components: baseline assessment; partner and key stakeholder engagement; approval of the Bangladesh government; supply of medication and vacuum aspiration commodities available in the Ministry of Health (MOH) and MISP procurement systems; supply of equipment for facility readiness; strengthening the capacity of health care providers; and strengthening of referral sites for severe complications of unsafe abortions. Capacity building and training strategies were developed to cause minimal

disruption, if any to service provision. The duration of the formal trainings was adjusted and time was prioritized for practicum sessions on pelvic models and women seeking care to ensure adequate uptake of skill and knowledge of the procedures. The approaches to training and site strengthening addressed stigma, values and attitudes about MR through values clarification and attitude transformation (VCAT) exercises. Following the training, clinical trainers and project staff provided support to ensure sufficient logistic supply and support to newly trained providers to assess for competency and confidence with providing MR and PAC services.

RESULTS: A total of 51 service providers representing many cadres participated in initial trainings. Service providers were from the 8 initial sites as well as from other stakeholders offering service provision in and around the camps. In the first 3 months of service provision, 283 women and girls sought services, 75% MR and 25% PAC. The majority (60%) were managed with medications while 38% were managed with MVA. Fifty-seven percent received post-abortion contraception.

LESSONS LEARNED: Menstrual regulation and PAC were imperative during this crisis. When services were made available, women sought assistance, saving them from complications of unsafe abortions and potentially nonexistent or poor-quality PAC. This project shows that demand for these services existed among these refugees but could have been easily overlooked in this complex environment of competing priorities. Introducing these services as early as possible opens the door for women to begin to heal and discuss exposure to violence, contraception, and other SRH issues important to them at a time when they face great challenges.

**MR is a procedure that uses manual vacuum aspiration or a combination of mifepristone and misoprostol to "regulate the menstrual cycle when menstruation is absent for a short duration."*

8.3.7 Advocacy

Comprehensive abortion care is a proven and necessary health intervention to prevent maternal mortality and morbidity. Too often political, religious, or cultural factors rather than medical evidence influence decisions around abortion care. Even when abortion is legal without restriction as to reason, there are often additional regulatory barriers and stigma that hinder access for women and girls.

There is important advocacy that can be done to alleviate these challenges to health providers and obstructions to care for women. Staff should be well informed on national and international laws and policies – as well as their organizational position – on abortion, including referrals, duties around conscientious objection, and reporting requirements. SRH Coordinators, health program managers, and other key staff should engage with local actors, Ministry of Health officials, donors, and other agencies to call for greater access to CAC by:

- Expanding circumstances under which abortion is provided/permitted
- Aligning national policies with international standards
- Presenting data on unmet need and consequences of limiting/not providing CAC services
- Adhering to international medical protocols, such as the WHO guidelines on safe abortion care
- Ensuring the provision of comprehensive abortion care by skilled health providers, including MVA
- Raising awareness around and ensuring the provision of safe abortion care at the onset of an emergency, as outlined in the Minimum Initial Service Package
- Prioritizing CAC for all women and girls by including it in humanitarian funding appeals
- Advocating for the inclusion of mifepristone and misoprostol in national medicine lists for medication abortion
- Engaging staff, beneficiaries, and community leaders in awareness raising campaigns

8.4 HUMAN RIGHTS AND LEGAL CONSIDERATIONS

The right to safe and legal abortion is supported by numerous international treaties and agreements. The International Conference on Population and Development (ICPD) commitments to ensure access to post-abortion care and safe abortion and to reduce maternal mortality due to unsafe abortion underpin the guidance given in this chapter.

Since the adoption of the ICPD Program of Action, multiple

human rights bodies have reinforced the link between unsafe abortion and maternal mortality and have found that the denial of access to safe and legal abortion violates the rights to life, health, privacy, equality, freedom from discrimination, and freedom from torture or ill-treatment. International human rights law requires States to take positive steps to ensure access to abortion services and information where legal, and to ensure that it is legal, at minimum, when a woman's life or health is at risk, in cases of severe or fatal fetal anomalies, and in cases of rape and incest. Failure to permit abortion in these situations has been found to constitute a violation of the state's human rights obligations. Human rights bodies have called on States to eliminate punitive measures for women and girls who undergo abortions and for health providers who deliver abortion services, recognizing the connection between criminalization of these services, high rates of unsafe abortion, and maternal mortality. Increasingly, these bodies have urged States to ensure access to safe abortion care without restriction and irrespective of its legality. Many countries have liberalized laws with respect to abortion, and abortion is legal in nearly all countries in at least some circumstances. The Center for Reproductive Rights maintains a database of abortion laws worldwide and updates this resource regularly; the WHO also launched an open access database dedicated to abortion laws, policies, and health standards in 2017 (see Section 8.6).

