THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH

POST ABORTION CARE (PAC) GUIDELINES:

Prevention and Management of Abortion Complications

An Addendum to the Essential Maternal and Newborn Care Clinical Guidelines for Uganda

MOH 2025

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Abbreviations and Acronyms

BCS+- Balanced Counselling Strategy Plus

BEmONC- Basic Emergency Obstetric and Neonatal Care

CEHURD – Centre for Health Human Rights and Development

CEmONC- Comprehensive Emergency Obstetric and Neonatal Care

CLEAR -Clarity, Listen, Encourage, Acknowledge, Repeat and reflect

D&E – Dilatation and Evacuation

EVA – Electric Vacuum Aspiration

FIGO – International Federation of Obstetricians and Gynaecologists

FP – Family Planning

GATHER- Greet Ask Tell Help Explain Return visit/Referral

HFA Health facility assessments

IUFD – Intrauterine fetal death

LMNS- Local Maternity and Neonatal System

MakSPH – Makerere University School of Public Health

MEC- Medical Eligibility Criteria

MMR- Maternal Mortality Ratio

MPDSR- Maternal Perinatal Death Surveillance and Response

MVA- Manual Vacuum Aspiration

NASMEC- National Safe Motherhood Expert Committee

PAC – Post Abortion Care

PAFP- Post Abortion Family Planning

REDI- Rapport building, Exploration, Decision making, implementing the decision

RH- Reproductive Health

RPOC – Retained Products of Conception

SGBV – Sexual Gender Based Violence

SOLER- Sit squarely, Open posture, Lean forward, Eye contact, Relax

SRHR – Sexual Reproductive Health and Rights

UDHS- Uganda Demographic and Health Survey

WHO – World Health Organisation

Operational Definitions

Abortion:
The loss of a pregnancy, whether spontaneously or by induction, before viability (currently 26 weeks of gestation in Uganda).

Health:
A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Post Abortion Care:
Is the medical, social, psychological, spiritual care and support given to a person after an abortion.

Reproductive health:
A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

Self-care:
The ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health worker.

Unsafe abortion:
A procedure for termination of pregnancy performed by an unskilled health provider, or in an environment not in conformity with the minimum medical standards, or both, often resulting in complications.

Foreword

Uganda has made significant strides in addressing maternal mortality, with the most recent maternal mortality ratio (MMR) being 189/100,000 live births (Uganda Demographic and Health Survey UDHS 2022) down from 336/100,000 live births in 2016. This is as a result of the several efforts to address preventable maternal death, such as the intensified maternal and perinatal death surveillance and review (MPDSR) system through the Local Maternity and Neonatal Systems (LMNS). This audits and accounts for every maternal death and near miss, thereby offering context specific, affordable, and sustainable solutions.

Despite this progress, abortion complications continue to put a big burden on the country, contributing at least 6% of all maternal deaths, not counting the short and long term morbidities that the survivors live with, such as infertility and other psychosocial complications. Maternal deaths affect the family, society and nation at large. Ultimately, maternal deaths curtail the national socio-economic development.

Maternal deaths and complications attributable to abortion are entirely preventable through timely provision of quality post abortion care (PAC). This addendum to the Essential Maternal and Newborn Clinical Care Guidelines (EMNCG) 2022 is meant to offer the detailed guidance to health workers and partners working on and with PAC clients to optimize positive outcomes.

There has been various sources of information and guidance on management of abortion complications in our guidelines and key documents as a country, most of which was not well harmonised and aligned to each other or adapted to the national context and current regulatory frameworks. Some of these are the Essential Maternal and Newborn Clinical Care guidelines 2022, Uganda Clinical Guidelines 2023, Uganda National self-care guidelines 2024, Uganda Combipack Training Manual 2024, Uganda Nurses and Midwives Scope of Practice 2022, among others. This addendum is meant will harmonise all the guidance while incorporating recent updates on PAC, such as from the International Federation of Gynaecologists and Obstetricians (FIGO) and the World Health Organization (WHO).

I commend the team that has put these guidelines together with the stewardship of the PAC steering committee, under the Reproductive and Child Health Division of the Ministry of Health (MOH). MOH commits to fully support the implementation of these guidelines, in order to achieve its objectives.

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Dr. Charles Olaro
Director General of Health Services

Acknowledgement

Understanding the psychosocial and economic burden that abortion related deaths and complications put on our country, I am glad that this PAC guideline, addendum to the EMNCG 2022 has been put together to alleviate that.

I would like to thank the Center for Health, Human Rights and Development (CEHURD), Population Services International (PSI), Ipas Africa Alliance, Association of Obstetricians and Gynaecologists of Uganda (AOGU), National Midwives Association of Uganda (NMAU), JHPIEGO, PP Global, Makerere University School of Public Health, Marie Stopes Uganda, National Safe Motherhood Expert Committee (NASMEC), NASMEC Institute Pathfinder, Clinton Health Access Initiative and all other partners that have directly or indirectly contributed to the development of this guideline addendum.

Special thanks go to CEHURD and Mariestopes International-Uganda for funding this work, and to the lead consultant - Dr. Simon Peter Kayondo for leading the study, review and harmonization of the various guidance documents on PAC in the country and internationally.

In the same way, I wish to extend sincere gratitude to the team of experts who participated in the review and validation of the PAC guidelines addendum; Prof. Dan K. Kaye, Dr. John Paul Bagala, Dr. Chris Ebong, Dr. Migadde Robert, Dr. Samuel Ssenkungu, Dr. Joannah Nalwoga, Dr. Peter Wanyera, Dr. Agrey Bameka, Dr. Peter Ssebadduka, Dr. Joseph Byamugisha, Dr. Nelson Twinamasiko, Dr. Inzama Wilfred, Dr. Peter Ddungu, Dr. Milton Awudo, Dr. Kenyangi Doreen, Dr. Isaac Odongo, Ms. Fatia Kiyange, Ms. Pamela Nahurira, Ms. Annah Kukundakwe, Ms. Rita Niwamanya, Ms. Ann Lumbasi, Ms. Kabene Mercy Jackline, Ms. M Amase . Carol, Ms. Lavoy Josephine, Ms. Sandra Arinaitwe, Ms. Edith C. Kemigisa, Mr. Ntege Wilberforce, Ms. Jacqueline Twemanye, Ms. Precious Mutoru, Mr. Kalule Joshua, Mr. Yewande Kamuntu, Mr. Rogers Kagimu, Ms. Irene Among, Ms. Kyohairwe Pamella, Mr. Wolayo Pius, Mr. Sylvester Ochieno, and Ms. Nanyunja Jackline.

I am optimistic that implementation of this guideline will further our efforts as a country, of ending preventable maternal death and disability.

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Dr. Richard Mugahi
Commissioner Reproductive and Child Health

01 CHAPTER

Introduction & Background

1.1 Introduction

Abortion refers to termination of pregnancy before the gestational age of viability (capacity for the fetus to survive outside the mother's womb). In Uganda, gestational age of viability is currently at 26 weeks of gestation. Abortion may be spontaneous or induced. Induced abortion may be for medical or non-medical reasons. In Uganda, induction of abortion is restricted by law to medical reasons. Both spontaneous and induced abortion can result in complications (both physical and psycho-social), and for these we must intervene timely to prevent death, as well as short and long-term complications.

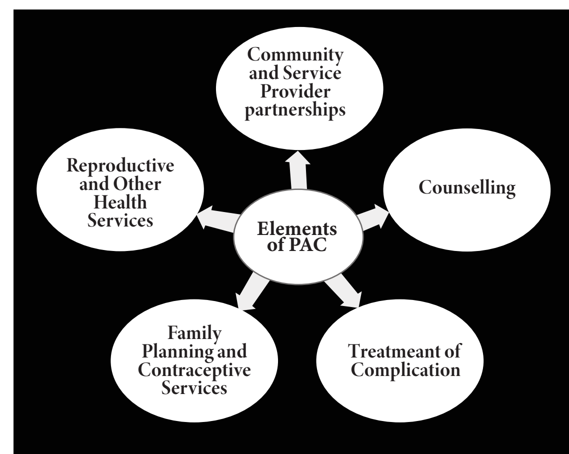
The effects of unsafe abortion extend beyond the individual, to the family, society and nation. The family loses a key member responsible for child upbringing, the society is deprived of a productive individual hence low socio-economic development. The nation not only loses able workforce, but spends significantly on managing abortion complications, which are preventable. These effects could be prevented/addressed by timely management of complications, counselling, involvement of the community in prevention efforts, and effective post abotion family planning and contraception.

Awareness in the community to prevent unintended pregnancies and the availability of postabortion care for whom it is needed are essential to prevent the untoward consequences of unsafe abortion. This needs to be coupled with the strengthening of the quality of PAC services. Facilities providing the services must be well equipped to manage abortion complications in a timely manner. This requires having the appropriate human resource skills mix and adequate standardized service sites including equipment and supplies, and referral linkages to manage complications.

1.2 Epidemiology

Despite an improvement in maternal mortality ratio in the last five years, from 336/100,000 live births in 2016 to 189/100,000 live births in 2022 (UDHS 2022), unsafe abortion remains a critical problem for maternal health, estimated to contribute about 6% of all maternal deaths (Uganda MPDSR report2022/2023). The Guttmacher Institute in 2022, reported a high incidence of induced abortions, with about 297,000 induced abortions annually, affecting about 54 per 1000 women aged 15-49 years. Many of these induced abortions are unsafe, and result in abortion complications and death.

1.3 Epidemiology



1Fig 1.1 PAC Model by the PAC Consortium

Post abortion care is a holistic approach for reducing morbidity and mortality from incomplete and unsafe abortion and resulting complications, and for improving women's sexual and reproductive health and lives.

The PAC consortium is a group of organizations working to improve post abortion care services so as to reduce maternal morbidity and mortality related to unsafe abortion using a public health strategy. The PAC Consortium's five essential elements of PAC are:

i Community and service provider partnerships for prevention (of unintended 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, respond to and meet community expectations and needs.

ii Counselling to identify and respond to women's emotional and physical health needs and other concerns.

iii Treatment of incomplete and unsafe abortion including complications that are potentially life-threatening.

iv Contraceptive and family planning services to help women prevent an unwanted pregnancy or practice birth spacing.

v Reproductive and other health sevices that are preferably providedon-site or via referrals to other accessible facilities in providers' networks.

1.4 Classification, diagnosis and management of abortion and its complications.

1.4.1 Types of abortion (Medical classification)

Threatened abortion:
There's a risk of a pregnancy loss with vaginal bleeding and abdominal cramping, but the cervix is still closed and the embryo/fetus is alive.

Inevitable abortion:
The pregnancy loss is almost certain and the products of conception are in the process of expulsion, with significant bleeding and

Complete abortion:
Complete expulsion of all the products of conception.

Incomplete abortion:
Abortion in which parts of the products of conception are retained in the uterus.

Missed abortion:
This is when the embryo or fetus has died inside the uterus but no subsequent expulsion of the embryo or foetus.

Septic abortion:
Any of the abortions associated with infection of the products of conception and endometrial lining, leading to generalized infection. products of conception and endometrial lining, leading to generalized infection.

