

# National Guidelines on Post Abortion Care

Second Edition



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**Ministry of Health, Nutrition and Indigenous  
Medicine Sri Lanka**

**2015**

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- i. Message from Director General of Health Services/ Ministry of Health Nutrition and Indigenous Medicine**
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**i. Message from Director General of Health Services/  
Ministry of Health Nutrition and Indigenous Medicine.**

The achievements of Sri Lanka in maternal and child health are impressive. Further improvements demand interventions in hitherto unaddressed areas, which have an impact on maternal and child health indicators.

Though accurate statistics are not available, it is estimated that a large number of induced abortions still take place in Sri Lanka. Illegal abortions and their complications have been a burden to the healthcare system of this country. Especially the efforts of the clinicians have helped in keeping the number of deaths due to septic abortions relatively low. However to further reduce the burden of maternal mortality and morbidity due to induced abortions, existence of specific guidelines that would ensure scientific management of victims of abortions is a pre-requisite.

I appreciate the efforts of the Family Health Bureau, Ministry of Health and Indigenous Medicine and Sri Lanka College of Obstetricians and Gynecologists to fill this gap by producing this guideline, and all the health staff are requested to abide by it.



**Dr. Palitha Mahipala,**  
Director General of Health Services,  
Ministry of Health, Nutrition and Indigenous Medicine.

## **ii. Message from Director/Family Health Bureau**

The maternal mortality ratio of Sri Lanka shows a dramatic improvement during the second half of the last century. However, the improvement during last few years has been modest. One reason for this stagnation seems to be non-reduction of certain causes of maternal deaths.

According to the data available with Family Health Bureau, 'septic abortions' has figured as the second or third main cause of maternal deaths during last few years, and has not decreased, unlike other leading causes. This must invariably be leading to a proportionate amount of maternal morbidity as well.

The most effective strategy to minimize induced abortions is to promote proper family planning practices. However, scientific management of women who have undergone induced abortions too is of utmost importance, especially in view of averting maternal deaths due to this cause. As a collaborative effort between Family Health Bureau and Sri Lanka College of Obstetricians and Gynecologists, and with the participation of relevant stakeholders, this guideline was developed to address those issues.

**Dr.B.V.S.H.Beneragama,**

Director/Maternal and Child Health,

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### **iii. Message from the President/Sri Lanka Collage of Obstetricians and Gynecologists (SLCOG).**

Unsafe abortion is currently a major health and social concern in Sri Lanka. According to the National maternal mortality reviews 10-12% of maternal deaths were due unsafe (septic) abortions and their complications. Information gathered from numerous sources including state data reveal that the prevalence of unsafe abortions among married couples being high as 94%, which is considering the high prevalence of contraceptive use in the country. Financial burden on the health budget to look after these patients, particularly those with complications is considerable. Providing high quality Post Abortion Care and Family Planning Services is key component of reproductive health services in order to prevent Physical and psychological consequences and further unsafe abortions.

The SLCOG has been able to compile a very comprehensive Guideline on Post Abortion care (PAC), thanks to the tireless efforts of the Guideline Committee. I take this opportunity to thank Dr. Lakshmen Senanayake, Dr.Mangala Dissanayake and other members of the committee on the Guideline on PAC for their valuable contribution . My sincere thanks to Mr. Palitha Fernando, Retired Attorney General and Dr.Loshan Munasingha formerly of Family Health Bureau for their expert input that enhanced the value of this Guideline

The SLCOG conducted several workshops in hospitals, island wide, on Post Abortion Care with the assistance of the governmental and non-governmental organizations while piloting this guideline.



Post Abortion care has now become an essential component of Safe Motherhood programmes conducted by SLCOG. We are very grateful to International Federation of Gynecology and Obstetrics, Family Planning Association and Population Services Lanka for their generous support and assistance in conducting these programmes island wide.

The SLCOG would very much appreciate contributions made by Family Health Bureau (FHB) and UNFPA. We would like to thank Dr. B.V.S.H. Beneragama (Director FHB), Dr.Chithramalee De silva and Dr.Sanjeeva Godakandage from FHB for their invaluable contribution in making this Guideline a reality.

**Dr. Kanishka Karunarathna,**  
President –SLCOG. 2015

#### **IV.        Acronyms and abbreviations.**

ABST	Antibiotic Sensitivity Test
GBV	Gender Based Violence
D&E	Dilatation and Evacuation
DIC	Disseminated Intravascular Coagulation
DT	Direct Test
ERPC	Evacuation of Retained Products of Conception
EVA	Early Vacuum Aspiration
FBC	Full Blood Count
FFP	Fresh Frozen Plasma
FIGO	International Federation of Gynecology and Obstetrics
HIV	Human Immune Deficiency Virus
HTSP	Healthy Timing and Spacing of Pregnancy
LFT	Liver Function Test
MO	Medical Officer
MVA	Manual Vacuum Aspiration
NGOs	Non-Governmental Organizations
PAC	Post Abortion Care
POC	Products of Conception
SRH	Sexual and Reproductive Health
WHO	World Health Organization

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# Part 1



## **1.1 Purpose of the guideline:**

The purpose of this guideline is to provide healthcare providers with essential information and guidance on the management of women presenting with an abortion, in order to provide comprehensive high quality post abortion care (PAC) services to them.

It is intended to support care providers in treating women with an abortion and its life-threatening complications, provide them with emotional support, family planning counseling and services, and thereafter ensure referral to other reproductive healthcare services.

## **1.2 Specific objectives of the guideline:**

The specific objectives of this guideline are to:

- Describe briefly basic concepts related to unwanted pregnancies and abortions, with emphasis on unsafe abortions, and the Sri Lankan situation related to unsafe abortions.
- Describe the importance and key elements of post abortion care.

- Detail the key steps in the initial assessment of women presenting with possible complications of abortion.
- Describe the immediate management of post abortion complications: shock, severe vaginal bleeding, infection/sepsis, and intra-abdominal injury.
- Describe in detail the procedure for the safe performance of evacuation of retained products of abortion viz. traditional dilatation and evacuation (D&E) and manual vacuum aspiration (MVA).
- Describe the management of possible complications of evacuation of retained products.
- Describe the basic process of providing emotional support.
- Describe the basics of post abortion family planning counseling.
- Describe briefly the guiding principles for provision of care.
- Describe the legal situation, and address the common concerns of healthcare providers on legal and ethical aspects of care provision.
- Describe the importance of working in collaboration with the field health staff and other community organizations, both state and non-governmental organizations (NGOs), in preventing unwanted pregnancies and unsafe abortions.

### **1.3 For whom the guideline is intended:**

To all healthcare providers working in health institutions in Sri Lanka and involved in the care of women following an abortion. Post abortion care is primarily provided in specialist gynecology units in Sri Lanka. The intended target group includes medical, nursing and other health professionals, both in the curative and preventive sectors.

### **1.4 Introduction:**

Sexual and reproductive health (SRH) is a universal need and a human right, with special interest to women, because they bear by far the greatest burden, due to their physiology and their ability to give birth.<sup>1</sup> Human rights which are universal, unalienable and interdependent make the State responsible for guaranteeing SRH, and individual choices regarding reproduction and sexuality.<sup>2</sup>

Of the different areas coming under reproductive health, unsafe abortion is a controversial and challenging area to ensure these rights. However, it is important to ensure that no healthcare provider would withhold treatment which is legally permissible, and do his/her utmost to help a woman when her life is at risk from complications of unsafe abortion, and make sure that they do not impose their religious, cultural, or other convictions regarding abortion on their patients.<sup>3</sup> The World Health Assembly, in as

early as 1967, in resolution WHA 2014, recognized that abortion constituted an important health problem for women .<sup>4</sup>

Complications due to unsafe abortions are responsible for around 10% of the approximately 500,000 maternal deaths that occur each year in the world, with 99% of them occurring in the developing world.<sup>5,6,7</sup> In Sri Lanka, contribution to maternal deaths from abortion ranges from 10 – 13%, and has been the second or third commonest cause of maternal deaths in the recent past.

