



ARAB REPUBLIC OF EGYPT
MINISTRY OF HEALTH AND POPULATION

POSTABORTION CARE TRAINING
COURSE FOR PRIMARY HEALTH CARE
FACILITIES

TRAINEE'S GUIDE

Draft

November 2005



The CATALYST Consortium is a global reproductive health activity initiated in September 2000 by the Office of Population and Reproductive Health, Bureau for Global Health, U.S. Agency for International Development (USAID). The Consortium is a partnership of five organizations: the Academy for Educational Development (AED), Centre for Development and Population Activities (CEDPA), Meridian Group International, Inc., Pathfinder International and PROFAMILIA/Colombia.



This publication was made possible through support provided by the Office of Population and Health, United States Agency for International Development, under the terms of contract No. HRN-A-00-00-00003-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the United States Agency for International Development.

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Background

The international health community contains a wealth of resources that, if coordinated, could have an **immediate** and **significant** impact in reducing global levels of maternal mortality and morbidity stemming from the complications of unsafe abortion. Deaths and injuries from incomplete abortion are almost wholly preventable through existing means.

In order to reduce the risk of long-term illness or disability, and death, to women presenting with the complications of incomplete abortion, health care systems must provide easily accessible, quality postabortion care at all service levels. Currently, emergency postabortion care is provided mainly in higher-level district hospitals. Not only does this lead to the high cost of providing these services, but it makes them inaccessible to many women. The prevention of abortion-related illness and mortality is dependent on the availability of emergency postabortion care throughout the health care system. “Whether it is health information and education, stabilization and referral, uterine evacuation, or specialized care for the most severe complications, at least some components of emergency care must be available at every service delivery site in the health care system.”¹

The concept of postabortion care presented in this manual provides the basis for reducing mortality and morbidity from incomplete abortion, whether spontaneous or induced.

Scope of the Problem

Recent estimates are that at least 15% of all pregnancies end in spontaneous abortion (miscarriage), and though death is less likely than in cases of unsafe abortion, women who present with suspected spontaneous abortion also need immediate care.² According to recent World Health Organization (WHO) estimates, up to 15% of pregnancy-related mortality worldwide is due to abortion.¹

WHO estimates that:

- Worldwide, 20 million unsafe abortions occur each year.
- 70,000 women die each year as a result of complications following unsafe abortion.
- 1 in 8 pregnancy-related deaths are due to unsafe abortion.

Maternal Mortality and Morbidity

Preventable deaths, avoidable injuries

The WHO defines maternal mortality as *the death of a woman during pregnancy or within 42 days after pregnancy, irrespective of the duration or the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management.*

Five direct causes:

1. Hemorrhage
2. Sepsis
3. Pregnancy-induced hypertension
4. Obstructed labor
5. Complications of unsafe abortion

Note: An anemic woman is five times more likely to die of pregnancy-related causes than a woman who is not anemic

1. **Hemorrhage.** The leading cause of maternal death, hemorrhage can kill a woman within just a few minutes.
 - ▶ During pregnancy or after delivery, hemorrhage can result from prolonged labor, uterine rupture, or early separation of the placenta from the uterine wall.
 - ▶ Hemorrhage also can occur after miscarriage or unsafely induced abortion.
2. **Sepsis.** Infection can develop after delivery, miscarriage, or unsafe abortion, when tissue remains in the uterus, when unclean instruments or other objects are placed in the vagina, or when aseptic procedures are not followed.

Septic abortion, when the endometrial cavity or its contents become infected, often follows incomplete abortion, spontaneous or induced.
3. **Pregnancy-induced hypertension.** This condition can be one of the most difficult of obstetric emergencies to prevent and to manage. The early stage of this disorder is characterized by high blood pressure, fluid retention (edema), and protein in the urine. Eclampsia can occur during pregnancy or after delivery and can result in convulsions, heart or kidney failure, cerebral hemorrhage, and death.
4. **Obstructed labor.** This condition occurs when the infant's head cannot pass through the woman's pelvic opening.
5. **Complications of unsafe abortion.** Common complications include incomplete abortion, infection, hemorrhage, and intra-abdominal injuries, including cervical laceration and uterine perforation. All can be fatal if left untreated.

Introduction

Abortion complications are responsible for around 14% of maternal deaths that occur each year, 99% of them in the developing world. Prevention of abortion-related maternal mortality is dependent on emergency abortion care and postabortion care being integrated throughout the health care system, from the most basic rural health units to the most sophisticated tertiary level facility (referral hospitals). Whether it is health information and education, stabilization and referral, uterine evacuation, or specialized care for the most severe complications, at least some components of emergency abortion care must be available at every service delivery site in the health care system.³

One of the most positive steps, which can be taken, is to provide *life-saving care at the lowest possible level of the health system*, in order to maximize the chances that the woman will reach that care before it is too late. Beginning emergency care at the primary care level is essential to achieving that goal. The first referral level must be able to build on the services provided at the primary level by providing life-saving surgical and medical procedures for all but the most serious complications.

Often care offered at the primary level can be improved dramatically with a relatively small number of changes. The primary level can work toward having staff trained and facilities available to (1) assess the woman's status (2) stabilize her condition, (3) initiate first aid treatment. They also need to be able to prepare patients for referral and arrange prompt reliable transport.

The institutionalization of quality abortion and postabortion care at all health care levels, including the primary level, dramatically decreases the risk of maternal mortality and morbidity.

Postabortion Care at Primary Health Care Facilities

Elements of Postabortion Care

Comprehensive postabortion care services should include both medical and preventive health care. The key elements of postabortion care are:

1. Emergency treatment of incomplete abortion and potentially life-threatening complications
2. Postabortion family planning counseling and services
3. Links between postabortion emergency services and the reproductive health care system

Emergency Treatment

Every health system provides some level of emergency postabortion care services because at least 15% of all recognized pregnancies end in spontaneous abortion. Emergency treatment of postabortion complications is often offered only at secondary and tertiary care centers in urban areas. Unfortunately, poor transportation systems in many developing countries place centralized services out of reach of most poor, rural women. This gap in services necessitates strengthening the providers' role at the 1st level (PHC) to enable them to provide first aid emergency postabortion care services.

Emergency treatment for postabortion complications includes:

At the PHC level:

1. An initial assessment to confirm the presence of abortion complications
2. Talking to the woman regarding her medical condition and the treatment plan
3. Medical evaluation (brief history, limited physical and pelvic examinations)
4. Prompt referral and transfer if the woman requires treatment beyond the capability of the facility where she is seen

At the secondary or tertiary levels:

5. Stabilization of emergency conditions and treatment of any complications (both complications present before treatment and complications occurring during or after the treatment procedure)
6. Uterine evacuation to remove retained products of conception (POC)

Table 1. Postabortion Care Activities Provided at the Primary Health Care Facility

Level	Staff may include	Abortion care provided
Primary	<ul style="list-style-type: none"> • General practitioner • Nurses • Lab tech • Trained midwives • Outreach health workers 	<p>All primary care facilities:</p> <ul style="list-style-type: none"> • Simple physical and pelvic examination • Diagnosis of the stages of abortion • Resuscitation/preparation for treatment or transfer • Hemoglobin testing • Referral, if needed • Initiation of essential treatments including antibiotic therapy, intravenous fluid replacement, and oxytocics • Simple analgesia and sedation

Source: WHO, Complications of Abortion: Technical and Managerial Guidelines for Prevention and Treatment

Types of Abortion

Table 2. Diagnosis of Abortion

Diagnosis	Bleeding	Cervix	Uterine size	Other signs
Threatened Abortion	Slight to moderate	Not dilated	Equal to dates	<ul style="list-style-type: none"> • Positive pregnancy test • Cramping • Uterus soft
Inevitable Abortion	Moderate to heavy	Dilated	Less than or equal to dates	<ul style="list-style-type: none"> • Cramping • Uterus tender/firm
Incomplete Abortion	Slight to heavy	Dilated	Less than or equal to dates	<ul style="list-style-type: none"> • Partial expulsion of products of conception • Uterus tender/firm
Complete Abortion	Slight to moderate	Dilated or closed	Less than dates	<ul style="list-style-type: none"> • Complete expulsion of products of conception
Missed Abortion	Little or none	Closed	Less than or equal to dates	<ul style="list-style-type: none"> • Fetus dead with delayed expulsion • Decrease in pregnancy signs and symptoms

In the case of threatened abortion, the woman should rest in bed for 24 - 48 hours. If the bleeding gets worse or she develops other symptoms, including any signs of infection, she should be assessed again immediately; otherwise, she should be reassessed in 1 to 2 weeks.

In the case of inevitable, incomplete, possible complete, or missed abortion, uterine evacuation is required for complete removal of the products of conception.