1.4.2 Making a diagnosis of abortion

i This requires proper history taking, abdominal examination and investigations.

ii Signs or symptoms of pregnancy (amenorrhea, nausea/vomiting, breast changes).

iii Vaginal bleeding of variable severity.

iv Passage of products of conception, liquor or blood clots.

v Vaginal examination. (Determine if it is induced or spontaneous from direct inquiry or abdominal and pelvic examination).

Identify complications ; Symptoms and signs of shock may be present (dizziness, weakness, tachycardia, hypotension, pallor), Symptoms and signs of acute abdomen, if there is intrabdominal injury there is abdominal pain,fullness, and abdominal tenderness, etc.).

vi Determine the plan of management.

1.4.3 Differential diagnoses of abortion

- i Ectopic pregnancy
- ii Bleeding due to sub-mucous uterine fibroids
- iii Dysfunctional/Abnormal uterine bleeding
- iv Some complications of family planning methods which cause bleeding (e.g.,side effects of Depo-Provera, IUD)
- v Sexual trauma
- vi Genital malignancies

1.4.4 Investigations

1) Ultrasound scan to determine gestational age, rule out retained products of conception (RPOC), pelvic organ injury and other complications
2) Complete blood count (CBC)/Blood for haemoglobin level estimation.
3) Blood for grouping and cross-matching.
4) Urinalysis and malaria tests to ascertain possible causes of the abortion.
5) Pregnancy test

1.4.5 Management

- i) Medical/surgical management will be dependent on the type of abortion.
- ii) Management of abortion should be done based on clinical guidelines, and investigations should not delay management.
- iii) Initiate management of shock and sepsis before uterine evacuation e.g. with manual vacuum aspiration (MVA). However, MVA should not be delayed.

1.4.6 Legal and policy framework on abortion and post abortion care in Uganda

Post abortion care is lifesaving emergency care that should be provided from at least Health Centre III, to all women that require it, regardless of whether it was a spontaneous or induced abortion.

The law in Uganda is restrictive regarding abortion, only permitting abortion to save a woman's life. The 2006 Sexual and Reproductive Health and Rights (SRHR) policy guidelines and service standards have laid out some of these circumstances where abortion is necessary to save a woman's life as;-

- i) Severe maternal illness threatening the health of a pregnant woman e.g.severe cardiac disease, severe pre-eclampsia, etc.
- ii) Severe fetal anomalies incompatible with extra uterine life e.g. molar pregnancy, anencephaly, etc.
- iii) HIV positive women requesting for a termination
- iv) Rape, incest and defilement
  Safe and legal termination of pregnancy as above can be carried out at a Health Centre IV, general and referral hospitals by a medical officer,

1.5 Objective of these guidelines

The objective of the PAC guideline addendum is to harmonise all existing PAC guidance within the different guidelines and frameworks in order to provide a strengthened guideline that offers holistic, comprehensive, clear and easy to implement guidance to ensure clients receive quality and safe post abortion care services, complete with dignity, psychological and emotional support. This in turn will reduce preventable death and disability attributable to abortion complications in the country.

02

CHAPTER

Prevention of Unsafe Abortion

This is intended to actualize the first element of the PAC model "Community and service provider partnerships for prevention (of unintended 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 needs"

2.1 Prevention interventions

The following interventions are effective in preventing unsafe abortion:

1. Prevention of unintended pregnancy which might lead women to seek unsafe abortion (Primary, secondary and tertiary prevention).
2. Effective post abortion counselling to break the cycle of unintended pregnancy.
3. Social protection to support those who wish to carry the pregnancy to term but have no means. For example kinship care.
4. Economic gender empowerment e.g. encourage them to initiate income generating activities such as savings schemes, and small businesses.
5. Implement evidence-based interventions to prevent unsafe abortion.
6. Re-integration of women with unintended pregnancy into the society to reduce stigma and discrimination.

2.2 Prevention models

Primary prevention:
Prevention of unintended pregnancy through effective contraception, age appropriate sexuality education and behavioural change.

Secondary Prevention:
Timely access to emergency contraception and non-judgmental counselling on options for an unintended pregnancy (abortion harm reduction counselling).

Tertiary prevention:
Effective and prompt post abortion care including post abortion family planning and counselling to prevent development of complications and future unintended pregnancies.

CHAPTER

03

Psychosocial support for Post Abortion Care

Psychosocial support refers to all actions intended to address the client's emotional, social and psychological needs. It should be provided to post abortion care clients to promote wellbeing, and assist them with coping mechanisms. Psychosocial support for PAC clients should be offered by the health providers and social workers through the following approaches:-

1) Emotional support - Comprehensive counselling services.
2) Social support – Referral and linkage for other reproductive health services and for legal support such as in Sexual Gender Based Violence.
3) Community Engagement – Involving the community in supporting the individual to cope.

This chapter will discuss in detail comprehensive counselling services, the others are discussed under chapter 8.

3.1 Comprehensive counselling services during post Abortion Care

3.1.1 Introduction

Comprehensive counselling aims to actualize PAC model element 2: "Counselling to identify and respond to women's emotional and physical health needs and other concerns". The guiding principle for comprehensive counselling is to achieve a woman centred and rights based approach for an informed choice and decision making.

Trained health professionals need to:-

1) Have knowledge, skills and the right attitude for counselling, as an important cornerstone for successful provision of post abortion care.
2) Identify and respond to women's emotional and physical health needs; address the immediate abortion related needs and institute preventive strategies to avert their recurrence.
3) Align personal with professional values and views in order to effectively provide quality care.

3.1.2 Considerations during Post Abortion Care (PAC) Counselling

1) Address the client's emotional and psychological needs.
2) Ensure confidentiality, privacy and dignity of the client while addressing her feelings.
3) Consider their sexual and reproductive health issues.
4) Effective communication techniques;

   i Use the two-way communication; Active listening and effective questioning.

   ii Ask open-ended questions using simple language and visual aids.

   iii Use effective communication techniques e.g. **GATHER** which stands for:
   (Greet Ask Tell Help Explain Return visit/Referral), **REDI** (Rapport building, Exploration, Decision making, Implementing the decision).

   iv Use the nonverbal communication skills; **SOLER** (Sit squarely, Open posture,
   Lean forward, Eye contact, Relax).

   v Use verbal communication skills **CLEAR** (Clarity, Listen, Encourage, Acknowledge, Repeat and reflect).

3.1.3 The PAC Counselling process

1Table 3.1 Pre-treatment counselling

Patient Obligations	Health professional obligations
Give correct information	Be gentle and non-judgmental.
Seek clarification	Ensure confidentiality and privacy.
Follow instructions	Be attentive to verbal and non-verbal communication relayed by the patient.
Be cooperative during the service	Explore with the client on the possible FP method of choice.
Communicate her feelings through the process to the health worker.	All women being treated for abortion complications have a right to information about their condition, including overall physical condition, results of physical and pelvic examination and lab tests.
	Obtain consent from the patient before treatment.
	Need for referral-first aid should be provided prior to referral and provide access to transport to another facility.

2Table 3.2 Steps in counselling

Initial welcoming of the client	i Approach the client in a friendly manner, greet and call her by name. ii Reassure her that she is in good hands and the treatment will be fine. iii Reassure her of privacy and confidentiality. iv Give her moral and psychological support. v Do not be judgmental. Find out if she has been referred or came in on her own.
Counselling before the treatment/pre-procedure	i There's need to perform quick assessment before counselling. ii The patient might need resuscitation first.
Counselling during the treatment	i The health care provider to explain the procedure to the client. ii Verbal support iii Give continuing emotional support by providing positive, empathetic, verbal and non-verbal communication.
Counselling after the treatment	i Explore patient's feelings, questions, and concerns and provide encouragement and support. ii Remind the patient of possible side effects, risks, and warning signs; patient should return when warning signs occur. iii Tell the client how to take care of herself at home by giving written post-procedure information consisting of:- sexual activity resumption after the bleeding has stopped and when comfortable, avoiding strenuous activity, and warning signs such as bleeding and cramping similar to a normal period for up to one week, fatigue, depression or sadness (for several days). iv Other complications requiring coming back or going to the nearest health facility e.g. continuous bleeding (more than 1 week), foul smelling discharge, lower abdominal pains, dizziness and fever. v Remind the client of the importance of follow-up; return to fertility in l0 days hence the need to uptake FP early. vi Advise on nutrition and iron supplements. vii Discuss available contraceptive methods as appropriate. viii Discuss Reproductive Tract Infections/Sexually Transmitted Infections including HIV. viii Assess the need for additional counselling and/or referral for other reproductive health needs or non-medical issues or linkages to SGBV care services including Trauma counselling.

3.1.3 The PAC Counselling process

Note:

1) In emergency situations, provide treatment but ensure counselling is provided prior to discharge.

2) Assess the client's ability to give or receive information.

3) Explore the client's needs and feelings.

4) Examine values and life plans/reproductive health needs.

3.4 Other approaches to counselling

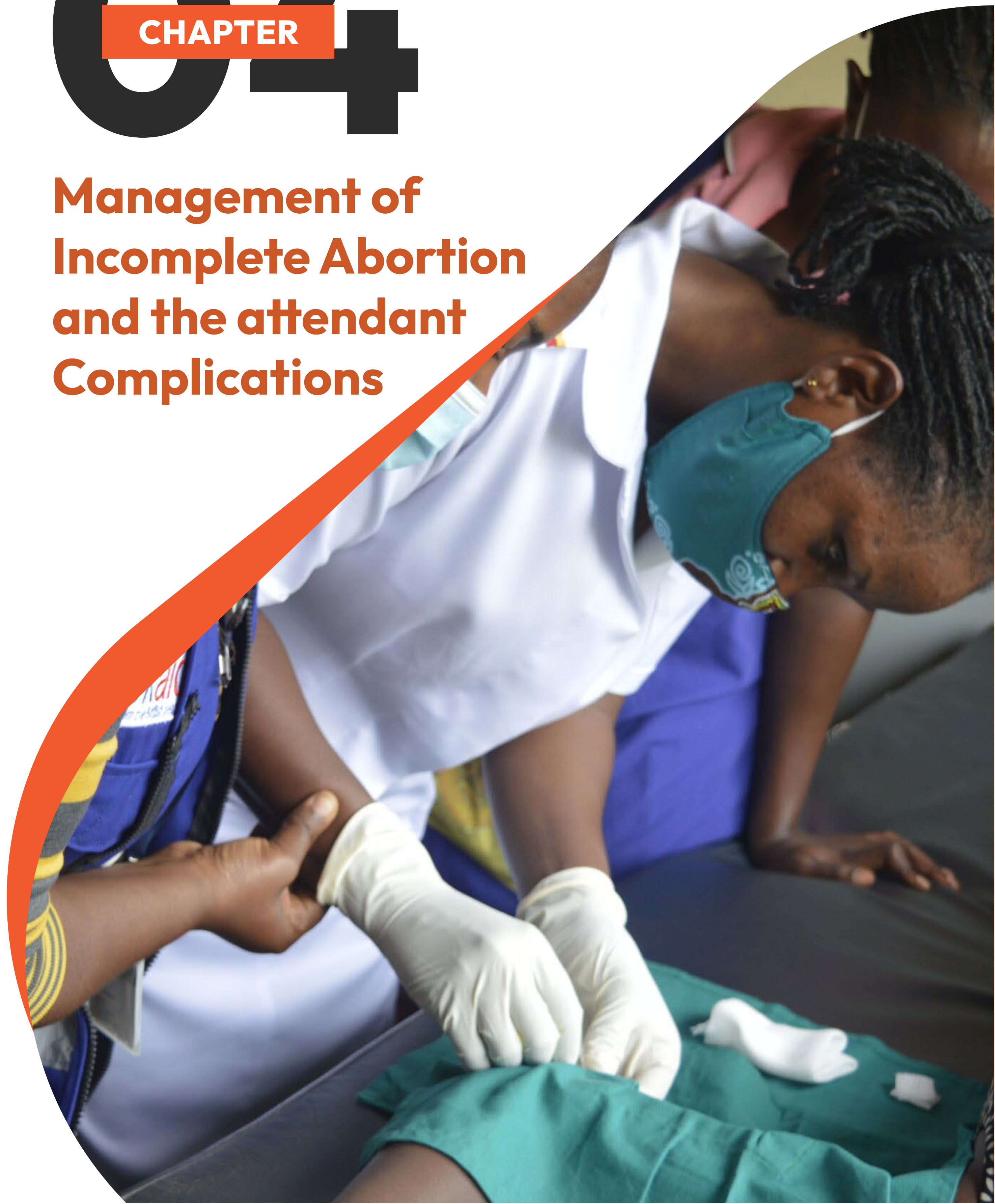
1) The Balanced Counselling Strategy Plus (BCS+), a toolkit for Family Planning service providers working in the high HIV/STI Prevalence settings, is an interactive, client-centred approach that uses job aids and emphasizes the client's right to make informed and voluntary decisions. It can be used in adolescent counselling and post-abortion care, among other applications. The updated cards include instructions for the service providers, guiding them through supplementary counselling and services that FP clients may need.