For every maternal death, 10–15 maternal morbidities are expected to occur.<sup>8</sup>

In spite of local and international efforts, 20 million unsafe abortions occur every year in the world, and of these, 9,900,000 happen in Asia, with between 10–50% of them needing medical care for complications.<sup>8</sup>

Although about 15–20% of all pregnancies will end up in spontaneous abortion or miscarriage, only a small percentage will lead to complications, in contrast to pregnancies undergoing unsafe abortions.

The most important strategy to prevent induced abortions is practicing proper family planning methods. At the same time,

emergency abortion care integrated throughout the healthcare system, from the most basic rural health post to the most sophisticated tertiary level facility, available 24 hours of the day,<sup>4</sup> is crucial in minimizing abortion related maternal mortality ratio.

However, in contrast to most other countries in the region, and considering the large number of abortions taking place in the country, relatively small number of women die in Sri Lanka.<sup>9</sup> The low case fatality rate is possibly due to many factors, but one possible factor is that post abortion care is provided mostly, if not totally, in the specialist gynecological units in Sri Lanka.

Starting emergency care at the primary care level is essential to maximize the chances that the woman will reach the specialist unit before it is too late. The first referral level must be able to build on the services provided at the primary level, by providing life-saving resuscitation procedures, early and effective antibiotic administration, and collection of samples for bacterial culture.

Often, the care offered at the primary level can be improved dramatically with a relatively small number of improvements and interventions. The primary level can work towards having staff trained, and making facilities available to assess the woman's status, stabilize her condition, and initiate treatment. They also need to be able to arrange prompt reliable transfer without any delay.

Life-threatening or serious conditions, primarily shock, severe bleeding, intra-abdominal injury, and sepsis may be present, and need urgent attention. Even when uncomplicated, unsafe abortion can become life-threatening if treatment is delayed. Therefore, an accurate initial assessment and prompt action to stabilize the patient, and initiating treatment is mandatory.

Most of the first contact level primary care facilities in Sri Lanka are staffed by a medical officer who should be able to diagnose and initiate management procedures. However, they need in-service training focused to update their skills and knowledge on PAC services.

As Sri Lanka has strict laws on abortion, women are very reluctant to divulge information on interventions done to terminate the pregnancy. Healthcare providers should always be vigilant to consider the possibility of unsafe abortion/septic abortion in women, married or otherwise, presenting with symptoms suggestive of abortion.

*It has been  
estimated that  
**every minute***

*around the world:*

- **380 women become pregnant**
- **190 women face unplanned pregnancies**
- **40 women have unsafe abortions**
- **1 woman dies<sup>4</sup>**

It is also important to recognize that this inquiry and concern should be made in a very sensitive manner, particularly because it is going to modify the management, and should not be done merely to fulfill a legal responsibility (see section 2.7 on legal matters).

The woman undergoing an induced abortion, particularly an unsafe abortion, makes this decision under pressure from multiple fronts, on a conception that occurred under circumstances often beyond her control. Her emotional state should always be a concern for the care provider, who needs to be ready to provide emotional support and counseling. Sadly, this is an aspect often neglected in care provision in Sri Lanka.

In addition, the attitudes of some of the care providers aggravate the stigmatization associated with the issue of unsafe abortion, thereby enhancing the negative emotional impact on the woman. The need for going through an abortion needs to be addressed at this point of care provision. Although the patient with an abortion is expected to receive advice on family planning services before being sent home, many constraints prevent effective implementation of this step, thereby missing a golden opportunity to provide these services to the woman who obviously has an unmet need.

Post abortion care, which is internationally recognized as an integral part of reproductive health services to address

complications related to miscarriage and induced abortion, needs to incorporate these issues, and should be considered as extending beyond the confines of the gynecological ward. It should reflect both provider and care seeker perspectives, and include a public health approach that responds to women's broader sexual and reproductive health needs.<sup>10</sup>

This document was developed in order to improve the skills and the capacity of the care providers to deliver effective, comprehensive, holistic and sensitive post abortion care to women of Sri Lanka, within the existing legal framework.

## 1.5 Definitions:

### **Abortion:**

- **Abortion** is defined in Sri Lanka as the loss or termination of pregnancy beyond 28 weeks. The terms miscarriage and spontaneous abortion are commonly used interchangeably.<sup>8</sup>
- **Septic abortion** technically means an abortion associated with infection.

Infection with spontaneous abortion is uncommon, whereas it is commonly seen with illegally induced abortions. Therefore, the term septic abortion is often used to mean an illegally induced abortion, even without obvious evidence of infection.



- **Unsafe abortion** is used when an unintended and unwanted pregnancy is terminated, either by persons lacking in necessary skills, or in an environment lacking in minimum medical standards, or both (WHO) <sup>11</sup>.
- **Illegal or criminal abortion** is used when an abortion is performed for any reasons other than the ones allowed by the Penal Code Under the existing Sri Lankan law. According to Section 303 of the Penal Code, abortion is a criminal offence, except when performed to save the life of the mother.<sup>12</sup>

Sri Lankan law does not allow termination of pregnancies with foetuses with abnormalities, lethal or otherwise.

The terms **threatened abortion, inevitable abortion, incomplete abortion and complete abortion** are used to describe the progressive stages, if a spontaneous or induced abortion goes through the natural course of events.

## 1.6 Prevalence of abortion in Sri Lanka:

In a country such as Sri Lanka with strict laws, accurate numbers are hard to come by, but many researchers have attempted to estimate the incidence of unsafe abortion. A national survey conducted in 1999 reported an abortion rate of 45/1000 women (95% CI: 38-52/1000) in the 15-49 year age group<sup>13</sup>.

A wide variation was seen in the abortion rates from different geographical regions. The highest abortion rate was found in the Uva Province (63/1000) while the lowest (29/1000) was reported from the Western Province.<sup>14</sup>

## **1.7 Contribution of unsafe abortion to maternal mortality:**

Although the estimated number of abortions taking place is high, the absolute number of women dying of abortions is low<sup>15,16</sup>. This is a paradoxical situation when a large number of illegal abortions are being done in Sri Lanka.

While this may be attributable to liberal usage of antibiotics, and immunization of the total female population against tetanus, this favorable situation cannot be extrapolated to morbidity due to unsafe abortion.

The impact of unsafe abortion on people and health system is yet to be studied in an organized manner. Few studies conducted in selected samples indicate that about 12%-14 % of abortion seekers in Sri Lanka experience some form of medical complication following abortion<sup>6</sup>.

## **1.8 Pathway to unsafe abortion:**

An unplanned or unexpected pregnancy is a necessary but insufficient condition for an unwanted pregnancy. However these pregnancies often end up as unsafe abortions.

Few studies done in Sri Lanka have shown that nearly 50% of pregnancies are unplanned. Though they are unplanned, with the advancement of pregnancy and restricted laws on abortion, many couples make up their minds to accept these pregnancies, and continue with due care.

In situations where couples who decide not to continue with the pregnancy, many seek the services of clandestine providers with limited or no skills and resources, who conduct their trade in unhygienic environment, and become the unfortunate victims of the circumstances, often beyond their control. This result in unsafe abortions and some of these unsafe abortions lead to maternal deaths and severe maternal morbidity.

Unplanned pregnancies may occur due to a multitude of circumstances such as lack of adequate knowledge and information on services for family planning, inaccessible or ineffective services, sense of complacency over the likelihood of pregnancy, the inability to take decisions due to family pressure, and domestic violence.

Fear of side effects and some social mores also hinder usage of contraceptives, while instances of contraceptive failures too contribute to unwanted pregnancies.

In a country with a high number of female-headed households, a high mean age of marriage and a high number of widowed when young, leaves a relatively large population of young women, who are sexually active within a relationship, though not necessarily within a marriage, who may find access to family planning services relatively difficult.

Women who face an unplanned or unexpected pregnancy seem to follow one of the two courses. Some make up their minds to continue the pregnancy, and the rest resort to induce an abortion.

Globally 1:4 woman live in countries where abortion is forbidden or allowed only to save a women's life, and abortion services are not legal or safe for women with an unwanted pregnancy. The same situation is found in Sri Lanka according to the existing law.

## 1.9 Reasons for seeking abortions in Sri Lanka:

There are few studies on common reasons for induced abortion in Sri Lanka.