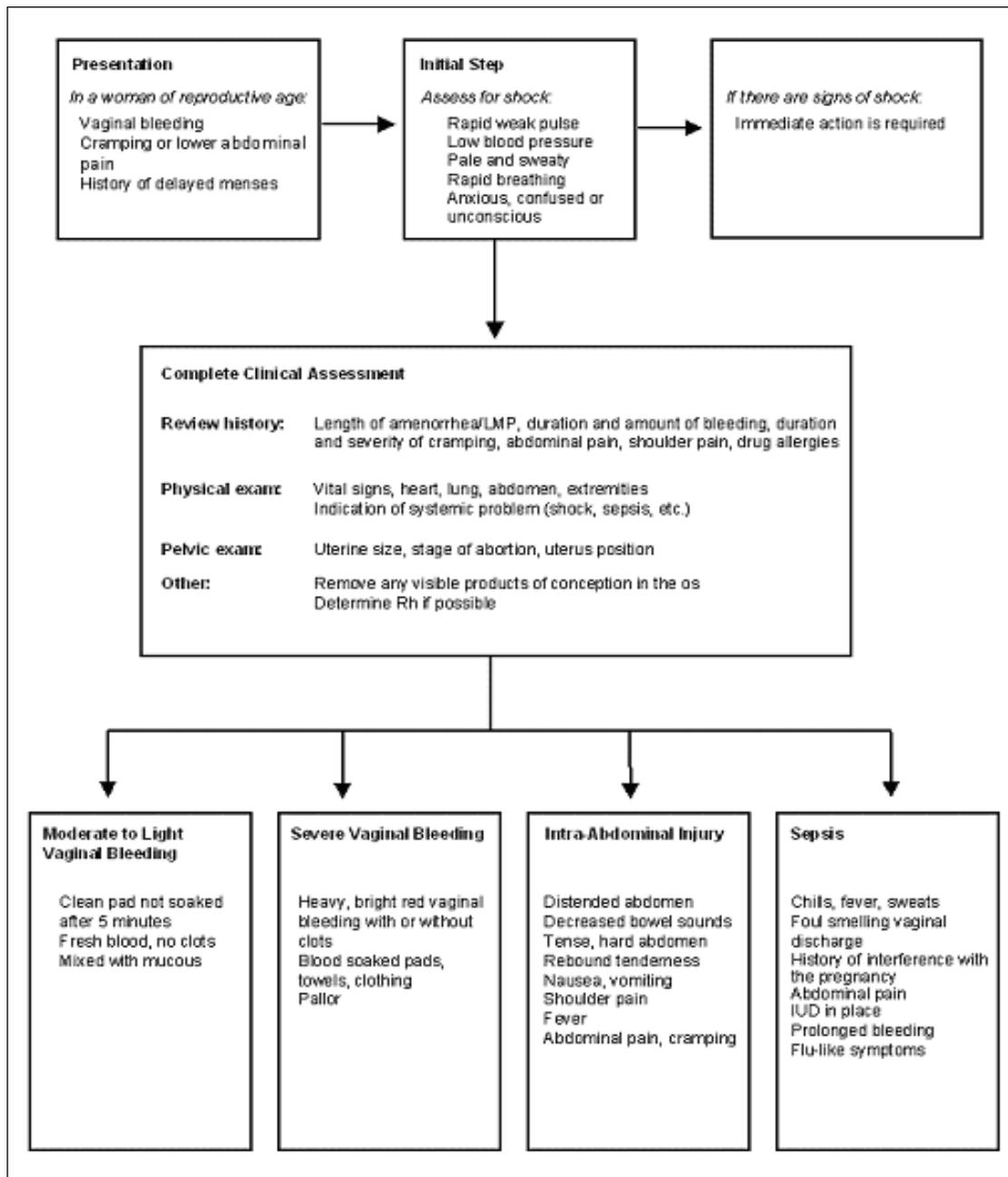


Figure 1. Initial Assessment of Abortion Patients

Initial Assessment: Determining the Woman's Needs for Immediate Treatment

Initial Assessment

1. **Identification of abortion patients:** any woman of reproductive age experiencing at least two out of three of the following symptoms should be considered as a possible abortion patient:
 - ▶ Vaginal bleeding

- ▶ Cramping and/or lower abdominal pain
- ▶ A possible history of amenorrhea.

Note: If none of the above symptoms are present, consider another diagnosis

If abortion is a possibility, assess immediately for the critical conditions described below. Interference with a pregnancy through unsafe means is a major cause of serious complications; however, the woman may not provide this information as a part of medical history for various legal and social reasons. Therefore, the possibility should always be kept in mind while assessing physical signs and symptoms.

2. Quickly assess the patient for the following signs of shock:

- ▶ Fast, weak pulse (rate 110 per minute or greater)
- ▶ Low blood pressure (hypotension); systolic less than 90 mmHg
- ▶ Pallor (inner eyelid, conjunctival, around the mouth, or palms)
- ▶ Sweaty
- ▶ Fast breathing (respirations 30 per minute or greater)
- ▶ Anxious, confused, or unconscious (diminished mental state)

If shock is suspected, ***immediately*** begin treatment.

Even if none of these signs is currently visible, keep shock in mind as you evaluate the patient further; her status may worsen rapidly. If shock develops later, it is important to begin treatment immediately.

- 3. Complete clinical assessment:** several life-threatening conditions requiring immediate treatment may be present at the same time. A complete clinical assessment is necessary to determine all conditions that are present in order to decide the order in which to treat them.

Table 3. Complete Clinical Assessment

History	Ask about and record the following information: <ul style="list-style-type: none"> • Amenorrhea - how long ago did she have her last menstrual period (LMP) • Bleeding (duration and amount) • Cramping (duration and severity) • Abdominal or shoulder pain • Drug allergies
General Physical Exam	<ul style="list-style-type: none"> • Check and record vital signs (temperature, pulse, respirations, blood pressure) • Note general health of woman (malnourished, anemic, general poor health) • Examine lungs, heart, abdomen, extremities (In examining the abdomen first check bowel sounds, then check to see if the abdomen is distended or rigid, if there is rebound tenderness, abdominal masses, and presence, location, and severity of pain) • If a patient's Rh status is routinely assessed in pregnancy, it should be done during the clinical assessment in cases of abortion as well. If the patient is Rh(-), give a dose of anti-D globulin within 48 hours of uterine evacuation or of complete abortion.
Pelvic Exam	<ul style="list-style-type: none"> • Remove any visible products of conception from the vaginal canal or cervical os • Note if there is a foul-smelling discharge • Note the amount of bleeding and whether the cervix is open or closed • Check for cervical lacerations • Perform a bimanual exam: estimate the size of the uterus, check for any pelvic masses and pelvic pain (note severity, location, and what causes the pain [at rest, with touch and pressure, movement of the cervix])

4. Diagnosis and treatment: compare the woman's presenting condition, and findings from the history and examination with the signs and symptoms for each of the life-threatening conditions outlined below:

- ▶ Diagnose and begin treatment according to the recommended guidelines.
- ▶ Decide which condition is most urgent and must be treated first.
- ▶ Keep in mind that choosing the order of treatment does not mean that other conditions can be ignored while taking care of the most severe condition.
- ▶ Attention must be given to any or all life-threatening conditions.
- ▶ If definitive treatment is not possible, prepare the patient for referral after initial stabilizing steps have been carried out.

4.1 Moderate to light vaginal bleeding

Many women who present with an incomplete abortion have moderate to light vaginal bleeding and no sign of life-threatening conditions. Treatment should not be delayed, however, because the condition may get worse. The following signs indicate moderate to light bleeding:

- Clean pad not soaked after 5 minutes
- Fresh blood, no clots

- Blood mixed with mucus

4.2 Severe vaginal bleeding

If the patient has any of the following signs, she has severe vaginal bleeding. Begin treatment immediately to replace lost fluid and control bleeding:

- Heavy, bright red vaginal bleeding with or without clots
- Blood-soaked pads, towels, or clothing
- Pallor (inner eyelid, conjunctival, around the mouth, or palms)

4.3 Intra-abdominal injury

If the patient has any of the signs in the table below with any of the symptoms listed there, she is probably suffering from an intra-abdominal injury (or an ectopic pregnancy). The differential diagnosis should also include acute appendicitis.

Table 4. Signs and Symptoms of Intra-abdominal Bleeding

Signs	Symptoms
<ul style="list-style-type: none"> • Distended abdomen • Decreased bowel sounds • Abdomen tense and hard • Rebound tenderness 	<ul style="list-style-type: none"> • Nausea/vomiting • Shoulder pain • Fever • Abdominal pain, cramping

4.4 Sepsis

If the patient has any of the signs in Table 5 below with any of the symptoms listed there, she probably has local or generalized infection (septicemia).