2) The use of the phones to follow up clients by health providers, strengthening counselling messages.

3) Self-care: Promoting client self-awareness including self-monitoring for recovery and complications (Uganda self-care guideline October 2024, page 64).

04 CHAPTER

Management of Incomplete Abortion and the attendant Complications



This is to actualize PAC model element 3 "Treatment of incomplete and unsafe abortion and complications that are potentially life-threatening"

4.1 Management of Incomplete Abortion

4.1.1 Definition and introduction

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

Uncomplicated incomplete abortion can result after an induced or spontaneous abortion (i.e. miscarriage); the management in both cases is the same. Incomplete abortion may be managed expectantly, medically or surgically (vacuum aspiration). Managing uncomplicated incomplete abortion with vacuum aspiration (MVA)-when uterine size (fundal height) is less than 12 weeks and Electric vacuum aspiration (EVA)-when uterine size (fundal height) is less than 14 weeks, includes recognizing the condition, assessing uterine size (fundal height), performing the actual procedure and pain management.

4.1.2 Client assessment

Inform the patient/client what you are going to do. The purpose of the initial assessment is to assess for immediate life threatening complications such as shock, severe vaginal bleeding, infection/sepsis or intra-abdominal injury. Address these complications immediately if present.

3Table 4.1 Medical History for PAC assessment

History	What to ask for
Presenting complaints	Vaginal bleeding, passing of clots, lower abdominal pain
Reason for seeking care	Circumstances of pregnancy loss and possible complications.
Obstetric history	Details of the past pregnancies and their outcomes including ectopic gestations, abortions, still births, live births and mode of
Gynaecological history	Last Normal Menstrual Period (LNMP) Estimated gestational age Menstrual cycle history and pattern Previous gynaecological conditions and surgeries Contraceptive history
Sexual history	Current partners and whether the current partners may have other partners. History of correct and consistent use of condoms History of symptoms of STIs e.g. chronic pelvic pain, genital ulcers, abnormal vaginal discharges, HIV/AIDs.
Past Medical history	Chronic diseases such as Hypertension, Diabetes, Sickle cell anaemia, blood clotting disorders, liver disease, heart disease, psychiatric disease, etc. History of admissions to hospital
Past surgical history	Previous major surgical operations Previous major accidents and injuries Previous history of blood transfusion
Current medical treatments and allegies worker.	Allergies to medications Daily medications, use of herbs.
Family and Social history	Marital or partner status and family environment. Gender based violence or coercion by partner or family Use of alcohol and illicit drugs History of smoking

4Table 4.2 Physical examination for PAC assessment

Assessment needed	What to check for
General health assessment	General appearance (clothes soaked in blood, weakness, lethargy, anaemia, nutrition status, state of mind e.g.agitation, depression) Vital signs (Blood pressure, pulse rate, respiratory rate and temperature)
Abdominal examination	Observe for scars, distension, masses, movement with breathing or obvious deformities Palpate for uterine size, tenderness, masses, fluid.
Pelvic examination	Inspect the genitalia for bleeding, injuries, signs of infection, ulcers, warts, swellings e.g. Bartholin's gland abscess, and inguinal swellings. Do a speculum exam for bleeding, cervical dilation, tears and lacerations, visible products of conception, and intra- peritoneal contents such as gut. Digital and bimanual examination for state of the cervix (soft, open), presence of POCs, cervical motion tenderness/excitation. Assess the size of the uterus and feel for any foreign bodies.

4.1.3 Laboratory and Ultrasound

5Table 4.3 Investigations for PAC

Investigation	Recommendation
A pregnancy test	A pregnancy test, except where pregnancy is already confirmed or abortion obvious.
ABO blood grouping and Rhesus factor.	Indicated in recurrent or second trimester abortions or a suspected Rhesus negative mother. Do cross match if there's a need for blood transfusion.
CBC/Haemoglobin estimation	CBC/Haemoglobin estimation especially if anaemia is suspected or blood transfusion is considered.
Abdominal/pelvic Ultrasound	This is not mandatory to make a diagnosis of incomplete abortion, except where clinical assessment is inconclusive, or is used to rule out other complications.

6Table 4.4 Recommendations for management of uncomplicated incomplete abortion

Gestational age	Recommended	Level of care
< 14 weeks	Either Vacuum aspiration (Manual Vacuum Aspiration - MVA for up to 12 weeks or Electric Vacuum Aspiration - EVA up to 14 weeks) or Medical management (800mcg Misoprostol administered buccally, or 600mcg Misoprostol administered orally, or 400mcg Misoprostol administered sublingually)	Health Centre III and above
≥ 14 weeks	Medical management (repeat doses of 400 µg misoprostol administered sublingually, vaginally or buccally every 3 hours until complete expulsion). Ensure there's hemodynamic stability of the patient if the repeat doses are to continue, otherwise consider other management options.	Health Centre IV and above

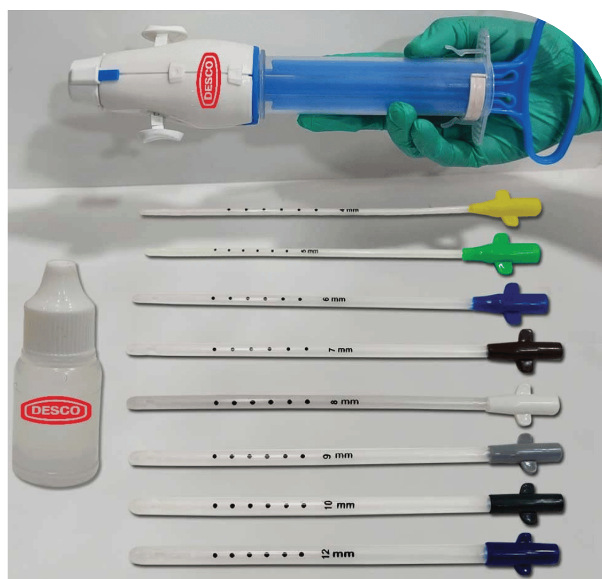
Note:

1) The decision about the mode of management of incomplete abortion should be based on the individual's clinical condition and preference for treatment.

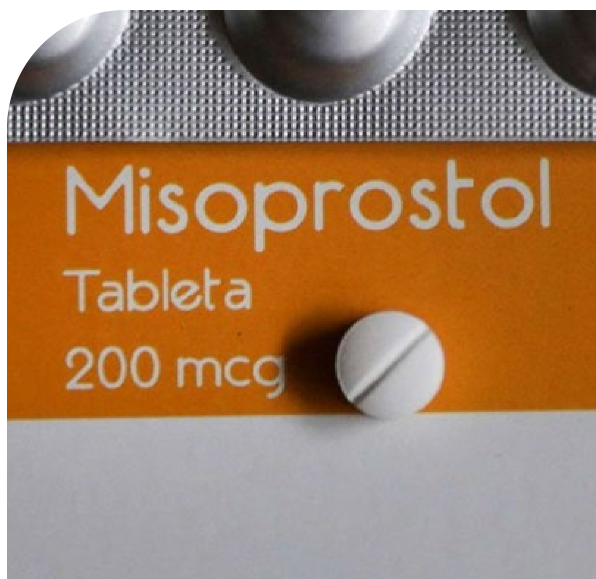
2) Expectant management of incomplete abortion can be offered in some cases as an option, on the condition that the patient is informed of the longer time for expulsion of the pregnancy tissue and the increased risk of incomplete emptying of the uterus.

3) Give Anti-D Immunoglobulin in a dose of 250IU during the first trimester to Rhesus negative women.

2Fig 4.1 MVA kit



3Fig 4.2 Misoprostol only tablets



7Table 4.5 Service delivery recommendation: Vacuum aspiration for management of uncomplicated incomplete abortion at gestational ages less than 14 weeks.

Type of health worker	Recommendation	Rationale
Community Health Workers (CHWs)/ Village Health Teams (VHTs)	Not Recommended	Role limited to: i Sharing of factual information with communities on PAC. ii Timely & appropriate referral of clients to the health facilities. iii Psychosocial support to clients.
Nurses	Recommended	Safety and effectiveness of these health workers providing vacuum aspiration for the management of uncomplicated incomplete abortion. The option is feasible, including in low-resourcesettings.
Midwives	Recommended	Safety and effectiveness of these health workers providing vacuum aspiration for the management of uncomplicated incomplete abortion. The option is feasible, including in low-resource settings.
Medical Clinical Officers	Recommended	Safety and effectiveness of these clinicians providing of vacuum aspiration for the management of uncomplicated incomplete abortion.
General Practitioners and Specialist Obstetricians & Gynaecologists	Recommended	Within their typical scope of practice.

Note:

Similar to the WHO, The Scope of Practice for Nurses and Midwives in Uganda, 1st Edition March 2022 recommends nurses and midwives to offer post abortion care services. Enrolled midwives (Page 25), Registered midwives (Page 29), Registered Nurses-Bachelors (Page 58) and Registered Midwives- Bachelors (Page 59). It is important that these cadres develop adequate skills and the right attitude to offer PAC services, as they are available in bigger numbers and at the lowest level of health facilities, increasing access to timely and quality PAC services.

4.1.4 Advantages of MVA

MVA is the preferred method of uterine evacuation to treat incomplete abortion 12 weeks and less because;-

1) Risks: The risk of complications is decreased.
2) Access: Access to services is increased as it can be performed by lower-level cadres at the lowest level of health facility (HC III) as long as the health provider is skilled.
3) Cost: The cost of post-abortion services is reduced.
4) Histology: Retained products of conception evacuated can be sent for histology to exclude gestational trophoblastic disease.