It is interesting to note that being unmarried was a very uncommon cause given by the abortion seekers in Sri Lanka, while the two reasons which accounts to nearly 50% were either,

- 'youngest child being too small' or
- 'has completed the family'

It is very unfortunate that these couples have not had the opportunity to use, or declined to use family planning services, which are provided free of charge, and delivered to the doorstep. This reiterates the need to counsel couples at every opportunity, particularly after an abortion.

*..... Every year close to 5 million women are estimated to have permanent or temporary disabilities due to unsafe abortion.*

*It is all the more significant when one realises that more than 60 % of unsafe abortions in Asia are carried-out among young women in the 20- 34 year age group.....*

## 1.10 Consequences of abortion:

One in four instances of unsafe abortions is known to lead to complications.

They may result in,

- Negative health consequences which include death, severe intrauterine damage leading to hysterectomy, fulminant sepsis, haemorrhage, reproductive tract infections, pelvic inflammatory disease, intra uterine adhesions, poisoning, and secondary infertility.<sup>17</sup>
- Apart from being a formidable cause of preventable deaths of women, unsafe abortions account for a considerable disease burden and disability, both of permanent and temporary nature.
- More than 3 million suffer from reproductive tract infections, of which almost 1.7 million are said to develop secondary infertility<sup>7</sup>.

Other consequences include:

- Increased risk of ectopic pregnancy.
- Cervical damage leading to spontaneous abortions and premature delivery in subsequent pregnancies.
- Psychological trauma.
- When mothers die, children left behind are up to 10 times more likely to die in infancy or childhood.

## Part 2



## 2.1 What is Post Abortion Care:

While most health systems including that of Sri Lanka, provide treatment for complications of abortion as a part of emergency gynecological management, comprehensive post abortion care promoting other interventions that include abortion-related public health concerns are often not given their due place, particularly when the abortion laws and policies of the country are strict.

The term “Post Abortion Care (PAC)” was first articulated as a critical element of women’s health initiatives in 1991, as “the integration of post abortion care and family planning services in healthcare systems”, as a means of breaking the cycle of repeat unwanted pregnancy and improving the overall health status of women in the developing world<sup>18,10</sup>. Subsequently, linking PAC with comprehensive reproductive health services was considered essential.

The importance of family planning counseling was reiterated in programme of Action of ICPD+5 Conference in 1999, which recommended to “recognize and deal with the health impact of unsafe abortion as a major public-health concern by reducing the number of unwanted pregnancies through the provision of family planning counseling, information and services, and by ensuring that health services are able to manage the complications of unsafe abortion.”<sup>19</sup>

In order to reduce the risk of long-term illness or disability and death to women presenting with the complications of incomplete abortion, healthcare systems must provide easily accessible, high quality comprehensive post abortion care (PAC) at all service levels.

## 2.2 Essential elements of Post Abortion Care:

The Essential Elements of the PAC model, endorsed by the PAC Consortium in 2002, reflects, from a provider and a consumer perspective, an enhanced vision of high-quality, sustainable services.

The model's five elements shift the focus from facility-based medical treatment to a public health approach that responds to women's broader sexual and reproductive health needs.<sup>20</sup>

### ***The Essential Elements of PAC model includes:***

- 1. Treatment: Medical management of complications including evacuation of products.***
- 2. Provision of family planning services.***
- 3. Provision of emotional support and counseling.***
- 4. Provision of other reproductive health services.***
- 5. Community and Service***

### **2.2.1 Treatment:**

#### **Medical management of complications including evacuation procedure**

Treatment remains a crucial component of care, because the woman who had an abortion, whether spontaneous or induced, will in many cases need uterine evacuation and other medical interventions. Early and aggressive medical treatment in unsafe abortions with complications becomes a life saving measure.

It needs to be recognized that post abortion care may not always involve managing complications that are life-threatening. However they may become life threatening in the absence of swift and appropriate medical attention.

Safe and effective treatment involves-

- Evacuation
- Standard infection prevention precautions
- Appropriate pain management
- Sensitive physical and verbal patient contact
- Follow-up care.<sup>10,21</sup>

This topic is dealt in detail in section 2.3- 2.5.

### ***2.2.2 Provision of family planning services:***

Nearly half of women who undergo an unsafe abortion in Sri Lanka do so, either because,

- the space between the unwanted pregnancy and the previous one is too small, or
- the family is already completed <sup>13</sup>.

The importance of overcoming barriers and challenges to offer family planning services at the same location as post abortion care services, needs to be recognized not to miss the opportunity to prevent a subsequent unwanted pregnancy. Women may not make another visit to that facility or another for such services.

Ideally, the woman should leave the hospital with at least an interim method to use, until she obtains her preferred method at a referral site where continuation of the contraceptive services could be sustained.

However, it is essential to understand that the ultimate decision to use contraceptives is hers, and that treatment of the abortion is not dependent on women's acceptance of a contraceptive method. This topic is dealt in detail in section 2.6.

### ***2.2.3 Provision of emotional support and counseling:***

The woman who undergoes abortion has actually succumbed to many pressures, emotional, economical, social and sometimes even violence, before reaching this decision. They continue to suffer from guilt feelings, in addition. Therefore, emotional support and counseling becomes an important part of PAC. Unfortunately this is an area which is given low priority in a busy hospital setting.

Post abortion care counseling covers more than fertility and family planning, and consists of information provision and emotional support in a sensitive communication. This counseling provides an opportunity to help women explore their feelings about their abortion, assess their coping abilities, manage anxiety, and make informed decisions.<sup>10</sup>

Counseling helps to make PAC from being purely curative to being preventive and supportive. It helps to determine whether and when women need special care because of extreme emotional distress or complicating circumstances such as unmarried, young age or with extramarital relationships.

Some expected benefits of counseling include more respectful client-provider interactions, treatment becoming more acceptable and effective, increased understanding and use of other health services such as family planning by women, improved satisfaction

of clients with the healthcare encounter, and improved health outcomes<sup>10</sup>

The aims of counseling are to:

- Solicit and affirm women's feelings, and provide emotional support throughout the post abortion management process.
- Ensure that women receive accurate and appropriate information about their medical conditions, test results, treatment and pain management options, and follow-up care.
- Ensure that women understand about symptoms of complications that may occur later, and that they know when and where to seek care if they arise.
- Help women to clarify their concerns, and provide relevant information to make their decisions, treatment, resumption of ovulation, future contraception and future reproductive health.
- Enable providers, by listening to and discussing with couples, to better understand and respond to factors that can affect a woman's healthcare needs, such as experiences with sexually transmitted infections (including HIV), and prevailing domestic violence<sup>10</sup>.

If the care provider feels that in-depth emotional support is needed, an effective mechanism should be identified to link up with state or NGO managed counseling services.

### ***2.2.4 Provision of reproductive and other health services:***

Provision of all appropriate health services at the time women receive PAC, preferably at the same facility, is encouraged. However if a facility is unable to provide needed services, it should have functional mechanisms in place for making referrals. The following additional services need to be offered:

- Sensitization about the prevention of sexually transmitted infections, including HIV, as well as voluntary screening, diagnosis and treatment.
- Services addressing gender-based violence, including screening for domestic violence, counseling and referral for relevant services. Some hospitals in Sri Lanka have dedicated centers to address GBV by the name “Mithuru Piyasa”, which could provide such services.
- Screening, counseling and treatment for reproductive-related cancers, and offer screening tests such as Pap smear.

### ***2.2.5 Field health staff, institutional health staff and community partnership:***

This element of PAC recognizes the vital role of community healthcare providers and community members in prevention and advocacy efforts.

Community health education and mobilization increase early access to hospitals and reduce mortality and morbidity related to unsafe abortion, and thereby improves women's reproductive health and quality of their lives.

To achieve universal access to sustainable, high-quality PAC related health services, field health staff, community healthcare professionals and advocacy groups and other stakeholders interested in women's health, must work in partnership.

In Sri Lanka, where enforcing the law is strict, it is important to conduct community awareness programmes on consequences of unsafe abortion, the value of family planning and emergency contraception in avoiding unwanted pregnancies, the age of consent for sex, and marriage and basic reproductive health matters. This must be considered as a part of the PAC offered in hospitals.