Table 5. Signs and Symptoms of Septicemia

Signs	Symptoms
<ul style="list-style-type: none"> • Chills or sweats (rigors) • Fever • Foul-smelling vaginal discharge • Distended abdomen • Rebound tenderness • Slightly low blood pressure (mild hypotension) 	<ul style="list-style-type: none"> • History of interference with the pregnancy • Abdominal pain • IUD in place • Prolonged bleeding • General discomfort; flu-like symptoms (malaise)

Management of Shock

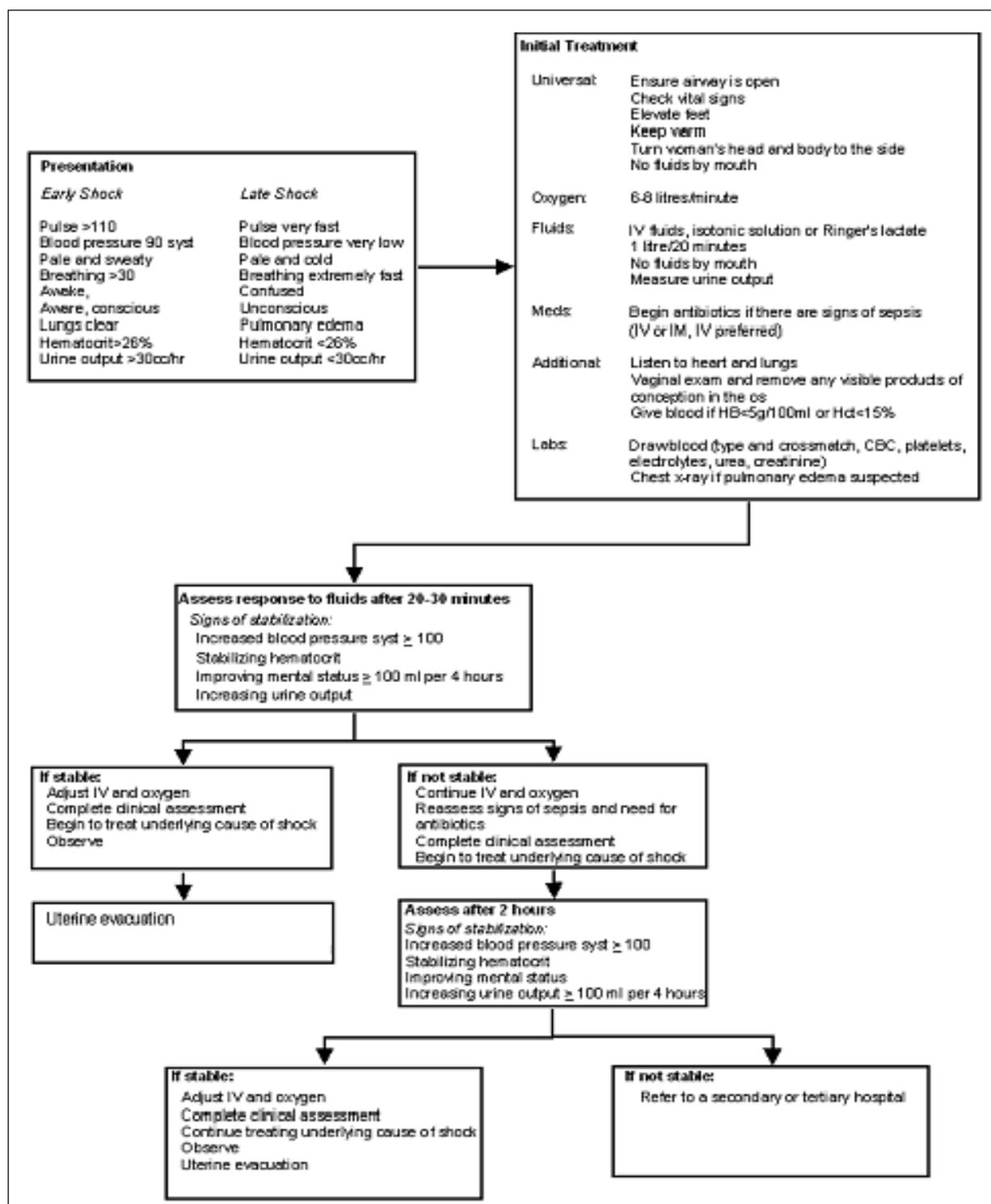


Figure 2. Management of shock

Introduction

Shock is a life-threatening condition and requires immediate and intensive treatment to save the patient's life. With shock the oxygen supply and blood flow to the tissues is interrupted due to general, severe failure of the circulatory system. In the case of abortion, shock is usually caused by:

- Hemorrhage (hemorrhagic, hypovolemic shock)
- Sepsis (septic shock)

When a patient is in shock, the relative volume of blood circulating is reduced in one of two ways, either through loss of blood (hemorrhage) or through dilation of the blood vessels (vasodilation) from sepsis. In both cases, the amount of blood and fluids circulating must be increased.

Shock can progress from early, “mild” to late, “severe” and, if not treated, the patient may die. Patients suffering from shock must be treated vigorously and watched closely as their condition can worsen quickly.

The primary goal in treating shock is to stabilize the patient; that is, to restore volume and efficiency of the circulatory system. Life-saving care must begin immediately, with intravenous fluid for volume replacement. Antibiotics must be given immediately if sepsis or an intra-abdominal injury is also present. In facilities where shock cannot be treated, initial measures of care should be given and prompt referral is required.

Presentation

When a patient is first seen with complications of abortion, she should be assessed immediately for signs of shock. If hemorrhage, trauma, or sepsis are immediately apparent the possibility of shock should also be considered.

Signs of shock

- Fast, weak pulse (rate 110 per minute or greater)
- Low blood pressure (hypotension); systolic less than 90 mmHg
- Pallor (inner eyelid [conjunctival], around the mouth, or palms)
- Sweaty
- Fast breathing (respirations 30 per minute or greater)
- Anxious, confused, or unconscious (diminished mental state)

Assessment

When shock is suspected, assess its stage and severity immediately. Early shock is reversible and may respond well to treatment generally available at the primary care level. If early shock is not recognized and not treated, it will progress to late shock. Late shock is more difficult to treat with the facilities typically available at the primary level and requires referral for more intensive care once emergency care has been started.

Table 6. Signs of Shock

Early shock	Late shock
<ul style="list-style-type: none"> • Awake, aware, anxious • Slightly fast pulse (110 per minute or greater) • Slightly fast breathing (30 respirations per minute or greater) • Pale • Mild low blood pressure (systolic less than 90 mmHg) • Lungs clear • Haematocrit of 26% or greater • Haemoglobin of 8 g/100 ml or greater • Urine output of 30 cc per hour or greater 	<ul style="list-style-type: none"> • Confused or unconscious • Very fast and weak pulse • Extremely fast and shallow breathing • Pale and cold • Very low blood pressure • Heart failure, pulmonary edema* • Haematocrit less than 26% • Haemoglobin less than 8 g/100 ml • Urine output less than 30 cc per hour

*¹ Assessment of heart failure, pulmonary edema: severe difficulty breathing when lying down may indicate heart failure. Listen to the heart and lungs to assess cardiac and pulmonary status. Clinical evidence of an enlarged heart or fluid in the lungs (rales, severe difficulty breathing when lying down, pink frothy sputum, distended neck veins, swelling of hands and feet) indicates heart failure and pulmonary edema. This can be confirmed with a chest x-ray and by the measurement of central venous pressure.

Initial Treatment

The first steps in the care of shock can be life saving.

Universal Measures

These measures can be taken even at peripheral levels of care and should be given before or during transfer to the next level of care.

- Make sure that the airway is open.
- Check vital signs.
- Do NOT give fluids by mouth as the woman may vomit and inhale (aspirate) the vomit.
- Turn the woman's head and body to the side so that if she vomits, she is less likely to aspirate.
- Keep her warm because hypothermia is a danger (it can worsen the shock). Blankets are useful, but do NOT apply any external sources of heat (heating pad, hot water bottle) as a person in shock may be easily burned. Raise the legs to help the blood return to the heart and if possible, raise the foot of the bed.
- If lying down causes severe difficulty in breathing, there may be heart failure and pulmonary edema. In this case, lower the legs and raise the head to relieve fluid pressure on the lungs.
- Make sure that the airway is open. If oxygen is available, start oxygen at 6-8 liters per minute by mask or nasal cannulae.