4.1.5 Pain Management during uterine evacuation

1) Management of pain will follow the evaluation of the situation and cause of the pain.
2) Severe pain can be due to unrecognized perforation/ injury to the uterus, hematometra, infection, psychic, retained products of conception, or all of the above.

8Table 4.6 Alternatives for pain control

Type of intervention	Examples	Possible adverse effects, complications and management	Notes
Analgesic	Ibuprofen 400-800mg Diclofenac injection 75mg Diclofenac suppository 100mg	Possible gastrointestinal upset with NSAIDs	Administer 30 to 60 minutes before performing the procedure, can last 3-6 hours.
Anxiolytic/Sedative	Pethidine 0.5mg/kg Tramadol 1-3mg/kg	Sedation, Dizziness, Nausea, Vomiting Severe respiratory depression (Antidote-Naloxone 1-3mcg/kg	Takes 10-20 minutes to take effect. Lasts 2-4 hours.
Local anaesthesia: Paracervical block using Lignocaine	The provider must be trained in Paracervical block performance.Ensure there's no allergy to all the drugs used in local anaesthesia. Lignocaine 1% without epinephrine limited to 3.5mg/kg body weight, maximum dose of 20mls. Lignocaine 2% can be used, maximum dose 10mls. Aspirate before injecting.	Toxic reactions are rare. Avoid them by using the smallest effective dose, and aspirate before each injection to prevent intravascular injection. Mild reactions: numness of the tongue and lips, metallic taste in the mouth, dizziness, light headedness, ringing in the ears, difficulties in focusing eyes. Wait and support the patient verbally. Severe reaction: sleepiness or slurred speech.	Wait 4-5 minutes for the block to take effect before starting the procedure. Duration of effect is 60 – 90 minutes.
General anaesthesia, Regional anaesthesia and Ketamine	When necessary, it should be administered by a person with anaesthetic skills.	Expected anaesthetic complications managed appropriately	Carries higher risks of complications including hypotension, hypoxia and cardiac arrest.

4.1.6 Infection prevention

Prevention of infection is the cornerstone of quality and safe post abortion care, as it contributes to prevention of short and long term complications such as sepsis and infertility respectively. Below are some of the approaches to achieve effective infection prevention:

9Table 4.7 Approaches to infection prevention during MVA

Procedure	Comment
Cleaning, Disinfection, and Sterilization of MVA Equipment	All MVA aspirators and adapters must be pre-soaked, rinsed, or sprayed with water or enzymatic spray at the point-of-use, then cleaned and high-level disinfected or sterilized between patients, in order to prevent the spread of infection through reused equipment.
Prophylactic Antibiotics	Administer prophylactic broad spectrum antibiotics prior to MVA procedures as a standard practice to reduce the risk of infection following the procedure. Examples are such as Metronidazole 400mg orally, single dose, or Doxycycline 200mg orally, single dose.
Other important considerations	i Screening for STIs: Individuals with signs or symptoms of sexually transmitted infections (STIs) should receive appropriate antibiotic treatment alongside their MVA procedure. ii In case of uncomplicated abortion; patients could be discharged on the same day. iii Follow-up care: post-MVA, individuals should be monitored for any signs of infection and receive appropriate treatment if needed. iv Patient Counselling: It's important to counsel individuals about the risks of infection and the importance of follow-up care.

4.2 Management of attendant complications of incomplete Abortion.

Many patients may present with one or more of the complications below and therefore there is need to have a high index of suspicion during client assessment. PAC should be provided to all without threat of reporting, criminal prosecution, stigma or punitive measures.

4.2.1 Management of Haemorrhage due to Abortion

Haemorrhage is the commonest complication of abortion. If not managed timely, its likelihood of resulting in death is high. Table 4.6 outlines the stepwise management of haemorrhage.

10 Table 4.8 Management steps for haemorrhage due to abortion

Timing	Management
Immediate management	1 Quickly assess the patient's condition. If in shock, resuscitate. 2 Set up an IV line, using wide-bore needle 16 gauge 3 Take a blood sample for haemoglobin estimation, grouping and cross-matching 4 Transfuse with crystalloids (lactated Ringer's or normal saline solution) and blood products if required 5 Pass Foley's catheter, monitor urine output. 6 Perform vaginal examination and manually remove products of conception and clots from the vagina and cervix. 7 Evacuate the uterus as appropriate 8 Start antibiotic therapy. 9 Give oxygen by face mask, if needed. 10 Give analgesics for pain control.
Secondary management	1 Evacuate uterus (MVA preferable). 2 Identify and suture any lacerations (vaginal/cervical). 3 If uterine perforation is suspected treat as intra-abdominal injury. 4 Administer broad-spectrum antibiotics. 5 Transfuse with blood if necessary. Give Ferrous sulphate/ Folate tables or Iron sucrose if needed. 6 Counsel on and provide post-abortion contraception. (see chapter 6) 7 Provide or refer for other reproductive health needs. 8 Respectful maternity care.
Subsequent management	1 Maintain a high index of suspicion for early diagnosis and treatment of abortion-related complications. 2 Ensure removal of all retained products (suction evacuation is preferable). 3 Replace excessive blood loss by transfusion.
Follow-up care	1 Review after 2 weeks and then 6 weeks; recheck haemoglobin. 2 Continue with ferrous sulphate and folate if still needed 3 Counsel and provide family planning. 4 Telehealth services can augment self-care for post abortion care

4.2.2 Management of Post Abortion Sepsis

4.2.2.1 Definition

Presence of localised or generalised infection involving the genital tract following an abortion.

4.2.2.2 Risk factors for sepsis

- i Retained products of conception
- ii Performing an abortion in an unsafe environment
- iii Use of unsafe methods to terminate pregnancy
- iv Delay in seeking care following unsafe abortion
- v Presence of intra-abdominal injury.

4.2.2.3 Diagnosis

a) Suspect sepsis if:

- i Hyperthermia temp>38C or Hypothermia temp < 36C
- ii RR>25 bpm
- iii Heart rate >100bpm
- iv Systolic BP <100mmhg
- v Altered level of consciousness
- vi Evidence of infection on CBC

Abdominal signs

- i Guarding with rebound tenderness
- ii Presence of a mass or free fluid
- iii Low or absent bowel sounds
- iv Adnexal tenderness

b) Assess severity of sepsis: In mild/ moderate sepsis, the vital signs are stable and temperature is less than 38.50C (101.50F)

Investigations

- i Blood grouping and cross matching
- ii CBC to assess level of anaemia, evidence of infection
- iii Abdominal ultra sound scan may reveal fluid pockets with internal echoes, retained products, perforations of the myometrium and foreign body.
- iv Culture and sensitivity where available

4.2.2.4 Management

If at BEmONC facility, refer to CEmONC facility after initial resuscitation and starting antibiotics and analgesics.

At the CEmONC Facility:-

- i Continue with resuscitation- give IV crystalloids (N/S or R/L) at least 3L in 24 hours
- ii Give IV/1M broad-spectrum antibiotics for 5 days or change depending on culture and sensitivity results
- iii Evacuate retained products of conception appropriately.
- iv Arrange and perform exploratory laparotomy if uterine perforation or abscess is suspected.
- v Inspect and make sure there is no other intrabdominal organ injury
- vi Hysterectomy may be considered in extensive uterine damage
- vii Correct any anaemia. Transfuse if clinically severely anaemic, Haemoglobin < 7 g/dl or haematocrit < 30%.
- viii If response to emergency treatment is unsatisfactory, refer or review antibiotic therapy in line with blood culture and endocervical culture reports.
- ix Monitor for evidence of renal failure and manage or refer appropriately.
- x Post procedure counselling of the patient and next of kin.
- xi Counsel woman and partner on post-abortion family planning.

4.2.3 Management of post abortion Intra-abdominal injury and/or genital injury

The post abortion intra- abdominal injury can occur as a result of unsafe abortion procedure or the management used.

4.2.3.1 Intra-abdominal injuries

Initial treatment:

i Ensure airway is open and check vital signs.

ii Give oxygen (6-8 litres/ min.);

iii Give IV fluids (Ringer's lactate or normal saline);

iv Immediately begin broad spectrum antibiotics (IV Ceftriaxone 2g start, IV Metronidazole 500mg start, followed by Oral Amoxicillin 500mg 6 hourly for 7 days and Oral Metronidazole 400mg 8 hourly for 7 days)-UCG 2023

v Draw blood for grouping and cross-match.

vi Transfuse if Haemoglobin <7g/dl.

Definitive treatment:

i Repair the gut or bladder, with the assistance of a surgeon, if necessary.

ii Repair uterine perforation after evacuating the uterus.

iii If uterine perforation is not repairable then a hysterectomy is indicated.

4.2.3.2 Genital injuries

After initial assessment and stabilization measures, repair the vaginal, cervical or uterine injuries under local, regional or general anaesthesia.

Vulval injuries, if any, may be repaired under local anaesthesia.

For infected genital injuries, first manage the infection and then do secondary

Refer if not possible to repair the injuries repair afterwards

05 CHAPTER

Diagnosis and Management of the other types and complications of Abortion

5.1 Definitions

Threatened abortion:
There's a risk of a pregnancy loss with vaginal bleeding and abdominal cramping, but the cervix is still closed and the fetus/embryo is alive.

Inevitable abortion:
The pregnancy loss is almost certain and the products of conception are in the process of expulsion, with significant bleeding, abdominal cramping, and an open cervical os.

Missed abortion:
This is when the embryo or fetus has died inside the uterus but not expelled.

Complete abortion:
Complete expulsion of all the products of conception.

5.2 Diagnosis and management

Table 5.1 below, outlines how to make a diagnosis of the different types of abortion basing on history, abdominal and cervical examination, and the relevant management.

11 Table 5.1 Diagnosis and management

Diagnosis	Bleeding	Cervix	Uterine size	Other signs	Management
Threatened abortion	Slight to moderate	Not effaced Not dilated	Equivalent to dates by last normal menstruation period	Positive pregnancy test, Cramping minimal or absent Uterus soft	Confirm viability by ultrasound scan Rest at home or health facility, abstain from sex for two weeks from last bleeding. Room for progesterone , smooth muscle anti-spasmodics & antibiotics Cervical cerclage in cervical insufficiency
Inevitable abortion	Moderate to heavy	Dilated and effaced, membranes may be ruptured	Less than or equal to dates by LNMP	May be severe cramping	MVA or Misoprostol if 12 weeks and below Above 12 weeks, augment with misoprostol-refer to misoprostol only dosing chart for gestational age appropriate dosing (appendix 2); or Oxytocin in later gestational ages -25 weeks and above (Be mindful of poor oxytocin sensitivity in earlier gestations).Antibiotics & analgesia
Missed abortion	There may or may not be bleeding (pregnancy symptoms cease)	Cervix is closed	Uterine size is less than or equal to the gesta-tion age	No abdominal pain	Medical evacuation with Combipack (Combina-tion of Mifepristone and Misoprostol) preferred. It is more effective than Misoprostol only, or Oxytocin with shorter induction to expulsion time,and less complica-tions.
Complete abortion	Little bleeding or bleeding has stopped	Soft or closed and no RPOC	Less than as estimated by LNMP Firmly contracted	Less or no cramping Uterus firm	May confirm by ultra-sound scan Treat complications if any and proceed with the other aspects of post abortion care such as Antibiotics, FP and counselling.