## ***2.2.6 Establishing the patient- provider relationship:***

In Sri Lanka, the patient often presents with preconceived guilt, possibly with remorse, and the situation is worsened by the stigma attached to “illegal” abortions. The technical term in the local language “saparadhi gabsa” directly criminalizes the act as well as the woman in a very profound manner.

Therefore it is important for healthcare providers to respect all women presenting with abortion, regardless of provider’s personal values, patient’s social status or personal situation. It is essential to have a compassionate attitude, and provide competent care in a confidential manner, ensuring safety and privacy, while being non-discriminatory (see section 2.7 on legal issues).

### ***Guiding Principles in providing PAC:***

- ***Confidentiality***
- ***Privacy***
- ***Safety***
- ***Treating with dignity and respect***
- ***Being non-judgmental and non-discriminatory***
- ***Compassion***
- ***Involvement of husbands***

In addition, the way healthcare providers communicate with women can affect the completeness and accuracy of information women give, their comfort and resultant cooperation during examination and procedures, the success or failure of treatment, compliance for family planning advice, and their ability to recognize and seek care for complications that may occur after being discharged from hospital.

***For life-threatening conditions such as shock or severe hemorrhage, institute emergency measures and delay complete assessment until the client is stabilized and is no longer in imminent danger.***

Women may be hesitant to give information about how the bleeding started, or details of specific method of intervention used (which helps to predict possible complications), unless they understand that it is important to their treatment. An atmosphere ensuring confidentiality and respect will encourage women to give this information.

Clear communication, both from patient-to-provider and provider-to-patient, is essential to collect accurate medical information and to provide women with information before, during and after treatment. Such communication is best achieved when there is a trust built in the relationship between the woman and her care providers.

Before treatment, it is important to obtain sufficient medical information to make an accurate diagnosis and develop a treatment plan.

Assure the patient that these questions are being asked to get the information needed to best treat her medical condition. Let her know that her honesty will help decide the best course of treatment. Ask open-ended questions so that the patient does not simply answer “yes” or “no.”

## **2.3 Emergency treatment:**

Emergency treatment is the prompt management of potentially life-threatening complications of abortion including haemorrhage, and/or infection from retained products of conception, injury to internal organs and other related problems such as shock<sup>22</sup>.

In order to pick up the patient who is critically ill and provide urgent attention, timely evaluation and treatment, **initial assessment is essential** in all patients who present with abortion.

***Table 1 - List of possible complications of abortion***

<b>Complication</b>	
Haemorrhage	Can result from retained products of conception, trauma or damage to the cervix or uterine perforation. Could be internal, vaginal or both. Depending on the amount of blood loss, the patient will have signs and symptoms of hypovolaemia.
Infection	Fever with chills, foul smelling vaginal discharge, abdominal and pelvic pain, prolonged vaginal bleeding, uterine tenderness and or an elevated white cell count.
Septicaemia	DIC and septic shock.
Injury to organs	Uterine perforation and cervical trauma - depending on the degree of perforation, signs and symptoms vary. Damage to the bowel and blood vessels or other structures will cause signs and symptoms of acute abdomen.
Long term sequelae	Acute and chronic pelvic inflammatory disease, adhesions leading to intestinal obstruction, secondary sub fertility.
Psychological consequences	Both long and short term emotional disturbances.
Failed termination	Continuing pregnancy with concerns about the foetal health.

### ***2.3.1 Initial assessment of the patient:***

Women seeking advice or treatment with unanticipated vaginal bleeding, with or without a missing a period, fever or lower abdominal pain, may or may not divulge that they are pregnant.

The possibility of pregnancy and abortion should be considered, regardless of the woman's menstrual or contraceptive or marital history. An accurate initial assessment is essential to ensure appropriate treatment or prompt referral.

**One of the main objectives of the initial assessment is to do a rapid survey to rule out life-threatening conditions, and take immediate management steps.**

Initial client assessment/evaluation can be considered under two headings.

- **Rapid assessment** which includes evaluation for shock, other life-threatening conditions, resuscitation/ stabilization, preparation for treatment or transfer when relevant.
- **Continuing assessment** and monitoring for recognition of signs and symptoms of post abortion complications and deterioration of the clinical condition.

### **2.3.1.1 Rapid assessment:**

The rapid assessment of vital parameters may reveal or suggest the presence of an immediate life-threatening complication such as shock.

Shock should be addressed immediately without any delay, in order to prevent death or the woman's condition from worsening, and leading to permanent

organ damage. When shock is due to blood loss, external or internal, early and adequate blood transfusion should be instituted.

***Post abortion complications that require immediate attention and treatment include:***

- ***Shock***
- ***Severe vaginal bleeding (haemorrhage)***
- ***Signs of intra-abdominal injury (e.g., uterine perforation)***
- ***Sepsis or septic shock***

#### **Steps in rapid assessment:**

- Brief history of presenting problem
- Rapid evaluation of the woman's general condition:
  - Vital signs
  - Level of consciousness
  - Assessment of colour

- If shock is suspected, begin treatment IMMEDIATELY.

Shock can develop at any time, so careful monitoring throughout PAC is important.

- Once shock is ruled out, assess quickly for other serious problems.
- Initial assessment of vaginal bleeding:
  - Amount of bleeding
  - Presence of clots or products of conception (POC)
  - Pallor
  - Presence or history of blood-soaked clothing, pads or bedding
- Assessment for intra-abdominal injury
- Assessment for sepsis.

### ***2.3.1.2 Continuing assessment and diagnosis:***

It is important to monitor the vital signs, even if there are no obvious signs of circulatory collapse. Young women in reproductive age tend to compensate blood loss well, and maintain blood pressure in spite of considerable loss. There should not be complacency even when the blood pressure is “normal”, if there is evidence of considerable blood loss.

The septicaemia shock may be seen on admission, or precipitated by interventions, and is characterized by the circulatory

collapse of a woman who is not pale, and who is mentally very lucid. Continuous monitoring is essential, and in the presence of septicaemia, evidence of circulatory decomposition and tachypnoea, the patient is best managed in an ICU or in a high dependency unit.

Complications need to be treated immediately under the guidance of specialist staff. Prompt referral and transfer may be needed if the woman requires treatment beyond the capability of the facility to deal with such cases. All possible steps to stabilize the patient need to be taken before she is transferred to a higher-level referral service.

### ***2.3.2 Pain management:***

Appropriate pain management ensures that the woman experiences a minimum of anxiety and discomfort. Women's needs for pain management will vary, depending on their physical and emotional state. Drug of choice vary from:

- mild analgesics like paracetamol to
- strong analgesics like pethidine or morphine depending on the clinical situation.



## 2.4 Management of critically ill patient:

### 2.4.1 Shock:

With abortion, shock is usually caused by blood loss, internal or vaginal (hypovolemia), endotoxic shock (vasodilatation) from infection/sepsis, or vagal inhibition due to traumatic interventions such as dilatation of cervix.

#### Steps in managing shock-

- Do not give fluids by mouth. Keep airway open. Turn head and body to one side, and keep warm.
- Insert two wide bore I.V. cannulae.
- Volume replacement: IV fluids including plasma expanders, blood and fresh frozen plasma.

*The following basic elements of emergency resuscitation should be available without delay wherever women seek care, especially in preparation for referral and transport or when definitive management delayed.*

- *Control of bleeding, evacuation by MVA /D&E and oxytocics*
- *Intravenous fluid replacement with fluid plasma expanders, blood products or blood as indicated*
- *Management of airway and respiration*
- *Intravenous antibiotics*
- *Control of pain*

- Give oxygen at 6–8 liters per minute (mask or cannula).
- Keep the client warm.
- Elevate her legs to increase return of blood to her heart.
- Take appropriate samples (full blood count, liver function tests, renal function tests, blood grouping and DT, and high vaginal swab for culture and antibiotic sensitivity tests)
- Monitor vital signs including respiration and urinary output
- Broad spectrum antibiotics intravenous.

### ***2.4.2 Severe vaginal bleeding:***

Prolonged and/or excessive bleeding is the most common and sometimes life threatening complication, seen after abortion with retained products of conception, often seen as cause of bleeding.