Management of Shock

a. IV Fluids

To restore fluid volume, start intravenous fluids immediately. Use a large-bore needle (16 to 18 gauge recommended), and collect the necessary blood samples. Infuse a compound solution of sodium lactate or normal saline (sodium chloride) at the rate of 1 liter in 15-20 minutes. Normally it takes 1 to 3 liters of IV fluids, infused at this rate, to stabilize the patient in shock. It is important to monitor the amount of fluids given.

Note: Do not give any medicines by mouth to a woman in shock

b. Antibiotics

If there are any indications that infection may be present, including fever, chills or pus, give broad-spectrum antibiotics effective against Gram-negative, Gram-positive, anaerobic organisms and chlamydia.

c. Referral to secondary level of care

Retained products of conception are often the underlying cause of shock. Uterine evacuation is required and is an essential part of definitive management. This should be done as soon as possible.

Once steps have been initiated to stabilize and manage any other severe conditions, and the underlying cause of shock cannot be treated at the site, maintain supportive treatment and refer the woman to a secondary facility where treatment is available.

Management of moderate to light vaginal bleeding

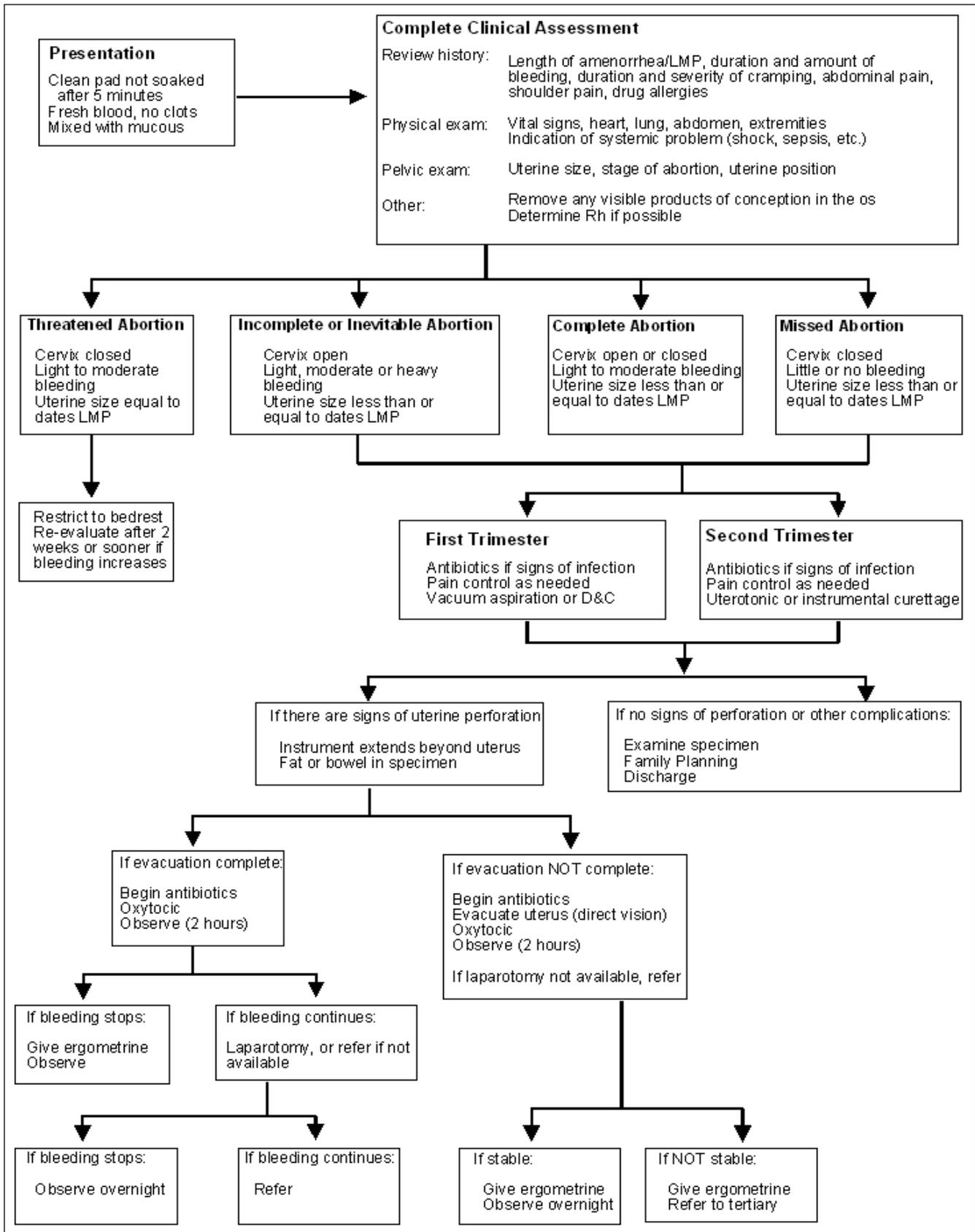


Figure 3. Management of Moderate to Light Vaginal Bleeding

Treatment

Universal Measures

- Monitor the woman's vital signs and general condition. When complications exist, it is important to continue stabilizing steps and to achieve some stabilization before treating the incomplete abortion. If the patient suddenly worsens, reassess for shock or other complications and treat as appropriate. (See management of shock).
- Oxygen
 - ▶ If the woman is stable and there are no life-threatening complications (i.e. NOT in shock and vital signs normal), oxygen is NOT required. If she is being given oxygen because of a complicating condition, continue oxygen.
- Fluids
 - ▶ If the woman is stable and there are no complications (i.e. NOT in shock and vital signs normal), IV fluids are NOT required.
- Medicines
 - ▶ Oral medicines may be given if the woman is stable and there are no life-threatening complications.
 - ▶ IV or IM route of administration is the ONLY acceptable route for medicines if the woman is in shock.
 - i. **Antibiotics.** IV preferred. If there is any sign of infection, abdominal injury, ectopic pregnancy, or cervical or uterine perforation, give broad spectrum antibiotics effective against Gram-negative, Gram-positive, anaerobic organisms and chlamydia.
 - ii. **Tetanus Toxoid.** IM. If there is a possibility that the woman was exposed to tetanus, and there is any uncertainty of her vaccination history, give her tetanus toxoid and tetanus antitoxin. (If the abortion was not performed with sterile instruments, and/or if there was any contamination of the instruments or wound with dirt, there is a chance of exposure to tetanus).
 - iii. **Pain control.** Give medications as needed.

Uterine Evacuation Techniques (at the district hospital or any secondary health care facility)

The woman should be referred to evacuate the uterus by any of the following techniques:

- The techniques of uterine evacuation typically used in the first trimester of pregnancy are *manual vacuum aspiration (MVA)*
- Dilation and curettage (D&C).

Manual vacuum aspiration (MVA): This technique uses a hand-held vacuum syringe and flexible plastic cannulae. Where staff are trained in the technique and equipment is available, MVA can be used to treat abortions through 12 weeks uterine size.

Dilation and curettage (D&C): This technique, also called instrumental uterine curettage or sharp curettage, uses metal surgical instruments to empty the uterus, usually under general or regional anesthesia, or heavy sedation. The use of D&C requires operating theatre facilities and staff trained in surgical techniques and general anesthesia.

General Principles of Emergency Postabortion Care

Introduction

A number of issues must be considered in providing emergency postabortion care. Treatment may include stabilization and referral, oxygen, intravenous (IV) fluid replacement, blood transfusion, medicines (antibiotics, pain control, and tetanus toxoid). These topics are discussed below.

Stabilization and Referral

Stabilization and appropriate and timely referral can be essential to help women reach life-saving care. Whether the woman is referred from the primary to the first referral level, or from first referral to tertiary care, the referring site must do what it can to stabilize and treat the woman. The ability of a referring site to get prompt transport for the patient to the referral center can be life saving. Standing arrangements for transport should exist at all health delivery facilities. These may require raising funds through coordination with community resources such as mosques, churches, political leaders, businessmen, drivers, and so forth. If possible, the referring center should alert the referral center that the patient is coming.

The central elements in stabilizing the patient for referral are outlined in Table 7.

Table 7. Stabilizing a Patient for Referral

Elements of emergency resuscitation/preparation for referral and transport
<ul style="list-style-type: none">• Management of the airway and respiration• Control of bleeding• Intravenous fluid replacement• Control of pain

Adapted from WHO, Complications of Abortion: Technical and Managerial Guidelines for Prevention and Treatment

In general, physicians at the PHC level should call the ambulance and arrange for referral or a trained staff member should accompany the patient to the referral center (if ambulance is not available).