Note:

1) In Uganda, Combipack can be used for missed abortion and IUFD up to 28WOA Contraindicated in previous caesarean section scars, grand multipara, and known allergies to the drugs. Doses, routes of administration and schedules vary with gestational age-Refer to Combipack dosing chart-Appendix 3 Combipack can be used with self-care below 12WOA (UCG 2023 Pg. 790) "These medications can be taken by the person herself, or administered on an outpatient basis by trained health workers"

2) **Alternatives to Combipack for management of missed abortion/IUFD**

   Medical-
   Misoprostol only (refer to Misoprostol only dosing chart for gestational age appropriate dosing, schedules and routes of administration.

   Surgical:-
   MVA- below 12 weeks
   D&E- second trimester
   Hysterotomy- Late second trimester (after failed expectant and medical management, previous uterine scars, cervical stenosis)

3) For abortions more than 20 weeks of gestation, provide medications for breast symptoms such as engorgement, using Bromocriptine 0.5 mg three times a day for 5 days or Carbegoline 1 mg (which may be repeated after 2 weeks)

12Table 5.2 Specific investigations for each of the abortion types

Type of abortion	Specific investigations
Threatened	Pregnancy confirmation (e.g. pregnancy test, Ultrasound scan), Investigate cause (e.g. Malaria test, Urinalysis, CBC, Rhesus factor, etc.)
Inevitable abortion	Investigate cause (e.g. Malaria test, Urinalysis, CBC, Rhesus factor, etc.) Blood grouping and cross matching
Missed abortion	Pregnancy confirmation (e.g. pregnancy test, Ultrasound scan) Investigate cause (e.g. Malaria test, Urinalysis, CBC, Rhesus factor, etc.) Blood grouping and cross matching, bleeding and clotting time especially second trimester.
Complete abortion	Confirm completeness with clinical assessment or Ultrasound. Investigate cause (e.g. Malaria test, Urinalysis, CBC, Rhesus factor, etc.)

4Fig 5.1 Combipack for management of missed abortion/IUFD

Post Abortion Contraception and Family Planning Services

6.0 Post-abortion contraception and family planning methods

This is to actualize PAC model element 4:
"Contraceptive and family planning services to enable women prevent an unintended pregnancy or practice birth spacing"

6.1 Post-abortion contraception: WHO Recommendation

6.1.1 Introduction

Following an induced or spontaneous abortion, ovulation can return as early as 8–10 days later and usually within one month. Therefore, contraception initiation immediately, or as soon as possible (within the first month) is important for women who desire to delay or prevent a future pregnancy.

The client's wishes are paramount; if the individual wishes to start or resume a contraceptive method, then all contraceptive options may be considered at any point in care and some methods can be initiated at the time of the post abortion care.

The criteria laid out in the WHO publications "Ensuring human rights in the provision of contraceptive information and services and Medical eligibility criteria for contraceptive use" should be adhered to. WHO recommends that all nations should ensure there is access to a wide range of modern, safe and affordable contraceptive methods.

Where possible, provide long term and reversible methods of contraception (LARC). These have been found to be more effective and more reliable in preventing a repeat unintended pregnancy. Such methods include implants and intra-uterine devices.

There's a role of self-care in post abortion family planning supported by WHO and Uganda National Self Care Guideline 2024 (Pages 51 – 56) for methods such as oral contraceptives, injectable contraceptive, cycle beads, condoms and calendar method.

6.1.2 Medical Eligibility Criteria of Contraceptive methods used in PAFP

Table 6.1 below outlines the various contraceptive methods and their safety for use in the immediate Post abortion period based on WHO's Medical Eligibility Criteria.

13 Table 6.1 Medical Eligibility criteria for post abortion contraception

Category	Meaning	Examples
MEC Category 1	A condition for which there is no restriction for the use of the contraceptive method.	After an abortion (first and second trimester, and also after a septic abortion): combined hormonal contraceptives (CHCs), progesterone-only contraceptives (POCs) and barrier methods (condoms, spermicide, diaphragm, cap – note: The diaphragm and cap are unsuitable until 6 weeks after second-trimester abortion).
MEC Category 2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks.	Intrauterine devices (IUDs) after a second trimester abortion.
MEC Category 3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method.	CHCs for women who have a history of Peri-partum Cardiomyopathy, severe headache, migraine, hypertension (160/100mmHg), stroke. Progesterone only injectables/implants for women with multiple risk factors for Cardiovascular disease.
MEC Category 4	A condition which represents an unacceptable health risk if the method is used.	Intrauterine devices (IUDs) after a septic abortion

Note:

1) Fertility-awareness-based (FAB) methods: Symptom-based methods should only be started after abortion with "caution" (special counselling may be needed to ensure correct use of the method in this circumstance) and the use of calendar-based methods should be delayed (until the condition is evaluated; alternative temporary methods of contraception should be offered).

2) Symptoms-based methods include the cervical mucus method (also called the ovulation method) and the Two Day Method, which are both based on the evaluation of cervical mucus, and the sympto-thermal method, which is a double-check method based on evaluation of cervical mucus to determine the first fertile day and evaluation of cervical mucus and temperature to determine the last fertile day.

3) Calendar-based methods include the Calendar Rhythm Method (avoiding unprotected intercourse from the first to the last estimated fertile days, after recording the length of several menstrual cycles as a basis for calculation) and the Standard Days Method (avoiding unprotected intercourse on cycle days 8–19, for people whose cycles are usually 26–32 days long).

4) CHCs include combined oral contraceptives (COCs), the contraceptive patch (P), the combined vaginal ring (CVR) and combined injectable contraceptives (CICs). POCs include progesterone-only pills (POPs), levonorgestrel (LNG) or etonogestrel (ETG) implants, depot medroxyprogesterone acetate (DMPA) injectables, and norethisterone enanthate (NET-EN) injectables. IUDs include copper-bearing IUDs (Cu-IUD) and hormonal IUDs (H-IUD).

6.2 Role of contraception counselling immediately after Post Abortion Care

The role of contraception counselling is to ensure the woman makes a voluntary informed choice of a contraceptive method that will assist her to avoid future unintended pregnancies. Use BCS+ counselling strategy to assist the woman choose the method of her choice.

07

CHAPTER

Integration and management of other reproductive health conditions during post abortion care

7.0 Integration and management of other reproductive health conditions during post abortion care

This is to actualize PAC model element 5

“Reproductive and other health services that are preferably provided on-site or via referrals to other accessible facilities in providers' networks”.

Patients who present with abortion complications also present with other pre-existing reproductive health conditions. During counselling, screening for some of these conditions should be done and if found, treated or appropriately referred. Refer to other guidelines specific to these conditions to effectively manage them.

Examples of these services are such as these shown in table 7.1 below:

14Table 7.1 RH services to be integrated with PAC and possible interventions

Services to be integrated with PAC	Possible intervention
Screen for genital tract infections including bacterial vaginosis, sexually transmitted infections, endometritis, pelvic inflammatory disease and pelvic abscess. Thismay be difficult to differentiate from post abortion sepsis.	Rule out post abortion sepsis. Refer to treatment guidelines in the EMNCG and UCG
Screen for Human Immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).	Refer for ART and Chronic care Appropriate counselling
Screen for Cervical lesions, both benign and malignant.	Refer to Cancer cervix screening and treatment guidelines. In case of malignant lesions, refer to Gynaecological Oncology clinic.
Screen for pelvic pathology including ovarian cysts and uterine fibroids	Involve a gynaecologist to assess and institute appropriate treatment.
Screen for Urinary tract infections.	Refer to treatment guidelines in UCG
Screen for Breast lesions, both benign and malignant.	Involve a surgeon, and a breast cancer clinic for malignant lesions.
Screen for Vaginal lesions such as cystoceles, rectoceles, fistulae and prolapses	Involve an Uro-gynaecologist for appropriate management.
Screen for Gestational trophoblastic disease.	Refer to management guidelines in EMNCG.
Screen for Infertility (Primary or secondary)	Refer to a gynaecologist for assessment and management.
Screen for Recurrent pregnancy loss.	Involve a gynaecologist for medical and surgical interventions. Ascertaining the possible cause, Hormonal support, Cervical cerclage, etc. Individualised care.
Screen for Sexual and Gender Based Violence	Link to organisations that support SGBV survivors, to police and legal support.
Screen for teenage pregnancies/adolescent health issues.	Link to probation officers, youth/adolescent friendly services, and support organisations. Provide sexuality education and contraception to avert repeated unintended pregnancies. Support re-integration into school.

CHAPTER 08

Standards for post abortion care services

8.1 Introduction

Post abortion care is emergency care that should be accessed at primary health care facilities. Where actual services cannot be directly offered, proper referral mechanisms should be established.

While setting up a centre for post abortion care services, consider critical components such as an appropriate site with adequate infrastructure and equipment, well trained personnel, and a community engagement plan among other things.

The clinical services delivery should clearly delineate the steps that a client/patient takes during the post abortion care pathway. Post abortion care should be delivered via a comprehensive model in public and private facilities. In addition, support services at community level via self-care and telemedicine services.

Other models may include community outreach services (such as mobile clinics), using digital platforms and support tools to provide information and messages reminders about unsafe abortion, PAC or abortion complications.

8.2 Site set-up for Post abortion Care

While setting up Post abortion Care services it is important to consider:

1) Space available and existing infrastructure for site set up.
2) Integration of Post abortion Care services with existing maternal health services- (Cervical cancer screening, family planning, HIV counselling and testing).
3) Cadre and number of personnel available to provide Post abortion Care.
4) Where possible, Post abortion Care services should be offered in the outpatient department.
5) Where possible, the Post abortion Care procedure room should be separate from the delivery room.

8.3 Infrastructure:

Each facility should have a post abortion care procedure room which should be established with adequate space to facilitate service delivery.
In an ideal setting the Post abortion Care service set-up should have the following;

1) A reception area
2) A patient waiting area
3) Consultation and counselling room
4) Well-equipped procedure room
6) Sterilization and instrument processing area
7) Patient recovery room
8) Washrooms/ Lavatories for patients where possible
9) Audio and Visual Privacy in all the areas of patient counselling and care.
10) Hand washing facilities

Table 8.1 below outlines the key equipment, drugs, supplies, information dissemination and data collection needs that a PAC services centre will require.

15Table 8.1 Key equipment, drugs and supplies for a PAC room

Equipment	Drugs	Others
1 Blood pressure machine	1 Misoprostol	1 Relevant educational and informational materials
2 Thermometer	2 Combipack	2 Client record and referral forms
3 Stethoscope	3 Local anaesthetic-Lignocaine	3 PAC procedure register
4 Vaginal speculum (various sizes)	4 Antibiotics	4 Informed consent forms
5 Non traumatic tenaculum	5 All contraceptive methods available	5 Counselling job aids
6 Gynaecological/procedure table with stirrups	6 IV fluids	6 Contraceptive methods board with all methods of contraceptives
7 Strainers	7 IV infusion line	7 Clinical handbook/ guidelines
8 Angle lamp	8 Blood transfusion sets	8 Balance counselling scorecard table/wall chart
9 Cover for perineum (drapes)	9 Sterilisation chemicals	9 Complete referral map
10 MVA kits with cannulae of various sizes	10 Disinfectants	
11 Steriliser (autoclave/boiler)	11 Personal protective Equipment (gloves, boots, face masks)	
12 Waste segregation bins and liners	12 Non-alcohol based antiseptics e.g. povidone iodine	
13 Instrument trolley with at least two trays		
14 Instrument storage		
15 Clear glass or plastic bowl		

8.4 Personnel

1) The post abortion care service centre should be headed by a health care provider trained to provide and manage post abortion care services.