Some of the other causes of severe bleeding include:

- Genital tract trauma due to injury from instrumentation
- Coagulation failure secondary to septicaemia
- Missed abortion

Genital tract trauma may lead to bleeding that is obvious as vaginal bleeding, but coexisting intra-abdominal bleeding needs to be considered. Bleeding should be attended urgently, and

where relevant, possible injuries to other pelvic or abdominal organs such as bowel and bladder need to be considered.

Although attempts to reduce severe bleeding due to retained products include the use of uterotonic drugs, it is important to recognize that cessation of bleeding will take place only after evacuation of retained products, which is described in detail in section 3.5.

In hospitals where evacuation cannot be performed immediately, uterine tamponade may be considered prior to transfer, if the officer has prior experience in the procedure.

Assessment of blood loss, and replacing blood loss with blood and blood products will be life saving in severe bleeding, particularly when associated with injury and sepsis.

Blood pressure, pulse rate, haematocrit or hemoglobin assessment, clinical evidence of pallor are useful indicators of blood loss, but it is important to recognize that in most of these patients, being young and healthy prior to the abortion, compensatory mechanism in response to blood loss being efficient, parameters such as pulse and blood pressure tends to remain within “normal”, even with a significant amount of blood loss.

Therefore it is better to err on the side of safety, particularly when the history and color of mucosa indicate significant blood loss, in spite of minimal changes in pulse and BP.

### ***2.4.3 Infection and sepsis:***

Infection in patients after abortion should be considered seriously if the woman has any of the following:

- Fever with chills
- Foul smelling vaginal discharge
- Pain and tenderness in the lower abdomen or pelvis
- Prolonged bleeding or spotting
- Tenderness of the uterus and adnexae during pelvic examination, or pain on moving the cervix with the examining finger.

These patients require aggressive antibiotic therapy, after taking bacteriological samples wherever possible, and evacuation of retained products as soon as possible, provided that the patient is stable.

Patients with sepsis should always be managed in the hospital, and if septicaemia is diagnosed, shifting to a critical care /Intensive care unit is necessary wherever possible. In a situation where

such facilities are not available, the clinical situation of the patient needs to be evaluated by relevant experts, and transferred with the consensus, provided that the benefits outweigh the risks.

#### ***2.4.4 Uterine perforation and Intra- abdominal injury:***

Any injury to internal organs, if not readily diagnosed and treated, can lead to serious and irreversible consequences including bleeding, infection and death. Therefore, whenever a woman is treated for complications following an unsafe abortion, the possibility of a genital tract injury should be considered.

The common injuries seen are uterine perforation and cervical lacerations. Damage to the ovaries, fallopian tubes, bladder, bowel and rectum can also occur.

If uterine perforation is suspected after an unsafe abortion, appropriate steps that may be taken include observation with readiness to explore, laparoscopy or exploratory laparotomy and repair.

### ***2.4.5 Transfusion of blood and blood products:***

Timely replacement of blood loss is critical in Post Abortion Care, as delays in volume expansion by replacing blood and blood products can be fatal. Blood loss can be assessed by,

- colour of mucosa,
- measuring blood pressure
- pulse rate
- urine output as an indicator of renal perfusion.

After initial assessment and intravenous fluid replacement, refer as soon as possible to a hospital with blood transfusion services and facilities for evacuation. Acute blood loss, mild or moderate, usually can be managed through the use of normal saline and plasma expanders, rather than with packed red cells or whole blood.

In such cases, replacement of the blood volume rather than red cells quickly is needed, and plasma expanders are safer and can be transfused faster. However, women who have both low haemoglobin levels (where lab facilities are available) or clinically pale and have symptoms and signs of acute blood loss, should receive transfusions without delay.

### **2.4.6 Management of DIC:**

Disseminated intravascular coagulopathy (DIC) is an infrequent but important complication of missed abortion or sepsis following unsafe abortion.

Risk of DIC increases with-

- advanced gestational age
- prolonged foetal demise
- massive blood loss accompanying the abortion

What begins as vaginal bleeding, usually seen in cases of abortion, may be accompanied by accumulation of intrauterine clot mimicking post abortal hematometra, before evolving into DIC. The transformation from clotted bleeding to serosanguinous flow due to DIC may take from 30 minutes to 6 hours or more. A coagulation screen is useful, and drop in fibrinogen level and platelet count, and increased fibrin split monomer are the most sensitive indices of presence of DIC.

Clinicians in settings where lab facilities are minimal, may be able to use a crude coagulation time to diagnose DIC early in its course. Failure of 10 cc of whole blood to produce a clot in a plain glass tube in 5–10 minutes indicates impaired clotting.

Once the diagnosis of DIC is made, the therapy consists of replacement of clotting factors supplementary to volume replacement, and if needed, red cell transfusions.

Two large (16–18 gauge) intravenous ports should be established for rapid infusion. Clinicians should be aware that true blood loss may substantially exceed measured blood loss, since DIC is a systemic process.

When clotting factor is administered early in the treatment of DIC by the use of 4–8 units of fresh frozen plasma (FFP), clotting function is usually restored. Additional therapeutic measures could be instituted in consultation with other relevant specialists.

Monitoring is the rule and should include monitoring of vital signs, vaginal pad counts, serial haematocrit and clotting indices, urine output, inspection for cutaneous bleeding sites, and evaluation of consciousness of the patient.

Cessation of vaginal bleeding is often the first sign of successful therapy. A concurrent crude bleeding time reveals the beginning of clot reformation.



## 2.5 Evacuation of retained products:

A key component of PAC is to ensure that products of conception have been completely evacuated from the uterus, as retention of these will lead to bleeding and sepsis, which could be life threatening.<sup>23</sup>

The guiding principles for surgical evacuation of the uterus include strict asepsis and complete removal of the products of conception with minimal trauma. In case of septic abortion or where infection is suspected, delaying surgical intervention for 12 hours is recommended to allow intravenous antibiotic administration.

Consensus statement by the International Federation of Gynecology and Obstetrics (FIGO) recommends that “the uterus be evacuated by vacuum aspiration or medications, not by sharp curettage (also known as dilatation and curettage or D&C).”<sup>21</sup>

Use of misoprostol to evacuate uterus after early pregnancy failure can completely evacuate the uterus in 50-96% of the time, if given orally or vaginally.<sup>23, 24</sup> This drug is not registered as a drug to be used in cases of incomplete abortion in Sri Lanka, and as such not recommended at present.

**Table 2 - Methods available for evacuation of products of conception**

<b>Gestation</b>	<b>Available methods</b>
Up to 15 weeks- Emergency	Vacuum Aspiration – involve minimal trauma and generally preferred for first trimester uterine evacuation
	Dilatation and Evacuation of retained products (D&E /ERPC)
Up to 15 weeks- Elective	Vaginal prostaglandins
	Vacuum Aspiration
15 weeks and above	Vaginal prostaglandins

### **2.5.1 Manual Vacuum Aspiration**

#### **Indications:**

- Early Pregnancy loss.
- Incomplete abortion.
- Termination of early pregnancy for indications within the law.
- Completion of evacuation of retained products in incomplete evacuation after medical treatment.

#### **Contraindications:**

- Should not use MVA beyond 15 weeks of gestation.

**Cautions:**

- However It should be used with caution in women who have:
  - uterine anomalies
  - coagulation problems
  - active pelvic infection
  - extreme anxiety
  - any condition causing the patient to be medically unstable.

Pain relief is dealt with in a later section.

**Possible but rare complications of MVA procedure**

These complications are somewhat similar to those of traditional D&E, but much less likely to occur with MVA, and described here for convenience and completeness.

**Incomplete evacuation:**

Using a cannula that is too small, or stopping the aspiration too soon can result in retained tissue, leading to subsequent haemorrhage and infection. Careful observation for signs of completion of the procedure, and meticulous tissue examination are the best ways to minimize the likelihood of incomplete evacuation. Risk factors for retained products of conception include patient's greater age, higher body mass index, and higher gestational age. Incomplete

evacuation can be managed by repeating the uterine aspiration.