- IV therapy (if needed) could be continued during transport
- Oxygen (if needed) could be continued during transport
- The woman should be kept warm and her feet should be elevated in cases of shock or hemorrhage (do not use external sources of heat, as the skin could be easily burned, instead use blankets or a similar type of covering).
- A summary of the case should be sent with the woman to the referral center. This should include:
 - ▶ Immediate and past history of the presenting problem
 - ▶ Assessment made at the referring site of the patient's condition
 - ▶ Actions taken at the referring site

- ▶ Other relevant information obtained by the referring site (for example, patient has a seizure disorder)

Intravenous (IV) Fluid Replacement

In many instances of abortion complications, women will require some fluids for volume replacement. Generally, an isotonic solution (0.9 % sodium chloride, also known as normal saline) or a compound solution of sodium lactate is preferred. Saline with or without glucose can be used, depending upon availability.

Note: Glucose solutions without saline do not provide the salt required to restore fluid balance

- A large bore needle, preferably 16-18 gauge, is desirable for starting IV fluids so that fluids may be given rapidly and so that blood can be given later, if needed. However, a 20 gauge is acceptable if a larger size is not available.
- Any necessary blood samples for laboratory tests should be drawn when the IV needle is being inserted. Blood drawing at a later point could be more difficult as veins tend to collapse and are found deeper from the surface when shock or other life-threatening complications are present. In addition, this protects the woman's comfort and is a more efficient use of sterile supplies.
- Rapid infusion of fluids can be life-saving in the case of shock from reduced blood/fluid volume. Fluids can be infused at 500 cc to 1 liter in 15-20 minutes while the woman's condition is being monitored. Normally it takes 1 to 3 liters of IV fluids, infused at this rate, to stabilize the patient in shock.
- Once the woman's low fluid volume has been corrected, fluids should be infused at a maintenance rate of 1 liter in 6-8 hours.

Table 8. IV Fluid Rates

Amount of fluid	Time period	Drops per minute
1 liter	20 minutes	Too fast to count
1 liter	20 minutes	Too fast to count
1 liter	4 hours	40
1 liter	4 hours	80
1 liter	6 hours	28
1 liter	6 hours	56

1 liter	8 hours	20
1 liter	8 hours	40

- When the patient has recovered sufficiently to take fluids by mouth, the IV may be discontinued unless it is required for giving medicine.
- If the IV is **only** being used to give medicines, a single liter should be infused over 10-12 hours.
- It is important to monitor the amount of fluids given. As the patient recovers, take care not to overload her with fluid. Any evidence of swelling, shortness of breath, or puffiness may indicate fluid overload. If this happens, discontinue fluids. Diuretics may be necessary if fluid overload has caused pulmonary edema.

Administration of Medicines

- Safety, need, and route of administration are important issues to consider when deciding when, what, and how to use medicines to treat a patient.
- Before giving medicine it is important to always ask if the patient has ever had an allergic reaction to that medicine and if so choose a different medicine less likely to cause a reaction. It is important to NOT give oral medications to a patient in shock, as she may vomit and inhale the vomit.
- The route of administration is an important decision for reasons of safety and for choosing the best possible way to treat the condition. The choice of routes - IV (intravenous), IM (intramuscular) or oral (by mouth) - must be made BEFORE choosing the specific medicines because not all medicines can be given by all 3 routes.
- IV (intravenous)
 - ▶ This route is preferred in the following situations: shock, any life-threatening complication that may urgently require surgery, any serious infection resulting from an incomplete abortion, including sepsis and septic shock.
- IM (intramuscular)
 - ▶ This route is acceptable when IV is not available and if a required medicine can be given this way; some medicines are not effective when given IM.
- Oral (by mouth)
 - ▶ It is not preferred to give medication by mouth to abortion or postabortion women because after referral, the providers at the secondary level may need to anaesthetize the patient.
 - ▶ Do NOT give any medicines by mouth to a woman in shock or if there is an intra-abdominal injury, uterine perforation, ectopic pregnancy, incomplete abortion or other serious condition requiring immediate surgery.

Antibiotics

- Antibiotics should be used whenever an infection is present. Antibiotics can be life-saving in cases of sepsis, septic shock, intra-abdominal injury and uterine perforation. When there are no complications, no signs of infection, and the woman is stable, antibiotics are not necessary.
- It is very important to start antibiotics early whenever infection is suspected or present. Antibiotics should be started before surgery.
- IV administration of antibiotics is preferred because it helps to speed delivery of the drug to the affected tissues. When IV fluids are not available, IM administration of the antibiotics is acceptable. Giving antibiotics by mouth is acceptable if IV or IM antibiotics are not available and the woman is not in shock, if the infection is minor, or to prevent an infection that has not yet developed.
- In most cases, broad spectrum antibiotics effective against Gram-negative, Gram-positive, anaerobic organisms and chlamydia are preferable because identification of the particular pathogen is not usually possible and because multiple pathogens may be present. Antibiotics should be given in combination to achieve broadest coverage. More than one choice of antibiotic combinations is listed, in order of preference. If a particular antibiotic is not available or the patient is allergic to it, then one of the other recommended combinations can be used.

Frequently Used Medicines at PHC Level

Analgesics

- Acetylsalicylic acid
- Ibuprofen
- Paracetamol

Antibiotics

- Derivatives of penicillin
- Ampicillin
- Chloramphenicol
- Metronidazole
- Tetracyclines
- Sulfamethoxazole
- Sulfamethoxazole-trimethoprim

Antiseptics

- Chlorhexidine
- Betadine

Disinfectants

- Bleach
- Formaldehyde
- Glutaraldehyde

Uterotonics

- Ergometrine (injected and by bone)
- Oxytocin injection

Intravenous Solutions

- Glucose
- Ringer
- Sodium chloride
- Potassium chloride

Antirhesus globulin

Antitetanus serum and vaccine

Table 9. Antibiotic Therapy for Infected Abortion

Antibiotic	Dosage	Comments
Ampicillin	1g IV every 4 hours or 500 mg oral every 6 hours	Good broad spectrum antibiotic, inexpensive
Benzympenicillin	10 million units IV every 4 hours	Few serious side effects; effect limited to Gram (+) cocci and gonorrhoea (if not resistant)
Chloramphenicol	1g IV every 6 hours	Good aerobic and anaerobic coverage; effective against chlamydia. Serious side effects are associated with it: <ul style="list-style-type: none"> • Anemia and leucopenia (dose related) • Aplastic anemia (not dose related, rare); • Must be able to monitor blood count to watch for anemia
Gentamicin	1.5 mg/Kg/dose IV or IM every 8 hours	Effective against Gram (-) organisms such as GI tract flora (e.g. E. coli)
Doxycycline or Tetracycline	100 mg IV every 12 hours	Adequate for both Gram (+) and Gram (-) organism, most especially chlamydia; can replace or be used along with ampicillin; good in combination with metronidazole
Metronidazole	1g IV every 12 hours, or 500 mg oral every 6 hours	Good Gram (-) and anaerobic coverage; can be used in combination with ampicillin, doxycycline, inexpensive, generally available; oral administration achieves serum levels equivalent to IV administration

Notes

Penicillin (or ampicillin), gentamicin, and metronidazole are most commonly used together as the broadest spectrum treatment of patients with severe infectious sepsis of a pelvic origin.

Chloramphenicol is quite often available when other drugs are not. It is effective in combination with penicillin or ampicillin.

Once started, intravenous therapy should be continued until the patient is afebrile at least 24 hours, preferable 48 hours. If there is no response in 48 hours, regimen should be changed.

When recovery is underway, intravenous therapy should be followed by oral medication.

Generally tetracycline (500 mg by mouth 4 times daily) or doxycycline (100 mg by mouth 2 times daily) for 10-14 days is advisable. Allergic reactions to tetracycline are very rare. Some patients on tetracycline may develop a rash when their skin is exposed to the sun.

Pain Control

- Many women having abortion complications suffer pain and need prompt and effective medication for their pain. To select appropriate pain control, one must consider the conditions present, the timing and the route of administration, and the precautions for each type of pain control.
- Assess the woman's condition before choosing and giving analgesics. These medications given before the examination can hide symptoms (pain, fever) that are essential to an accurate diagnosis. A patient in shock or requiring surgery should only receive IV or IM medicines.
- Avoid over-sedation because it can cause the patient to be unable to answer questions well. In addition, over-sedation can hide symptoms that are essential to diagnosis. Any narcotic can depress breathing, which can be fatal, therefore, patients receiving narcotics must be under reasonably close observation so that slow or interrupted breathing will be noticed. This is particularly true of patients who are already sick and may be in early shock. It is essential to consider the transit time and transfer conditions for referral patients. Avoid the use of narcotics if the transfer will be without adequate medical supervision and ability to respond to respiratory depression. The dose should be selected to provide adequate pain control during transfer, yet not interfere with the woman being able to answer questions and be accurately diagnosed upon arrival at the referral center.
- Recommended analgesics are:
 - ▶ Morphine (if available) 10-15 mg IM or 1-5 mg IV
 - ▶ Pethidine (if available) 50-100 mg IM
 - ▶ Paracetamol 500 mg PO (by mouth).