2) All staff working in the post abortion care service point should be provided with Values Clarification and Attitude Transformation (VCAT) sessions and thus values clarified.

3) Health care providers providing post abortion care services should be trained on surgical uterine evacuation (MVA and EVA- where applicable) and medical uterine evacuation. These procedures should be performed by trained health professionals (doctors, clinical officers and nurses/midwives).

4) Providers should mitigate or address abortion stigma as well as ensure privacy and confidentiality

5) All staff in the post abortion care service unit should be trained in provision of the whole range of post abortion care services.

6) To ensure continuity of PAC services, there is need for continuous training and mentorships of staff.

7) The post abortion service centre should be a one stop shop for provision of post abortion care services and related linkage services, hence staff should be trained in integration of other Reproductive Health (RH) services within PAC.

8.5 Access to services

1) Post abortion care services should be provided as emergency care in all health care facilities. Triage should be done to identify patients requiring immediate attention.

2) Nobody should be forced or coerced to have post abortion care against their will, preference or choice. Informed consent should always be obtained, and in surgical procedures, it should preferably be written, except in an emergency situation where it may be deferred for later.

3) To ensure access to all those in need, those with disability should not be denied services because of their condition.

4) Health facilities should address formal and informal barriers that deter access to healthcare, such as stigma, formal and informal costs, lack of commodities, untrained healthcare and other service providers as well as unwillingness of some providers to offer needed services for post abortion care.

5) Use Telehealth services to augment self-care for post abortion care , where individuals may receive information, advice on medication, emotional support or information on completeness or complications of abortion.

6) Proper referral pathways and mechanisms must be established in all health care facilities where service provision is not possible.

7) Integrate post abortion care with other existing RH services including HIV counselling, cervical cancer screening and other RH services.

8) Identification of complications: Providers of PAC must be able to identify complications of abortion such as haemorrhage, pain, shock, sepsis and injury to internal organs.

9) Observe proper infection prevention procedures including medical waste disposal.

   Workplace infection prevention guidelines and standard operating procedures (SOPs) must be implemented to reduce exposure and transmission of infections. These include hand washing, using protective gear, proper handling, sterilisation of instruments and handling of sharps.

   Segregate and dispose of waste properly. Pregnancy tissue should be treated as any other biological material unless the patient/client desires otherwise. However, individual preferences should be respected after voluntary informed consent.

10) Documentation is critical to support monitoring and evaluation of PAC services.

8.6 Information Provision

1) Information can be provided in person, by hotlines, via digital platforms, or via tele-medicine. It should be accessible, easy to understand, by individuals with low literacy, and by individuals with disability. From patient centred care, the right of individuals to refuse this information should be respected. No third party consent is needed to provide information on available post abortion care services.
2) Avail information for post abortion care services in a language that the woman understands, and that is sensitive to persons with special needs.
3) Provide counselling and decision-making support for post abortion care to the woman. Counselling should be free, voluntary and mot mandatory.
4) Respect for privacy and confidentiality
5) Information provision should be non-biased, non-judgmental and non-discriminatory
6) Avoid or address mis-information and dys-information
7) Information should be provided without the need for third party consent or authorization.

8.7 Sustainability

1) Integrate PAC services within the existing RH services at your facility, and effectively plan and budget for them.
2) Health facilities should ensure availability of resources to replenish post abortion care equipment and supplies.
3) The health facility management should be engaged and sensitized on post abortion care services by unit heads to support resource allocation for service continuity.
4) Provision and sustainability of PAC services should be promoted through the Local Maternity and Neonatal system-LMNS.

8.8 Quality Improvement:

1) Carry out regular post abortion care program audits for the purposes of improving service delivery and training.
2) Set up a quality improvement team at facility level to ensure post abortion care program quality assurance.
3) Ensure an enabling environment, which is key to quality service provision. Services should ensure:-

a) Availability of adequate numbers of competent service providers
b) Provision of patient-centred care.
c) Adequate communication and counselling to promote and ensure voluntary informed decision-making.
d) Values clarification to align personal values of service providers with their professional responsibilities.
e) Interprofessional team building
f) Empathetic and compassionate care

8.9 Community Engagement and Networking

The goal is to increase awareness on Post abortion Care (PAC) and services in the community, which include facility linkages, referral and subsequent re-integration into the community, to reduce maternal mortality and morbidity due to unsafe abortion.

1. **Community Entry**

    i Carry out a needs assessment.

    ii Mapping the community

    iii Plan of Action (POA) involving all community members

    Implementation of the Plan of Action.

    i Community sensitization and Education on PAC services

    ii Increase community knowledge on the dangers of abortion related complications.

    iii Inform the community about legality of providing PAC services and where to get the services.

    iv Initiate interventions to reduce stigma.

    v Collect and use data relevant case studies and stories to engage communities.

2. **Creating linkages and networking with partners.**

    i Youth friendly/responsive clinics

    ii SGBV Care and management.

    iii Local leadership

    iv Justice law and order sector -JLOS Actors

    v Schools and colleges

    vi Faith Based Organizations (FBOs)

    vii Media

    viii Civil Society Organizations (CSOs)

    ix Community Based Organizations (CBOs)

3. **Role of Community Health Workers (CHWs)**

    i To be trained in PAC Values Clarification and Attitude Transformation (VCAT) and PAC services for them to have knowledge on PAC provision and referrals.

    ii To communicate to the community that PAC services are legal and are available in all public and private health facilities.

4. **Follow-up partners.**

    Conduct quarterly data review meetings.

    Use the data obtained to improve community PAC strategies

09 CHAPTER

Monitoring, Evaluation and Learning

9.0 Monitoring, Evaluation and Learning

Monitoring, Evaluation and Learning is a key management function that must be continuous in order to examine programmatic progress, challenges, and what needs to be done to improve it.

Monitoring

Service provision: Services should provide human-rights-based patient-centred care, as well as standards and practices that protect or promote individual human rights, informed voluntary decision-making, confidentiality and privacy, and continuity of care

Post Abortion Care (PAC) data management

1) Use the Integrated Maternity Register (IMR) as the primary register for capturing and monitoring PAC data at health facilities.
2) Correctly and completely record all clinical findings in the patients file, whether physical or electronic.
3) Document PAC services data accurately and consistently in the registers.
4) Ensure Integrated Maternity Registers and all relevant reporting tools are availed in all the health facility offering post abortion care services.
5) Ensure the data is uploaded onto the District Health Information System (DHIS).

Documentation and Research

Documentation is a critical component of management in PAC.

1) Document clear history including where possible methods used to terminate the pregnancy and any possible complications such as pain, shock, haemorrhage, sepsis or internal organ injury.
2) Documentation ensures continuity of care within the health facility and during and after referral either to another facility or into community-based services.
3) Documentation ensures quality monitoring including for operations research and health systems research to identify and address areas for continuous quality improvement
4) Documentation may be required by regulatory frameworks such as for reporting complications or adverse events

   Typical documentation may include:

   a) Medical history
   b) History of the post abortion procedure (method, route, dates, approach, provider)
   c) Post-procedure care and complications
   d) Emotional support and counselling
   e) Post abortion contraception
   f) Referral and linkages and related care

16Table 9.1 Rationale for documentation of PAC data

Role of documentation	Explanation
Tracking service delivery	Documentation is crucial in post abortion care (PAC) to track service delivery, ensure quality of care, and identify areas and opportunities for service integration or improvement.
Transparency and accountability	Documentation also helps to ensure transparency and accountability. Availability and use of Standardized reporting tools and data management systems help monitor service utilization, resource needs, and potential issues with sundries, commodities and kit replacements or service. For instance, documentation helps track the number of women accessing PAC services, the types of services provided, and the outcomes of those services. This data can be used to monitor trends in PAC utilization, identify areas where service delivery may be lacking, and make improvements to the program.
As a key performance	PAC is one of the signal functions for emergency obstetric care. Documentation helps ensure that PAC services are provided openly and transparently, reducing the risk of providers offering services under the table or taking advantage of women's confusion or lack of information. Documentation can help in developing management checklists. The post abortion care checklists is for use with health providers at facilities during training and supportive supervision to ensure providers are performing steps or tasks according to standard procedure or guidelines.
Informing policy indicator	Data from PAC documentation can be used to inform policy decisions and program development at the national and local levels. This can help ensure that PAC services are accessible to all women, regardless of their location, socioeconomic status, or other factors. For example, data on the use of different contraceptive methods by women who have received PAC can be used to inform decisions about which methods to offer and how to promote their use.
	Documentation helps ensure that patients receive appropriate and safe care, including treatment for complications, follow-up check-ups, and contraceptive counselling as well as services. By recording details of each patient's care, providers can track their progress, identify any problems that may arise, and adjust their treatment plan accordingly. Documentation also allows for the evaluation of the effectiveness of different PAC interventions.

1) Ensure PAC registers are filled accurately, with completeness, and consistently, as critical data gaps have been repeatedly found in health facility PAC data, making the usability of this data for planning difficult.
2) Monitor, document and report serious adverse reactions and complications.
3) Do relevant operational research whenever the need arises.
4) Share data driven findings with various stakeholders.

Supervision

1) Do PAC supportive supervision as part of routine integrated support supervision for monitoring of the program, and support towards implementation of quality improvement interventions.
2) Carry out continuous mentorship for all facilities regarding PAC services in all LMNS.

Evaluation

1) Do Health facility assessments (HFAs) as external independent review mechanisms for ensuring that services are available and meet quality standards. Results from the PAC HFA should be used by the health ministries to identify and address gaps and weaknesses in the provision of PAC services, effectively allocate resources, plan the improvement and scaling-up of essential PAC services, and monitor progress in improving access to, and quality of PAC.
2) The evaluation can inform on the availability of different PAC services in health facilities at different levels of the health system and assess the readiness of health facilities to provide quality services.
3) Implement an effective evaluation pathway which includes planning, managing, high performance evaluation, rigorous impact evaluation and follow up.

Learning

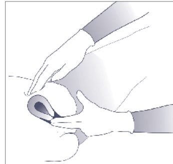
Use all documented lessons to continuously improve PAC services.

Appendix 1: The Ipas stepwise guide for performing MVA

Steps for Performing Manual Vacuum Aspiration (MVA) Using the Ipas MVA Plus® and Ipas EasyGrip® Cannulae

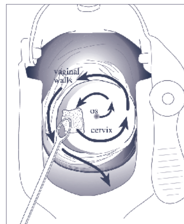
Step One: Prepare the Patient

- Administer pain medication before the procedure to have maximum effect when the procedure begins.
- Give prophylactic antibiotics to all women, or therapeutic antibiotics if indicated.
- Ask the woman to empty her bladder.
- Conduct a bimanual exam to confirm uterine size and position.
- Insert speculum and observe for signs of infection, bleeding or incomplete abortion.