BOX 8.7: A RIGHTS BASED APPROACH TO COMPREHENSIVE ABORTION CARE

The comprehensive definition of reproductive health and rights agreed upon at the 1994 UN International Conference on Population and Development provides a framework for legitimizing and protecting women's reproductive rights. Specific rights that support abortion-related care include:

- **The right to decide whether and when to have children. Women should have access to the contraceptive methods they want and to decide when to terminate a pregnancy**
- **The right to life. Women should not die due to unsafe abortion**
- **The right to health. This right includes access to comprehensive SRH services, including SAC. Women should not suffer short- and long-term injuries due to unsafe abortion**
- **The right to dignity and bodily integrity. Young women should be able to consent to their own uterine evacuation procedure**
- **The right to freedom from discrimination. For example, uterine evacuation is a procedure only women and not men need, so it should not be unduly restricted**
- **The right to freedom from inhumane and degrading treatment. For example, this may be violated when abortion or post-abortion care is denied**
- **The right to the benefits of scientific progress. For example, this right is upheld when providers are able to use WHO recommended uterine evacuation methods**
- **The right to freedom of opinion and expression. For example, this right is upheld when people are able to voice their support for safe abortion care**

In crisis settings, states must ensure the provision of comprehensive SRH services, including access to safe abortion services, among other key reproductive health services. Specifically, with regard to survivors of sexual violence, international agreements and expert bodies support the right of women raped in war to access safe abortion care. They have found that the denial of safe abortion to rape survivors violates the rights to health and privacy and could amount to a violation of the prohibitions on ill-treatment and discriminatory medical care.

The following have been found to constitute violations of human rights:

- Denial of abortion services to a woman whose pregnancy poses a risk to her life or health, results from rape or incest, or has severe or fatal fetal anomalies
- Denial of post-abortion care, including in settings with restrictive abortion laws, or conditioning

post-abortion care on the woman admitting inducing abortion or disclosing information about an abortion provider

- Violating patient confidentiality by reporting an illegal or unsafe abortion to authorities
- Requiring third-party authorization, either by law or in practice, to access abortion services or post-abortion care
- Forcing women to undergo abortion or sterilization against their will or without full and informed consent
- Forced pregnancy (can also constitute a war crime)

8.5 MONITORING AND EVALUATION

Engage beneficiary participation to continuously monitor and evaluate safe abortion and PAC services and the legal and policy framework governing the provision of comprehensive abortion care. 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, including by creating accessible mechanisms for beneficiaries to seek redress, provide feedback to staff, and intervene to correct any problems identified. Maintain a clinical register to record information about CAC clients; this information can be coded or masked to protect confidentiality.

The following information should be recorded in a gynecology or CAC register and kept in a confidential and locked location:

- Date
- Client name or, if required for confidentiality, unique identifier
- Client age and other demographic information
- Age of pregnancy (in weeks)
- Diagnosis (e.g., induced abortion, incomplete abortion, complete abortion)
- Complications (e.g., moderate/light vaginal bleeding, severe vaginal bleeding, sepsis, shock, injury to organs). This is more relevant for PAC clients coming in with an incomplete abortion
- Treatment/procedure (e.g., MVA, mifepristone and misoprostol, misoprostol alone, dilation and curettage, parenteral antibiotics, blood transfusion, pain management)
- Post-abortion contraception: Yes/No and method selected (e.g., oral contraceptive pills, injectable, implant, IUD, Sterilization)
- Referral to a higher level facility

Program may also choose to have an individual client record that contains more detailed clinical data.

8.6 FURTHER READING AND ADDITIONAL RESOURCES

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