**Uterine perforation:**

This complication is most likely to occur during dilatation rather than due to the insertion of the cannula. Careful pelvic examination prior to the dilatation to determine the position of the uterus and cervix, and gentle but steady traction on the cervix are essential precautions to minimize the risk of this complication.

**Cervical laceration:**

If treatment is needed, hemostatic agents may be sufficient for minor tears. In rare situations, suturing is needed.

**Pelvic infection:**

Should post-operative infection occur, treatment depends on location and type of infection.

**Haemorrhage:**

Heavy bleeding (e.g. the soaking of a maxi-pad every 20 minutes for 1 hour) is rare but can occur following MVA. Treatment depends on the severity of haemorrhage.

**Haematometra:**

This is a condition in which the uterus is distended with clots and blood. The most likely aetiology is an adherent clot in the

endocervical canal from a small tear that occurred during the procedure. The uterus may be larger than before the procedure, and extremely tender. This condition can be treated by re-aspirating the uterus, although dilatation alone is often sufficient.

### **Vagal reaction:**

Typically occurs near or after completion of the procedure. Woman may feel lightheaded or nauseated. If the procedure has not yet been completed, halt the procedure until the reaction has ceased. Have the woman lie either flat or in reverse Trendelenburg with her feet raised above the level of her heart. Provide a cool compress for her forehead and the back of her neck. Once the reaction has subsided, continue the procedure.

### **Clinical components of the MVA procedure -**

#### **Equipment required**

- MVA aspirator
  - Manual
    - Hand held vacuum syringe with a flexible syringe
    - Foot pump vacuum
  - Electrical vacuum
- Silicone lubrication
- Cannulae (4–12 mm)
- Adaptor for cannulae

- Specula
- Tenaculum (sharp-toothed or traumatic)
- Ring forceps
- Antiseptic solution, gauze, and small bowl
- Mechanical dilators
- Syringe, needle, and anesthetic agent for cervical block

### **Prevention of infection:**

Use of no-touch technique and prophylactic antibiotics can help to avoid infection. The first dose should ideally be administered 30 minutes before the procedure. One regimen often quoted in the medical literature is azithromycin 1g, and metronidazole 400mg one hour before the procedure and 200 mg 30 minutes afterwards.<sup>25</sup>

### **Analgesia:**

A paracervical or intracervical block is commonly used for vacuum aspiration abortions in North America. Deep injections using the Glick technique can be more effective than superficial injections, and injecting slowly has been found to be less painful than injecting quickly.

The cervix should be dilated in accordance with the size of the pregnancy if not already dilated, and the cannula the clinician plans

to use. Excessive force in dilation of the cervix can cause cervical or uterine injury. In addition, over dilatation should be avoided with MVA because it can compromise the vacuum pressure. Women experiencing early pregnancy loss or incomplete abortion may already have sufficient cervical dilation for the procedure. Women undergoing termination of an early pregnancy, to save the life of the mother, may be dilated using mechanical or plastic dilators or misoprostol vaginally.

### **Performance of the Procedure:**

The procedure is considered complete once the uterus feels empty to the clinician. (Note: If MVA is used for completion of incomplete or medical abortion, a sac may not be present). The syringe must be emptied on average of one to three times to complete the procedure. Routine use of a metal curette after MVA is not required.

### **Post procedure patient monitoring:**

After the procedure, the patient should be monitored for signs of pain and bleeding. A clinician should be notified in the event of fever or prolonged, worsening, or severe pain or bleeding.

### **Post-operative tissue examination**

It is critical to examine the products of conception (POC) after completion of the procedure. Examining the tissue helps ensure that the procedure is complete. For very early gestations, POC are

less likely to be disrupted during the aspiration when using MVA, as compared to EVA. Thus the POC may be more easily identified. Lack of complete POC identification may indicate an on-going or ectopic pregnancy. Patients should be evaluated carefully to identify the appropriate diagnosis.

A common technique for early tissue examination includes the following steps:

- o Wash the aspirate in a fine-mesh metal strainer under running water to remove blood and clots.
- o Transfer the remaining tissue into a clear glass dish containing about 0.5 inch of water or saline solution.
- o Place the dish on a radiograph box or photographic slide viewer, as back lighting greatly facilitates differentiation of the pregnancy elements.

A flashlight may provide some additional lighting if these resources are not available in the office.

Additional issues regarding tissue identification:

- o A woman experiencing early pregnancy loss (i.e., miscarriage) may have already expelled the pregnancy, and thus only limited tissue may be present.



- o POC from a very early pregnancy (< 6 weeks) may be difficult to identify without specialized training.
- o MVA may be unsuccessful when an abnormality in uterine shape is present, when it makes the cannula placement difficult or impossible. In such cases, the patient will need another option for her management such as traditional D&E.

### ***2.5.2 Dilation and Evacuation:***

This is still a commonly practiced method of evacuation in Sri Lanka.

The procedure may be performed under general anaesthesia, spinal (level of L3-L4 spine; inject 10-15 cc. of 0.25% marcaine carefully), par cervical block (0.25% marcaine injected just inside the vaginal mucosa, next to the cervix on each side; 5 cc.)<sup>26</sup>.

#### **Required Equipment:**

- Sterile surgical-grade gloves
- 0.25% marcaine, (or equiv.) solution and hypodermic needle kit, or
- 50-75 mg demerol and accompanying IV hardware.
- Lubricating jelly
- Speculum

- Antiseptic sponges
- Transfer forceps
- Tenaculum forceps
- Set of Hegar dilators (various sizes)
- 4-6 small, sharp curettes
- Uterine polyp forceps
- Continuous sterile roller gauze
- Antibiotics (as needed).

### **Steps in performing the dilation & evacuation**

- Patient is placed in the lithotomy position; empty the bladder, and perform a vaginal examination assessing the uterine shape and position.
- Insert a sterile speculum into the vagina. Ask the patient, if conscious, to relax and bear down.
- While carefully spreading the labia with a gloved hand, insert the speculum blades slowly downward and inward, watching the insertion closely.
- As the cervix is approached, slowly open the blades and allow the blades to straddle the cervix between them. Lock the screw lock of the speculum.
- Re-insert uterine polyp forceps and grasp gently for masses.

- Lightly curette the surface very carefully to ensure complete evacuation.
- Briefly massage the uterus bimanually and give an oxytocic.
- Withdraw the forceps. Bimanually massage the uterus and observe for bleeding.

#### **Post-operative care:**

- Release the cervix by removing the tenaculum and speculum, and using both hands push the uterus gently, but firmly, upward.
- Excessive bleeding may require packing the uterine cavity with long, continuous sterile roller gauze, and observing for shock, until the patient is out of danger and haemostasis is achieved.
- Monitor patient for any signs of infection during the recovery period.
- Provide emotional support, and allay anxiety and concerns during the recovery period.

## Complications of MVA and D&E-

*Table 3- Possible complications of MVA and D&E*

Complications	Vacuum Aspiration	D & C
Excessive bleeding	0 – 15.7%	0.5 – 28%
Pelvic infection	0.2 – 5.4%	0.7 – 6%
Cervical injury	0 – 3.1%	3 – 6.4%
Uterine perforation	0 – 0.5%	0 – 3.3%

### ***2.5.3 Evacuation of uterus by medical methods:***

Medical methods are an effective alternative in the management of abortion. Misoprostol, a prostaglandin-E1 analogue, is employed for many obstetric and gynecological indications, including treatment and prevention of postpartum hemorrhage and induction of labour. Misoprostol's ability to induce uterine contractions and soften the cervix makes it similarly effective in emptying the uterus following incomplete abortions.

There is increasing evidence that Misoprostol is a safe, effective, and acceptable method to achieve uterine evacuation for women needing post abortion care. Misoprostol reduces the cost of post abortion care services because it does not require the immediate availability of sterilized equipment, operating theatres, or skilled personnel. It is inexpensive, does not require refrigeration, and may be administered by several different routes and is rapidly absorbed from various routes.