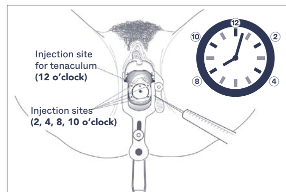
Step Two: Perform Cervical Antiseptic Prep

- Use antiseptic-soaked sponge to clean cervical os. Start at os and spiral outward without retracing areas. Repeat until os has been completely covered by antiseptic.



Step Three: Perform Paracervical Block

- Paracervical block is required prior to MVA.
- Perform paracervical block with 20cc of 1% lidocaine, or 10cc of 2% lidocaine. Inject a small amount of lidocaine (1-2cc) into the cervix at the tenaculum site (12 o'clock). Inject the remaining lidocaine in equal amounts at the cervicovaginal junction at 2, 4, 8 and 10 o'clock. Always aspirate before injecting to prevent intravascular injection of lidocaine.

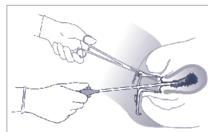


Step Four: Dilate Cervix

- Observe no-touch technique when dilating the cervix and during aspiration. Instruments that enter the uterine cavity should not touch your gloved hands, the patient's skin, the woman's vaginal walls, or unsterile parts of the instrument tray before entering the cervix.
- Use mechanical dilators or progressively larger cannulae to gently dilate the cervix to the right size.

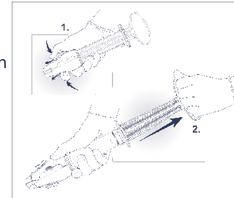
Step Five: Insert Cannula

- While applying traction to the tenaculum, insert cannula through the cervix, just past the os and into the uterine cavity.
- Do not insert the cannula forcefully.



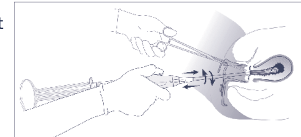
Step Six: Prepare the Aspirator

- Position the plunger all the way inside the cylinder.
- Have collar stop in place with tabs in the cylinder holes.
- Push valve buttons down and forward until they lock (1).
- Pull plunger back until arms snap outward and catch on cylinder base (2).



Step Seven: Suction Uterine Contents

- Attach the prepared aspirator to the cannula.
- Release the vacuum by pressing both buttons.
- Evacuate the contents of the uterus by gently and slowly rotating the cannula 180° in each direction, using an in-and-out motion.
- When the procedure is finished, depress the buttons and disconnect the cannula from the aspirator. Alternatively, withdraw the cannula and aspirator without depressing the buttons.

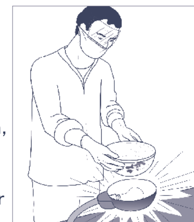


Signs that indicate the uterus is empty:

- Red or pink foam without tissue is seen passing through the cannula.
- A gritty sensation is felt as the cannula passes over the surface of the evacuated uterus.
- The uterus contracts around or grips the cannula.
- The patient complains of cramping or pain, indicating that the uterus is contracting.

Step Eight: Inspect Tissue

- Empty the contents of the aspirator into a container.
- Strain material, float in water or vinegar and view with a light from beneath.
- Inspect tissue for products of conception, complete evacuation and molar pregnancy.
- If inspection is inconclusive, reaspiration or other evaluation may be necessary.



Step Nine: Perform Any Concurrent Procedures

- When procedure is complete, proceed with contraception or other procedures, such as IUD insertion or cervical tear repair.

Step Ten: Immediately After the Procedure

- Reassure the woman that the procedure is finished.
- Ensure she is escorted to the recovery area.
- Immediately process or discard all instruments, according to local protocols.

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Appendix 2: The FIGO dosing chart for Misoprostol only

Misoprostol ONLY Dosing Chart

(For use ONLY when mifepristone is not available)

Recommended Regimens 2023

FIGO International Federation of Gynecology and Obstetrics
the Global Voice for Women's Health

≤12 weeks	13-17 weeks	18-24 weeks	25-27 weeks	≥28 weeks	Postpartum Use
Induced Abortion Misoprostol 800µg BU/SL/PV every 3 hours until expulsion[1]	**Induced Abortion** Misoprostol 400µg every 3 hours until expulsion BU/SL/PV[4]	**Induced Abortion** Misoprostol 400µg every 3 hours BU/SL/PV until expulsion[4]	**Induced Abortion** Misoprostol 200µg every 4 hours BU/SL/PV until expulsion[4,8]	**Induced Abortion** Misoprostol 25-50µg every 4 hours PV[8] OR Misoprostol 50-100µg every 2 hours PO[5,8]	**Prophylaxis of Postpartum hemorrhage (PPH)** Misoprostol 600µg SL x 1
Missed Abortion/ Anembryonic Pregnancy Misoprostol 800µg BU/SL/PV every 3 hours until expulsion[1]	**Missed Abortion** Misoprostol 400µg every 3 hours BU/SL/PV until expulsion[4]	**Fetal Demise** Misoprostol 400µg every 3 hours BU/SL/PV until expulsion[4]	**Fetal Demise** Misoprostol 200µg every 4 hours BU/SL/PV until expulsion[4]	**Fetal Demise** Misoprostol 25-50µg every 4 hours PV[9] OR Misoprostol 50-100µg every 2 hours PO[5]	**Treatment of Postpartum hemorrhage (PPH)** Misoprostol 800µg SL x 1
Incomplete Abortion 400µg misoprostol SL x 1 600µg misoprostol PO x 1 800µg misoprostol BU x 1 dose[4]	**Incomplete Abortion** Misoprostol 400µg every 3 hours BU/SL	**Incomplete Abortion** Misoprostol 400µg every 3 hours BU/SL	**Induction of Labor** Misoprostol 25-50µg every 4 hours PV [6,7] OR Misoprostol 50-100µg every 2 hours PO [5,6,7]	**Induction of Labor** Misoprostol 25-50µg every 4 hours PV[6,7] OR Misoprostol 50-100µg every 2 hours PO[5,6,7]	
Cervical Preparation Before Aspiration Not required[2]	**Cervical Preparation Before Aspiration** Misoprostol 400µg 1-2 hours BU/SL/PVbefore the procedure[3]	**Cervical Preparation Before D&E** (***Use of multiple modalities is recommended)*** Osmotic Dilators 1-2 days before and Misoprostol 400µg BU/SL/PV 1-2 hours before the procedure	**LEGEND: Buccal(BU) Sublingual (SL) Per Vagina (PV) Per Oral (PO)**		

1. <12 weeks induced & missed abortion can be self-managed at home.
2. Consider using 400mcg misoprostol 1-2 hours before procedure in patients ≤ 17 years of age.
3. Consider using Osmotic Dilators in patients ≤17 years old or in patients with a stenotic cervix.
4. Dosing based on Society of Family Planning Guidelines (20111, 20133) A comprehensive systematic review and Meta -Analysis published 2020
5. Dosing based on Cochrane Database Syst Rev. (CD014484) published 2021
6. Buccal and Sublingual Misoprostol is not recommended for induction of labor with viable pregnancies, it is associated with more tachysystole and fetal distress.
7. There is a lack of strong evidence for misoprostol dosing for this indication at this gestational age.
8. Induced fetal cardioplegia should be considered for induced abortion after fetal viability

NOTES:

- SL/PO route is associated with more side effects.
- Avoid vaginal route if there is vaginal bleeding.
- Misoprostol is SAFE below 28 weeks EVEN with history of Cesarean Delivery.
- Misoprostol is not recommended in women ≥28 weeks gestational age with a prior Cesarean Delivery.
- There is NO Maximum dose of misoprostol. If an abortion is not complete after 5 doses, you may continue additional doses or rest for 12 hours and start again
- Misoprostol is not contraindicated in grand multipara.
- Routine aspiration after medication abortion is not required or recommended.

Appendix 3: The FIGO dosing chart for Combipack

Mifepristone & Misoprostol Dosing Chart

Recommended Regimens 2023

≤12 weeks	13-17 weeks	18-24 weeks	25-27 weeks	≥28 weeks	Postpartum Use
Induced Abortion Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 800µg BU/SL/PV x1 ≥10 weeks give misoprostol BU/SL/PV every 3 hours until expulsion[1]	**Induced Abortion** Mifepristone 200mg PO Wait 1-2days then, Misoprostol 400 every 3 hours BU/SL/PV until expulsion[5]	**Induced Abortion** Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 400 every 3 hours BU/SL/PV until expulsion[5]	**Induced Abortion** Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 200 every 4 hours until expulsion BU/SL/PV[5,9]	**Induced Abortion** Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 50-100µg every 4 hours PV OR Misoprostol 50-100 µg every 2 hours PO[6,9]	**Prophylaxis of Postpartum heamorrhage (PPH)** Misoprostol 600µg SL x 1
Missed Abortion/ Anembryonic Pregnancy Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 800µg BU/SL/PV x1 ≥10 weeks give misoprostol BU/SL/PV every 3 hours until expulsion [1]	**Missed Abortion** Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 400 every 3 hours BU/SL/PV until expulsion[5]	**Fetal Demise** Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 400 every 3 hours BU/SL/PV until expulsion	**Fetal Demise** Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 200 every 4 hours BU/SL/PV until expulsion[5]	**Fetal Demise** Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 25-50µg every 4 hours PV OR Misoprostol 50-100 µg every 2 hours PO[6]	**Treatment of Postpartum heamorrhage (PPH)** Misoprostol 800µg SL x 1
Incomplete Abortion 400µg misoprostol SLx1 600µg misoprostol PO x1 800µg misoprostol BU x 1 dose[4]	**Incomplete Abortion** Misoprostol 400 every 3 hours BU/SL until expulsion	**Incomplete Abortion** Misoprostol 400 every 3 hours BU/SL until expulsion	**Induction of Labour** Misoprostol 25-50µg every 4 hours PV[7,8] OR Misoprostol 50-100µg every 2 hours PO[6,7,8]	**Induction of Labour** Misoprostol 25-50µg every 4 hours PV[7] OR Misoprostol 50-100µg every 2 hours PO[6,7]	
Cervical Preparation Before Aspiration Not required [2]	**Cervical Preparation Before Aspiration** Misoprostol 400µg 1-3hrs BU/SL/PV before the procedure[3]	**Cervical Preparation Before D&E (*Use of multiple modalities is recommended)*** Mifepristone 200µg PO & Osmotic Dilators 1-2 days before. [4]	**LEGEND:** Buccal(BU) Sublingual (SL) Per Vagina (PV) Per Oral (PO)		

1. <12 weeks induced & missed abortion can be self-managed at home.
2. Consider using 400µg misoprostol 1-2 hours before procedure in patients ≤ 17 years of age.
3. Consider using Osmotic Dilators in patients ≤17 years old or in patients with a stenotic cervix.
4. Can use Misoprostol 400µg 1-2 hours before D&E if mifepristone is not available.
5. Dosing based on Society of Family Planning Guidelines (20111, 20133) A comprehensive systematic review and Meta -Analysis published 2020
6. Dosing based on Cochrane Database Syst Rev. (CD014484) published 2021
7. Buccal and Sublingual Misoprostol is not recommended for induction of labour with viable pregnancies, it is associated with more tachysystole and fetal distress.
8. There is a lack of strong evidence for misoprostol dosing for this indication at this gestational age.
9. Induced fetal cardioplegia should be considered for induced abortion after fetal viability

NOTES:

- SL/PO route is associated with more side effects.
- Avoid vaginal route if there is vaginal bleeding.
- Misoprostol is SAFE below 28 weeks EVEN with history of Cesarean Delivery.
- Misoprostol is not recommended in women ≥28 weeks gestational age with a prior Cesarean Delivery.
- There is NO Maximum dose of misoprostol. If an abortion is not complete after 5 doses, you may continue additional doses or rest for 12 hours and start again
- Misoprostol is not contraindicated in grand multipara.
- Routine aspiration after medication abortion is not required or recommended

Appendix 4: The Ipas stepwise guide to processing an MVA.