Tetanus

- Women who present with complications of abortion may be at risk of developing tetanus. Few women are fully immunized against tetanus.
- Any evidence that the woman has trauma to the genital tract, which may have been contaminated with dirt or feces or has received an abortion in which dirty instruments were used, requires careful attention to the issue of tetanus. The woman's

report of interference with the pregnancy is important although she may not disclose such attempts.

- If the patient has not received a full immunization series in the last 5-10 years or is unsure of her immunization status, or liable to catch infection with tetanus (i.e. contamination is suspected) tetanus vaccine and tetanus antitoxin should be given.

Note: When vaccine and antitoxin are given at the same time, it is important to use separate syringes and separate sites of administration

Diuretics

Give diuretics such as furosemide **ONLY** if there is evidence of heart failure and pulmonary edema, **ONLY** if administered by an experienced provider, and **ONLY** with very careful monitoring of the patient's condition.

Postabortion Contraception⁴

A woman's fertility returns almost immediately after an abortion. She must consider, therefore, whether or not she wants to become pregnant again soon. In the case of spontaneous abortion, she may wish to become pregnant again quickly and, unless there are any medical problems, there is no reason to discourage her from doing so.

For many women, however, their experience with abortion represents a desire not to be pregnant at this time. Thus, the woman, and her partner if she desires, should receive counseling and information about her return to fertility and available contraceptive methods. The health worker must remember that the time of treatment for abortion complications may be a difficult time for the woman and that it may not be the best time to make decisions, which are permanent or long lasting. Selection of all methods, but especially a provider-dependent method, must be done with full and informed consent.

Unless there are major complications from the abortion, most methods of contraception may be started at the time of treatment.

Counseling Postabortion Women

Postabortion Contraception

Postabortion contraception is the initiation and use of family planning methods most often immediately after treatment for abortion, within 48 hours, or before fertility returns (2 weeks postabortion). The objective is to prevent unintended pregnancies, particularly for women who do not want to be pregnant and may undergo a subsequent unsafe abortion if contraception is not made available during this brief interval.⁵

Postabortion Counseling

Prior to more in-depth counseling, a provider may encourage women and their partners to consider issues such as:

- Whether they want more children, whether they are content with their current family size
- If they want more children, how long would they like to wait before having another child
- Their satisfaction, and successes and failures with contraceptive methods used previously
- Their plans regarding breastfeeding
- If the client is interested in contraception, providers should use counseling skills to help the client focus on which method or combination of methods may be most appropriate.
- Clients and their partners should be offered the opportunity to have their questions clarified, particularly the effect of family planning methods on breastfeeding, correct use of methods, and the resumption of sexual relations following delivery.

The goal of postabortion counseling

- To help each woman decide if she wants to use a contraceptive method

- If she does, to help her choose an appropriate method
- To prepare her to use the method effectively

Remember, acceptance of contraception or of a particular contraceptive method should never be a prerequisite for obtaining reproductive health care.

The GATHER Approach to Postabortion Family Planning Counseling

GATHER is an acronym for **GREET-ASK-TELL-HELP-EXPLAIN-REFER**. Each of these represents an important element of family planning counseling, including postabortion family planning counseling.

Following the GATHER approach, postabortion family planning counselors should:

G

GREET the woman politely by name. Introduce yourself by name. Ask the woman how she is feeling and if she feels well enough to talk with you about family planning.

If she does not feel well enough to talk: Make arrangements to return to speak with her later. Give her a brochure or card with your name on it, and invite her to ask for you before she leaves. If possible, find out when she will be discharged and make arrangements to return before she leaves.

If she feels well enough to talk: Go with her to a place where you can talk privately. Ask the woman if she would like to include her partner or anyone else in the discussion or if she prefers to speak with you privately. Explain to her that you will not tell others what the two of you discuss, and honor this commitment. Women treated for postabortion complications often need extra reassurance about confidentiality.

A

ASK the woman how she is and when she will go home. Express concern and empathy for her situation. Some women will want to talk about their treatment, and others may not. The woman has just experienced a medical emergency and may still be frightened and in pain. She may be worried about how she will get home or who is taking care of her children. Be prepared to talk with her about her immediate concerns first. If she has questions about her treatment or her health, be prepared to be her advocate and help her obtain information from doctors or nurses. Make sure she has been told about symptoms that would require her to return for further medical care.

Discuss with her in broad terms the events that led up to her emergency treatment. The woman's condition may have resulted from the miscarriage of a wanted pregnancy. Do not assume that all women treated for abortion complications want to avoid another pregnancy. Ask whether or not she wants to become pregnant again soon. Tailor your discussion to the woman's responses.

If she desires pregnancy again soon: Express compassion for her loss and help her to obtain the reproductive health services she needs.

If she does not want to become pregnant again soon: Help her to reduce the chances of another unintended pregnancy by offering her family planning.

The woman may lack access to family planning or may worry about side effects of using modern methods. She may be under pressure from her partner (or family) to use (or not to use) a particular method. She may be exposed to sexual coercion or violence. Do not assume anything about the woman, the circumstances of her unintended pregnancy, or her reasons for abortion. Instead, listen to her and express empathy. Help the woman to assess whether the events that caused her unintended pregnancy could lead to another pregnancy. Help the woman to assess her need for contraception, including a realistic view of whether or when she will have sexual intercourse again. For example, an adolescent may say that she is not going to have sex again, but she may either change her mind or be pressured into sex later. Some women who do not want to resume sexual relations immediately may nevertheless be pressured or coerced by partners.

In counseling the woman, emphasize three points:

1. She could become pregnant again right away.
2. She can delay or avoid another pregnancy by using family planning.
3. You can help her obtain and use family planning services.

Ask the woman if she is interested in learning more about family planning. Ask if she has ever used family planning.

If she has never used family planning: Ask her what she has heard about family planning. Ask if she prefers a particular method and for what reasons. Encourage her to ask questions, and answer them clearly and directly.

If she has used family planning in the past or was using a method when she became pregnant: Help her to assess what went wrong so that she can avoid another unintended pregnancy. She may distrust her contraceptive method or even all methods. She may need help correcting her method use, finding reliable resupply, talking with her partner, or switching to another method.

T

TELL the woman briefly about various family planning methods as appropriate, relating them to her particular situation and needs. For example, if she says she does not want another child for several years and wants a method that she does not have to worry about every day, tell her especially about the long-term effectiveness of injectables, *Norplant* implants, and the IUD, if these methods are available. Use any visual aids you have, such as flip charts, posters, and brochures, to better describe the methods. Have samples of various methods available so that the woman can see them and handle them if she wishes. Encourage her to ask questions.

H

HELP the woman consider her own situation and her contraceptive needs as well as any other issues that affect her ability to use contraception (including the situation that led to unintended pregnancy). Help her to decide which method or methods best fit her needs. If the woman wants a particular method and has no medical reason not to use that method, focus on that method to help her decide whether it will meet her needs. For example, you can ask, “Do you think you can remember to take a pill every day?” or “Can you tell your partner that you are using family planning?”

Do not choose a method for the woman; instead, help her to assess her needs, to match them with the various methods, and to choose the method that best meets her needs and fits her preferences.

Make sure that the woman's physical condition or recent treatment does not rule out the method she wants. (See wall chart, "PAC Counseling" in a later section) Provide the method she has chosen, if medically appropriate.

E

EXPLAIN:

- How to use the method, giving a step-by-step description
- How to discuss use with her husband, if possible
- How to become comfortable and accustomed to using the method
- How to continue use, including how and where to get supplies and follow-up care when needed
- How to deal with common side effects, if any, including which symptoms are not serious, and which, if any, could be warning signs of a more serious condition that requires seeing a doctor or nurse.
- Encourage the woman to ask any questions. Ask her to repeat instructions to be sure that she understands.

R

REFER the woman for a return visit and follow-up care, as needed. If the woman traveled a long distance for emergency treatment, refer her to a family planning clinic or another source of family planning close to her home, whenever possible. Encourage her to see a family planning provider any time that she needs more supplies or has questions or concerns.