The recent literature on misoprostol shows that it successfully completes expulsion in 80% or more for missed abortion and 92-99% for incomplete abortion, which is comparable to surgical evacuation. Misoprostol may be more successful at treating women experiencing an incomplete abortion compared with a missed abortion. Although studies show a range of efficacy, higher success has been achieved when clinicians wait for 1-2 weeks after misoprostol treatment before judging success or failure. In addition Misoprostol can be used for ripening of the cervix prior to the surgical evacuation of uterus. This will reduce complications like bleeding, cervical lacerations and uterine perforations. Please refer the annexure for the position statement of Sri Lanka College of Obstetricians and Gynecologists on use of Misoprostol for indications and dosages.

Misoprostol should be avoided in patients with shock, sepsis and allergic to prostaglandins or misoprostol. The side effects like nausea, vomiting, diarrhea, chills and fever has been reported in small percentage of women treated with misoprostol. The serious complications like heavy bleeding and anaphylaxis are very rare.

FIGO (International Federation of Gynecology and Obstetrics) recommendation is to use Misoprostol 400 micrograms by vaginal route three hours prior to surgery. Patients receiving medical management of miscarriage should be given analgesia and anti-emetics as needed.

### ***2.5.4 Anti- D Immunoglobulin prophylaxis:***

Non-sensitized rhesus (Rh) negative women should receive a dose of 250 IU of anti-D immunoglobulin in all miscarriages over 12 weeks of gestation, including threatened miscarriages. In addition, anti-D immunoglobulin should be given for all miscarriages where the uterus is evacuated by surgery.

Anti-D immunoglobulin is not recommended for miscarriages under 12 weeks gestation in cases of complete miscarriage, threatened miscarriage, and miscarriage receiving only medical management.

### ***2.5.5 Immunization against tetanus:***

A woman who underwent an unsafe abortion should receive a tetanus toxoid vaccine immediately. In addition, offer prophylaxis with Tetanus Immunoglobulin if the genital tract or instruments are contaminated with soil or animal excreta.

## **2.6 Family planning counseling and service provision in post abortion care:**

This section attempts to:

1. Provide essential information about family planning to all post abortion clients
2. Explain the importance of informed choice in providing family planning services
3. Describe personal and clinical factors that should be considered in family planning counseling for post abortion clients
4. Provide appropriate family planning counseling during different phases of care.

### **2.6.1 Role of the PAC provider (VOG, MO, NO, PHM):**

- The PAC provider is a crucial link in helping PAC clients to:
  - recognize their need for family planning,
  - overcome possible misconceptions and fears regarding family planning methods, and
  - gain confidence and trust in the healthcare system.

#### ***Family planning Counseling and Information.....***

- ***Family planning information and counselling should be offered to all PAC clients regardless of the method of treatment for uterine evacuation***
- ***Family planning methods should be available in all Institutions(general circular no: 01-05/ 2010).<sup>27</sup>***

#### **Integrating emergency treatment and family planning:**

- Offering family planning and treatment for incomplete abortion services in the same place and with the medical care provided can result in:



- More effective family planning use
- Reduction of repeat abortions
- Healthy timing and spacing of pregnancies.

### **Healthy timing and spacing of pregnancy (HTSP):**

Technical working group from WHO states that <sup>26</sup>:

- **After a live birth**, the recommended interval before attempting the next pregnancy is at least 24 months, in order to reduce the risk of adverse maternal, perinatal and infant outcomes.
- **After a miscarriage** or induced abortion, the recommended interval to the next pregnancy should be at least 6 months, in order to reduce risks of adverse maternal and perinatal outcomes.
- **Young women** should wait until they are at least 20 years of age for their first pregnancy.

### ***2.6.2 Informing the client about post abortion family planning choices and services:***

The PAC client needs to know that:

1. She can become pregnant again before the next menses, as fertility can return in as short as two weeks.
2. Safe contraceptive methods to prevent or delay pregnancy can be used immediately.
3. The risk for an adverse outcome to a pregnancy is less when there is an interval of at least six months between this miscarriage and her next pregnancy.
4. Where and how to obtain family planning services and methods, either at the time of treatment or after discharge, especially if the preferred method is not available in the same facility where PAC services are provided.

#### **Content of post abortion family planning**

As with all family planning services, PAC clients should receive:

- information on the importance and need for proper family planning practices,

- information and counseling about methods, their characteristics, effectiveness and side effects,
- choices among methods (e.g., short- and long-acting, hormonal and non-hormonal, permanent and temporary),
- Assurance of contraceptive re-supply,
- Access to follow-up care.

### **Goals of family planning counseling<sup>28</sup>**

Help the woman and her partner (if she agrees to his participation in counseling) to:

1. Understand the factors that led to an unwanted pregnancy (if appropriate) in order to ***avoid unwanted pregnancy and a repeated unsafe abortion.***
2. Understand that fertility can return almost immediately.
3. Decide if she wants to use a contraceptive method.
4. Choose an appropriate method.
5. Use the method effectively.

6. Space or prevent future pregnancies.

### **Family planning counseling: Informed choice**

- Free and informed choice means that the client chooses a contraceptive method voluntarily, and without pressure or coercion.
- It is based on a clear understanding of the benefits and limitations of the methods that are available.
- Help the client to understand that:
  - almost all methods can be used safely and effectively immediately after treatment of an incomplete abortion.
  - with the exception of permanent methods (tubal ligation and vasectomy), she can choose another method later if she wishes to change.
- Many women do not want to become pregnant again immediately, but some women may not want to make a decision about contraception at the time of PAC services.
- A mechanism should be in place to ensure that these women can return for contraceptive services, or are referred to a clinic in their community.

- The use of contraceptives should be completely voluntary.
- Acceptance of contraception or a particular method should never be a prerequisite for obtaining PAC services.

### **How family planning counseling helps the client:**

Family planning counseling should help a client to:

- consider her reproductive goals, including the need for protection against STIs, including HIV,
- make free, informed choices about family planning, and understand how to effectively use the method.

*Clients who have made a free and informed choice of a family planning method are:*

- *more likely to be satisfied with the method, and*
- *more likely to use the method effectively.*

### **2.6.3 Tailoring post abortion family planning to the client's needs:**

- Family planning services should be based on the assessment of each woman's /couple's unique situation, taking into account her personal characteristics, needs and reproductive goals.
- Her clinical condition.
- The service delivery capabilities where she receives treatment, and in the community where she lives.

#### **Client's personal situation:**

- Some aspects of the client's personal situation:
  - may be related to the unplanned pregnancy or incomplete abortion;
  - May be a barrier to contraceptive use.
- While maintaining confidentiality, the provider can obtain information to help clients select a suitable method.

Issues related to personal situation, affecting selection of a method:

- Does she want to become pregnant again soon?
- Was the client a survivor of sexual abuse or rape?
- Is she under stress, in pain or not prepared to make a long-term decision?
- Has she ever used a family planning method? If not:
  - Did she lack information about it, or did she choose not to use family planning?
  - What are some of the factors that led to her decision not to use family planning?
  - Does she desire family planning counseling now?
- Was she using a family planning method when she became pregnant? If so:
  - Was she using it correctly and consistently?

- Were there particular reasons why the method failed?
- Would she be able to use the method effectively in the future?
- Would she prefer a different method?
- Are there partner/family or other issues to consider, such as:
  - a partner who may not be monogamous,
  - a partner who is unwilling to use condoms,
  - a partner or mother-in-law who disapproves of contraception,
  - a partner desiring more children or children of a specific gender,
  - cultural restrictions,
  - limited resources or access to health services.



## **Involving men in family planning counseling:**

- Studies on male involvement in counseling show that:
  - Many men want to have more information about their partner's condition during PAC, and more information on family planning;
  - With the client's consent, counseling the husband/partner separately can increase both the use of family planning, and the support for PAC clients during recovery;
  - Some women want their husbands to be informed about family planning methods, and to be present for family planning counseling with them.
- Whichever approach is preferred by the couple should be supported and implemented.

## **Working with adolescents**

- Adolescents who have experienced incomplete abortion:
  - may not have the support of their partners or parents,

- are more likely to experience isolation and emotional stress, or
- may have been victims of coercive sexual encounters.
- Counselors need to:
  - be supportive and non-punitive (non-punishing);
  - take extra care to express openness and compassion; personal judgments about adolescent sexual activity should not affect the interaction;
  - Understand that thorough counseling is needed, as it may be more difficult for adolescents to use methods consistently and correctly.