Processing the Ipas MVA Plus® Aspirator and Ipas EasyGrip® Cannulae

The following options are consistent with best practices regarding reuse of the Ipas MVA Plus Aspirator and Ipas EasyGrip Cannulae.
Use care when developing site protocols regarding the processing of instruments.
Chemicals or processing methods other than the ones listed here may cause damage.

Basics of Infection Prevention

- Wash hands immediately before and after every patient contact.
- Consider **all** blood and body fluids from **all** patients to be potentially infectious.
- Use personal protective barriers (gloves, gowns, face protection, shoes) when contact with blood or other body fluids is expected.
- Avoid accidental skin punctures; use care when handling needles.
- Use *No-Touch Technique*: The tip of the cannula, or the tip of any other instrument that enters the uterus, should never touch nonsterile surfaces (including the vaginal walls) prior to insertion.

1 Point-of-Use Preparation

Immediately following the procedure, all Ipas MVA Plus Aspirators and Ipas EasyGrip Cannulae that will be reused should be kept wet until cleaning. Presoak, rinse or spray device with water or enzymatic spray. Do not use chlorine or saline.

CAUTION: Aspirators and cannulae are not safe to handle with bare hands until cleaned.

2 Clean and Disassemble Instruments

- Wear gloves and face protection. Clean all instrument surfaces thoroughly in warm water and preferably detergent—not soap.
- Disassemble the aspirator by pulling the cylinder out of the valve. Remove the cap by pressing down the cap-release tabs with one hand and pulling off the cap with the other hand.
- Open the hinged valve by pulling open the clasp. Place the right thumb alongside the right valve button and the left thumb on the valve latch. With the left thumb, pull up and to the left on the valve latch while pushing down and out on the valve body with the right thumb. Remove the valve liner.
- Disengage the collar stop by sliding it sideways under the retaining clip, or remove the collar stop completely.
- Pull the plunger completely out of the cylinder. Displace plunger O-ring by squeezing its sides and rolling it into the groove below.
- Instruments must be completely clean before further processing. If tissue is trapped in the tip of a cannula, flush water through the cannulae repeatedly or use a cotton- tipped probe, soft brush or soft cloth to gently remove material. If unable to remove blood or tissue during cleaning despite repeated attempts, discard the instrument.

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

3 Processing Options

The Ipas MVA aspirator does not directly touch the woman's body. However, when it is used, the cylinder fills with blood. There is the potential risk that some contaminants from a previous woman could be introduced to another woman if the MVA aspirator is not fully processed (soaked, cleaned and sterilized or high-level disinfected) between each use. Therefore, after cleaning, the Ipas MVA Plus must undergo high-level disinfection or sterilization between patients to remove contaminants. Once processed, the aspirator may be kept in a clean container. Aspirators must be completely disassembled for all processing methods. Ipas EasyGrip Cannulae require high-level disinfection or sterilization before re-use and must be high-level disinfected or sterile when inserted into the uterus. Chemical processing agents are hazardous substances. When processing instruments, take necessary precautions, such as using personal protective equipment. Refer to the manufacturer's safety instructions to establish safe use.

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

Sterilize

- Steam autoclave in linen or paper for 30 minutes at 121°C (250°F) and 106kPa (15lbs./in²). DO NOT USE OTHER AUTOCLAVE SETTINGS, SPECIFICALLY DO NOT USE HIGHER SETTINGS ("FLASH AUTOCLAVING"). Lay package flat in the autoclave to avoid bending the cannulae.
- Soak completely immersed in 2% glutaraldehyde solution (Cidex® or equivalent) for the time recommended by the manufacturer—most recommend 10 hours.
- Soak completely immersed in Sporox® II solution for 6 hours.

High-Level Disinfect

- Boil in water for 20 minutes. Grasping hot cannulae may cause flattening. Let water cool before removing cannulae and handle by the adapter/base.
- Soak completely immersed in a 0.5% chlorine solution for 20 minutes. Change chlorine solution daily or sooner if solution becomes cloudy.
- Soak completely immersed in 2% glutaraldehyde solution (Cidex® or equivalent) for the time recommended by the manufacturer—recommendations range from 20–90 minutes.
- Soak completely immersed in Sporox® II solution for 30 minutes.

After Processing MVA Instruments

- If chemical agents were used in processing, Ipas EasyGrip Cannulae are to be thoroughly rinsed with either boiled water (for instruments that were high-level disinfected) or sterile water (if instrument was sterilized) after processing. Ipas MVA Plus Aspirator parts can be thoroughly rinsed in clean potable water (drinking water).

4 Store Appropriately or Use Immediately

Storage

- Aspirators and adapters may be dried, the O-ring lubricated and the device reassembled and stored in a clean, dry area until use. The aspirator does not need to remain high-level disinfected or sterilized at the time of use and can be placed in a clean area or stored according to local standards.
- Cannulae must remain sterile or high-level disinfected until next use. Store cannulae in either sterile or high-level disinfected containers to preserve the level at which they were processed. Handle cannulae by the base ends.
- Instruments processed by wet methods should be reprocessed daily.

Assembly and Use

- Before use, reassemble, lubricate and check vacuum capability of the aspirator.
- Place the valve liner in position inside the valve by aligning the internal ridges. Close the valve until it snaps in place. Snap the cap onto the end of the valve. Push the cylinder into the base of the valve without twisting.
- Place the plunger O-ring in the groove at the end of the plunger and lubricate it by spreading one drop of lubricant around the O-ring with a fingertip. Silicone or other non-petroleum-based lubricants can be used. Squeeze the plunger arms and insert the plunger fully into the cylinder. Move the plunger in and out to lubricate the cylinder. Insert the tabs of the collar stop into the holes in the cylinder.
- Check vacuum by pushing the buttons down until they lock, and pulling the plunger back until the plunger arms lock. Leave in this position for two to three minutes, then release buttons. A rush of air indicates that the aspirator maintained the vacuum.
- If you do not hear the rush of air, remove the plunger. Check the plunger O-ring and instrument for foreign particles and cracks. If the aspirator still loses vacuum, it should be discarded.

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PROPLUS-E23

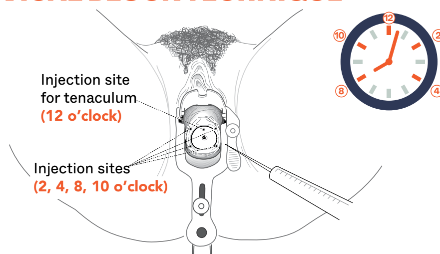
Appendix 5: The BCS+ steps for Post Abortion Family Planning Counselling

PRE CHOICE	**1. Establish and maintain a warm, cordial relationship. Listen for the client's contraceptive needs.** **2. Rule out pregnancy** **3. Display all of the counseling cards. If the client wants a particular method, go to Step 7.** **4. Ask all of the following questions. Set aside counseling cards based on the client's responses.** **a) Do you wish to have children in the future?** If "Yes," set aside vasectomy and tubal ligation cards. Explain why. If "No," keep all cards and continue. **b) Are you breastfeeding an infant less than 6 months old?** If "Yes," set aside the combined oral contraceptives (the Pill) and combined injectable. If "No," or she has begun her monthly bleeding again, set aside the LAM card. Explain why. **c) Does your partner support you in family planning?** If "Yes," continue with the next question. If "No," set aside the following cards: male condom, female condom, Standard Days Method, and TwoDay Method. Explain why. **d) Are there any methods that you do not want to use or have not tolerated in the past?** If "Yes," set aside the cards the client does not want. If "No," keep the rest of the cards.
METHOD CHOICE	**5. Give information on the methods that have not been set aside. Indicate their effectiveness.** a) Arrange the remaining cards in order of effectiveness (number on back of each card). b) In order of effectiveness (lowest number to highest), read the 5 to 7 features of each method not set aside. **6. Ask the client to choose the method that is most convenient for her/him.** **7. Using the brochure, determine if the client has any condition for which the method is not advised.** a) Together with the client review section under "Method not advised if you" in the brochure of the method chosen. b) If the method is not advisable for the client, ask the client to select another method from the cards that remain. Repeat the process from Step 5 (Step 4 if client already had the method in mind).
POST CHOICE	**8. Inform the client about the method chosen using the brochure of the method as a counseling tool.** **9. Determine the client's comprehension and reinforce key information.** **10. Make sure the client has made a definite decision. Give her/him the method chosen and/or a referral and back-up method, depending on the method selected.** **11. Complete the counseling session. Invite the client to return anytime. Thank her/him for the visit.** **End the session.**

Extracted from: León, F., Vernon, F., Martin, A., & Bruce, L. (2008). *The Balanced Counseling strategy: A toolkit for family planning service providers* Washington, DC: Population Council.

Appendix 6: Steps of performing a Paracervical block

PARACERVICAL BLOCK TECHNIQUE



Injection site for tenaculum **(12 o'clock)**

Injection sites **(2, 4, 8, 10 o'clock)**

Prepare lidocaine syringe.

i) Use 20mLof 1% lidocaine OR 10ml of 2% lidocaine.

ii) Do not exceed the lidocaine maximum dose of 4.5mg/kg or

Attach the needle to the syringe.

i) A needle 3cm in length is recommended to facilitate deep injection.

Place the speculum and perform

Inject a s mall amount of lidocaine superficially into the anterior lip of the cervix at the site where the tenaculum will be placed (12 o'clock).

i) Inject 2ml if using 20ml of 1% lidocaine.

ii) Inject 1ml if using 10ml of 2% lidocaine.

Grasp cervix with the tenaculum at 12 o'clock.

Inject remaining lidocaine in equal amounts at the cervicovaginal junction, at 2, 4. 8 and 10 o'clock.

i) Injections should be 3cm deep.

ii) Aspirate before injecting to prevent intravascular injection.

PRACTICE TIPS

i) Possible side effects seen with intravascular injection include tinnitus, metallic taste, dizziness or irregular/slow pulse.

ii) Midlevel providers trained to provide Paracervical blocks demonstrate similar safety and efficacy rates as physicians.

iii) Serious adverse events related to Paracervical blocks are rare.

Appendix 7: Sample of a Post Abortion Care (PAC) register

Name of Health Facility:..District:........................Sub-district........................

DOA	PATIENT NO.	NAME OF CLIENT	TEL. NO.	EDUC LEVEL	RELIGION	PARISH/ VILLAGE	AGE	MARITAL STATUS	PARITY	GEST AGE	DIAGNOSIS	MODE OF TREATMENT	COUNSELLED	FP METHOD USED	NAME OF STAFF

REFERENCES

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2. WHO Abortion Care Guidelines 2022 https://www.who.int/publications/i/item/9789240039483
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6. Guttmacher Institute report 2022 (Country specific estimates of unintended pregnancy and abortion incidence: a global comparative analysis of levels in 2015-2019) https://www.guttmacher.org/regions/africa/uganda
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