At any follow-up visit:

- Assess whether the woman is in good health and satisfied with the method she is using.
- Address any side effects
- Support and encourage the woman to continue effectively using contraception, if that is her intention.
- Help the woman stop or switch methods when she wishes or when it is appropriate for medical reasons.
- If the woman did not have the opportunity to make an informed choice at the time of her postabortion treatment, the follow-up visit should include complete family planning counseling.
- Always ask the woman if she has any questions, and provide the answers. Always ask if the woman needs other reproductive health care, and provide appropriate care or referral.

Essential Information for All Postabortion Clients⁶

- The prompt return of ovulation can lead to the possibility of unwanted pregnancy very soon after an abortion (even before the first post-abortion menses).
- The availability on-site or by referral of safe, effective contraceptive methods to prevent additional unwanted pregnancies.
- The availability and location of local sources of family planning services for re-supply of methods, provision of long-term and permanent methods, and related ongoing care.

Postabortion Contraception: Selection Guidelines For Contraceptive Method⁷

1. Non-fitted barriers and spermicides: condom, spermicides (sponge, suppositories, foam tablets, jelly, foam)

- Begin use as soon as intercourse is resumed
- Useful as interim methods if initiation of another chosen method must be postponed
- No medical supervision is required
- Provide some protection against STDs
- Easily discontinued when pregnancy is desired
- Requires continued motivation and regular use
- Resupply must be available
- Use related to intercourse

2. Oral contraceptives

- Begin pill use immediately, preferably on the day of the abortion
- Mechanisms to ensure adequate counseling and informed decision making must be in place
- Highly effective
- Can be started immediately even if infection is present
- Not related to intercourse
- Requires continued motivation and regular use
- Resupply must be available
- Effectiveness may be lowered when certain medications are used (for example, tetracycline, Rifampin, penicillin etc)

3. Injectables (DMPA, NET-EN)

- First injection can take place immediately after abortion in the first or second trimester
- Mechanisms to ensure adequate counseling and informed decision making must be in place
- Highly effective
- Easily administered
- Not related to intercourse
- May cause menstrual changes such as spotting, irregular bleeding; or amenorrhea
- Possible delayed return to fertility
- Resupply must be accessible

4. Implants (Implanon)

- Insertion can take place immediately after abortion

- If adequate counseling and informed decision making cannot be guaranteed, it may be best to delay insertion and provide an interim temporary method
- Highly effective
- Long-term protection (3 years)
- Immediate return to normal fertility following removal
- Not related to intercourse
- May cause menstrual changes such as spotting, irregular bleeding; or amenorrhea
- Less effective in heavier women
- Trained provider required to insert or to discontinue use
- Cost effectiveness depends on long-term use

5. IUD

- IUDs can be inserted immediately after first-trimester spontaneous or induced abortion, if the uterus is not infected.
- If adequate counseling and informed decision making cannot be guaranteed, it may be best to delay insertion and provide an interim temporary method.
- If infection is evident or suspected, delay insertion until the infection has been resolved and use an interim method.
- Highly effective
- Long-term protection (10 years)
- Immediate return to normal fertility following removal
- Not related to intercourse
- May increase menstrual bleeding and cramping

6. Female sterilization for medical reasons

Note: Female sterilization (tubal ligation method) is only indicated if the reoccurrence of pregnancy threatens the life of the woman OR if she suffers from a severe medical condition worsened by pregnancy such as renal failure, hepatic failure, malignancy, uncontrolled diabetes, etc.

- It is imperative that adequate counseling and informed consent precede sterilization procedures, which is unlikely in the emergency context.
- Technically, sterilization procedures can be performed immediately after first-trimester spontaneous or elective abortion and after treatment of abortion complications unless infection or severe blood loss is present.
- Infection or the potential for infection as in complications of unsafe abortion indicate the need to delay the tubal occlusion.
- Sterilization after a first-trimester abortion is similar to interval procedures; after a second-trimester abortion it is similar to a postpartum procedure.
- Permanent method
- Most effective female method

- Once completed, no further action required
- Permanence of the method increases the importance of adequate counseling and fully informed consent; this is not likely to be possible at the time of emergency care.
- Slight possibility of surgical complications

7. Periodic abstinence

- Not recommended for immediate postabortion use
- The first ovulation after an abortion will be difficult for the woman to predict and the method is unreliable until after the first postabortion menses.
- No cost associated with method
- Unreliable immediately after abortion
- Alternative methods are recommended until resumption of normal cycle
- Women and their partners must be motivated and have a thorough understanding of how to use the method.

Postabortion Contraceptive Choices for Breastfeeding Women⁸

First choice: non-hormonal methods

- Lactational amenorrhea method (LAM)
- Diaphragm
- Male and female condoms
- Spermicides
- Intrauterine devices (IUDs)
- Male and female sterilization
- Natural family planning (NFP)

Alternative choice: progestin-only methods

- Progestin-only pills (POPs)
- Injectables (DMPA, NET-EN)
- Subdermal implants (Implanon)

Less preferred choice: combined estrogen-progestin methods

- Combined oral contraceptives (COCs)
- Monthly injectables (Mesigyna, Cyclofem)

Postabortion Referral From Primary Health Care Level To Hospitals (Secondary Health Care Level)⁹

Definition of Referral

Referral was defined as a process in which the treating physician at a lower level of the health service, who has inadequate skills by virtue of his qualification and/or fewer facilities to manage a clinical condition, seeks the assistance of a better equipped and/or specially trained person, with better resources at a higher level, to guide him in managing or to take over the management of a particular episode of a clinical condition in a beneficiary.¹⁰

Types of Referral

In health center practice, a referral is requested in two main situations:

1. **Emergency:** Emergency referral is made in emergency cases, which cannot be totally managed at the health center. Emergencies are defined and classified according to *Principles and Practice of Primary Health Care*, which is used as a manual at the health centers.
2. **Routine:** Routine referral is usually made to:
 - ▶ Seek expert opinion regarding a patient
 - ▶ Seek admission and management of a patient
 - ▶ Seek facilities for investigation.

Referral system in all primary health care settings must:

1. Ensure the utilization of the health care system equally by all members of the community, including the socially vulnerable groups, and through this system achieve equitable accessibility to the secondary and tertiary health care network.
2. Raising public awareness of the referral system, and training health professionals and managers, are recommended to gain public trust and help achieve effective and efficient handling of referral tasks.
3. The private and NGOs sectors' roles in the provision of referral services within the national health policies should be clearly defined.
4. Detailed clinical criteria of referrals should be made for objective justification of referrals.

Setting Up a Referral System

A postabortion care referral system is a network among health care providers and facilities that makes emergency treatment more accessible more quickly to more women. A referral system offers women some degree of postabortion care at every level of the health care system, while linking the different levels through an established communication and transport system. In a well-designed referral system, postabortion care is decentralized as much as possible, with each level of care playing a specific role.

Within a postabortion care referral system, providers at all levels of the health care system are trained to:

- **Recognize** complications of abortion and gauge their severity
- **Treat** complications promptly when they have the skills and equipment
- **Refer** women they are unable to treat to a facility where they know adequate treatment is available.

Postabortion Care Referral Network¹¹

Table 10. Community Level and Primary Level Postabortion Care Referral Network

Staff May Include	Emergency Postabortion Care Provided	Facilities Needed	Equipment and Supplies Needed	Family Planning Services Offered
Community Level				
<p>Those given basic health training, including community groups who were trained with TAHSEEN such as:</p> <ul style="list-style-type: none"> • <i>Raedat rifat</i> (MOHP and NGO) • Agricultural extension workers • Religious leaders • Youth leaders • Literacy facilitators • Traditional birth attendants 	<ul style="list-style-type: none"> • Recognition of abortion complications and spontaneous abortion • Timely referral to formal health care system • Health education on unsafe abortion • Family planning information, education, and counseling 	<ul style="list-style-type: none"> • Usually none at this level • Good communication with primary health care facility is essential 	<p>If available:</p> <ul style="list-style-type: none"> • Health education materials (client brochures, leaflets) • Counseling materials (brochures, flipchart) 	<ul style="list-style-type: none"> • Counseling and education • Referral to health professionals at the health units

Staff May Include	Emergency Postabortion Care Provided	Facilities Needed	Equipment and Supplies Needed	Family Planning Services Offered
Primary Level				
<ul style="list-style-type: none"> • GP physician(s) • Nurses • Auxiliary health workers including: <ul style="list-style-type: none"> • Auxiliary nurse • Midwives • Health assistants • Lab technicians • Outreach workers (RR) 	<p>All community level activities plus:</p> <ul style="list-style-type: none"> • Simple physical and pelvic examination, especially taking vital signs and determining uterine size • Diagnosis of stages of abortion • Resuscitation and preparation for treatment or transfer, including: <ul style="list-style-type: none"> • Management of airway and respiration • Control of bleeding • Pain control • Hematocrit/haemoglobin test • Initiation of antibiotic therapy, intravenous fluid replacement, and oxytocics • Pain control including paracervical block, simple analgesia, and sedation • Referral 	<ul style="list-style-type: none"> • Outpatient clinic • Side laboratory • Family planning clinic • Antibiotics, and pain control medications 	<p>Those listed for the community level plus:</p> <ul style="list-style-type: none"> • Examination couch/table • Gloves, protective clothing • Vaginal specula • Soap/disinfectants • Emergency resuscitation kit • Essential drugs • Side laboratory equipment • Transport vehicle or standing arrangements for transport 	<p>All community-level services plus:</p> <ul style="list-style-type: none"> • Injectables • IUDs • Implanon implants (where available) • Referral for tubal ligation (if medical reasons exist) • Follow-up