**Clinical condition:**

- In general, all modern methods of family planning can be used immediately after emergency post abortion care, provided:
  - there are no severe complications requiring further treatment,

- the client receives adequate counseling, and
- the provider screens the client for any precautions for using a particular contraceptive method.
- To prevent infection, women should not have sexual intercourse until:
  - post abortal bleeding stops (usually 5–7 days), and
  - any complications are resolved.

### **Community resources for referral and follow-up**

- A client's ability to use a method effectively depends, in part, on:
  - her access to services;
  - support for use of her chosen method;
  - continuous supply of contraceptives; and
  - ability of the service delivery facility to maintain an adequate supply of methods.

- The family planning service provider can assist with matters such as side effects or changing methods, if desired.
- Are there private sector sources of family planning? What are they and what is the cost?
- What other community services are available, such as services for clients who are victims of domestic violence

### **2.6.4 Methods available for post abortion family planning:**

#### **1. Injectable: Depot Medroxy Progesterone Acetate- (DMPA)**

Timing for post abortion use:

- Injection may be given immediately after treatment. If started within 7 days of abortion, no need for a backup method.

#### **2. Combined oral pill**

Timing for post abortion use:

- Pill use may begin immediately. If started within 7 days of abortion, no need for a backup method.

### **3. Progestin-only implants:**

Timing for post abortion use:

- Implants may be inserted immediately after abortion. If started within 7 days of abortion, no need for a backup method.

### **4. IUD:**

Timing for post abortion use:

- IUD can be inserted immediately, if risk or presence of infection can be ruled out. If started within 12 days of abortion, no need for a backup method.
- Second-trimester miscarriage/abortion: The service provider should be specially trained, if the IUD is to be inserted within four weeks of miscarriage/abortion.
- If there are complications: Insertion should be delayed until serious injury is healed, infections are cured, hemorrhage is controlled or acute anemia improved.

## **5. Barrier Methods-** Latex and vinyl male/female condoms

Timing for post abortion use:

- May be used as soon as intercourse is resumed.

## **6. Female sterilization**

Timing for post abortion use:

- Can be performed immediately after treatment of post abortion complications.
- Delay until infections are fully resolved or injuries healed.

## **7. Vasectomy- for the male partner**

Vasectomy can be performed at any time:

- Not effective for the first 12 weeks immediately following the procedure.

## **Dual protection**

1. Dual protection achieves the simultaneous prevention of sexually transmitted infections and unplanned pregnancy.

2. There are 2 main ways to practice dual protection:
  - a. Condoms alone.
  - b. Condoms with another family planning method (such as oral pills or an injectable).
3. The primary goal of dual protection will influence which option a woman should select.
4. If the goal is to prevent pregnancy, dual method use may be appropriate, especially if she is not able to use condoms correctly and consistently.
5. If primary goal is prevention of infection, condoms alone may be a good choice.
6. Providers need to help PAC clients to determine their risks and goals, and select the best form of dual protection for their needs.<sup>29</sup>

## **2.7 Common legal and ethical concerns of providers:**

**Legal implications of termination:**

**(Contributed by Mr. Palitha Fernando -Solicitor General of Sri Lanka by invitation in 2014)**

- 1. Is a Medical Officer who comes to know of an illegal termination of pregnancy, bound to bring it to the notice of the Law Enforcement Authorities?**

**Section 21 and 22** of the Code of Criminal Procedure Act is relevant in this regard. The two sections deal with obligation on the part of persons to furnish information regarding the commission of offences.

**Section 21** deals with the duty cast on any person to give information about the commission of an offence. Several sections of the Penal Code are set out in that section, and a legal duty is cast upon all persons to furnish information to the authorities about the commission about such offences. Sections 302 to 309 of the Penal Code, which penalizes illegal terminations of pregnancies are not among those sections. Therefore, a civil person cannot be dealt with for failing to inform the authorities of commission of an illegal abortion.



Section 22 on the other hand casts a legal duty on all Peace Officers to inform the authorities of the commission of any offence within his local area of jurisdiction. Therefore, a Police Officer, who is a Peace Officer, should immediately bring to the notice of the authorities any information he receives of the commission of any offence within the local limits of his jurisdiction.

*In view of the above provisions, it is clear that a Medical Officer need not report to the authorities where a person after an illegal abortion visits him for treatment.*  
*There is no legal obligation to furnish information in respect of the omission of the offence of abortion.*

- 2. Where a person comes seeking an abortion, and you are aware that she will get it done at some other place, are you obliged to bring it to the notice of authorities?**

Where a person comes requesting an illegal abortion, though it is clear that the person would get it done somewhere else, still there is no legal duty on the part of the Medical Officer to furnish that information to the Police.

**3. In such a situation will it be an offence to refer the patient to someone else for the performance of the abortion?**

However, if a person comes for an illegal abortion and she is referred for that purpose to another Medical Officer, the person who made the referral would be guilty of the offence of abetment of abortion and such person had knowingly facilitated the commission of the offence. A Medical Officer who does not bring to the notice of the authorities where a person comes after an abortion will not be guilty of abetment of abortion, since the offence of abetment can be committed under our law only before or at the time the commission of the main offence. Even if the place you refer the patient to is a safe one, and you have done so with good intentions, still you will not be able to escape from being found guilty of abetment.

**4. Where a person comes for treatment after severe complications as a result of an illegal abortion, would it be in order to treat such a patient without informing the authorities?**

A Medical Officer, to whom a patient is referred to after severe complications after an abortion, will not be guilty of any offence if he treats the patient. However he takes a huge risk as he may be answerable for the patient's condition in

case the patient succumbs to his injuries due to the illegal abortion. Therefore, it is advisable to inform the authorities where a patient with serious complications seeks treatment from you after an illegal abortion.

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## Annexure

**Position Statement : 11th July 2014**

### **Sri Lanka College of Obstetricians and Gynecologists**

The Sri Lanka College of Obstetricians & Gynecologists endorses that the use of misoprostol in the following instances is backed by sound scientific evidence and global experience.

<b>Indication</b>	<b>Dosage</b>	<b>Notes</b>
Silent / Delayed miscarriage (1st Trimester)	800 mcg vaginally 3-hrly (max x2) or sublingual 600mcg 3-hourly (max x2) <sup>a,b</sup>	Give 2 doses and leave to work for 1-2 weeks (unless heavy bleeding or infection)
Incomplete miscarriage (1st Trimester)	600mcg orally single dose <sup>b,c</sup> or 400mcg sublingual single dose <sup>b,c</sup>	Leave to work for 2 weeks (unless heavy bleeding or infection).
Cervical ripening pre-instrumentation (E.g. Resection of myomas)	400mcg vaginally 3-hrs before or sublingually 2-3 hrs before procedure <sup>b,c</sup>	Use in selected cases for insertion of intrauterine device, dilatation and curettage, hysteroscopy
Mid-trimester fetal death	Intrauterine fetal death: 13-17 wks: 200mcg vaginally 6-hrly (maximum of 4 doses) <sup>b,d</sup> . Intrauterine fetal death:18-26 wks: 100mcg vaginally 6-hrly (max x4) <sup>b,d</sup> .	Reduce doses in women with previous caesarean section. For fetal death in the third trimester see 'Induction of Labor in Death in Utero' below.
Pre Induction ripening of cervix and induction of labour (IOL) for a live viable fetus at term	25 mcg orally 2-hrly <sup>b,e</sup> or 50 mcg 4hourly orally <sup>f</sup> or 25mcg vaginally 6-hrly	Recommended by the International Federation of Gynecology & Obstetrics – FIGO , WHO ) <sup>b,e</sup>
Pre Induction ripening of cervix and IOL for a death in utero after 26 weeks gestation	25 mcg orally 2-hrly <sup>b,e</sup> or 50 mcg 4hourly orally <sup>f</sup> or 25mcg vaginally 6-hrly	Recommended by the International Federation of Gynecology & Obstetrics – FIGO , WHO ) <sup>b,e</sup>
PPH treatment	800mcg sublingually or PR single dose <sup>h,i</sup>	As an adjunct/second line drug for the total care of such women



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