Referral from Secondary Health Care Level to Primary Health Care Level (Referral for Follow-up)

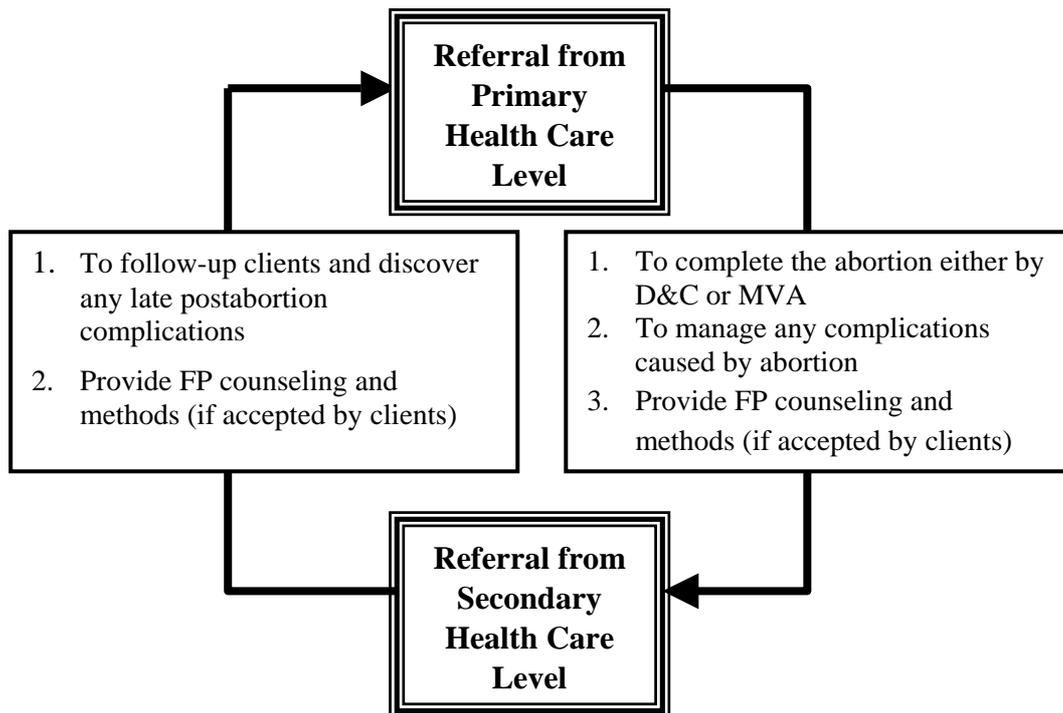
Secondary health care level refers postabortion care clients to the primary health care after stabilization and evacuation of the uterus for the following tasks:

1. Continue follow-up of the women through scheduled visits to the health facility or home visits conducted by physicians or trained nurses to:
 - ▶ Assess clients for bleeding
 - ▶ Assess clients for infection and fevers
 - ▶ Assess clients for pain
 - ▶ Assess clients for other medical complications
2. Provide family planning counseling and methods to non-users
3. Promote the health benefits of the Optimal Birth Spacing Interval (OBSI)

Tasks completed during home visits:

1. General examination includes:
 - ▶ Pulse rate
 - ▶ Respiration rate
 - ▶ Temperature
 - ▶ Pallor
2. Pelvic examination includes:
 - ▶ Measuring the uterine size and consistency
 - ▶ Detecting any vaginal discharge
 - ▶ Detecting any vaginal bleeding
 - ▶ Detecting any lacerations or traumatic pathologies
3. Health education and counseling includes:
 - ▶ Rapid return of fertility
 - ▶ Family planning methods

Figure 4. Referral Between Primary and Secondary Health Care Levels



Role of Primary Health Care Level in Community Awareness and Mobilization¹²

To reach local communities, it is important to establish, to the extent possible, direct contact with women of childbearing age and their partners as well as influential people in the family, such as mothers-in-law. At this stage, the objective is to eliminate, or at least reduce, the well-known causes that delay emergency interventions – namely, the time needed to identify a problem, make a decision, and find transportation and the time needed for the health care system to take charge.

The success of these efforts depends on a functional referral system.

The communities, for instance, could organize emergency transportation services and village funds to be ready for the actual services. They need to obtain the support of local authorities and influential people (“the decision makers”); the heads of local groups (especially women’s groups and youth groups); relevant nongovernmental organizations (NGOs); administrative, religious, and traditional leaders; and all those likely to promote PAC and RH education, such as sports clubs, worksites, and schools.

Community and Service Provider Partnerships¹³

- This element recognizes community members’ vital role in treatment, prevention and advocacy efforts.
- Community health education and mobilization have been identified as key strategies to combat:
 - ▶ Unsafe abortion

- ▶ Increase access to and quality of postabortion care programs
- ▶ Improve women's reproductive health and lives
- To achieve universal local access to sustainable, high-quality postabortion care and related health services, community leaders and advocacy groups, lay health workers, traditional healers and formally trained service providers must work in partnership. Components of this partnership include the following:
 - ▶ Education to increase contraceptive use and thereby help women prevent unwanted pregnancy, space births and reduce unsafe abortion
 - ▶ Participation by community members in decisions about availability, accessibility and cost of services
 - ▶ Education about obstetric emergencies and appropriate care-seeking behaviors
 - ▶ Mobilization of community resources, including transportation, to ensure that women experiencing obstetric emergencies receive timely care
 - ▶ Access to services for special populations of women, including adolescents, women with HIV or AIDS, women who have experienced violence or genital cutting, women who have sex with women, refugees, commercial sex workers, and women with cognitive or physical disabilities
 - ▶ Advocacy for holistic, human rights-based reproductive health policies and services that meet community expectations, priorities and needs
 - ▶ Planning for sustainability

Role of Unit's Health Team

1. Plan and conduct meetings and seminars with the community leaders
2. Plan and conduct meetings and seminars with the target audiences such as women of reproductive age, mothers, husbands, and mothers in law
3. Participate in community events to present the philosophy behind PAC
4. Communicate with NGOs to support PAC activities
5. Establish fund raising mechanisms to facilitate transport of PAC cases
6. Conduct outreach visits to women who received PAC
7. Promote family planning services and methods to prevent abortion and its complications
8. Encourage community groups who trained with the TAHSEEN Project, such as religious leaders, agricultural extension workers, NGO outreach workers, youth groups and others to promote OBSI and FP to prevent abortion

PAC Counseling Wall Chart

خطوات المشورة لحالات ما بعد الإجهاض

بعد العملية

التحدث مع المريضة بطريقة ودية
وطمأننتها على صحتها مع توضيح الآتي:

- الحاجة إلى الراحة
- التغذية السليمة
- عودة الخصوبة في خلال أسبوعين
- أهمية استخدام وسيلة لتنظيم الأسرة
- علامات الخطر
- مواعيد وأهمية المتابعة



أثناء العملية

- التحدث إلى المريضة بطريقة ودية
وتهدئتها
- شرح مبسط لما يحدث أثناء العملية
- مساعدة المريضة على الاسترخاء
والتخفيف من آلامها



قبل العملية

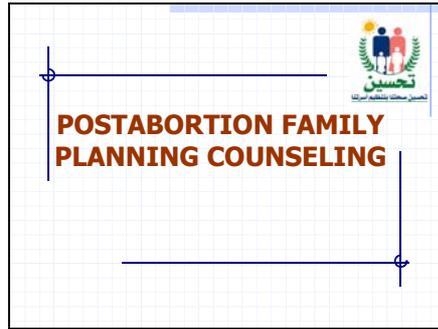
- طمأنة المريضة وتشجيعها
- أخذ موافقة المريضة على إجراء العملية
- شرح مزايا المخدر الموضعي مقارنة
بالمخدر الكلي
- وصف مبسط لخطوات العملية
- الرد على تساؤلات المريضة
ومخاوفها
- بدء المشورة بخصوص تنظيم الأسرة



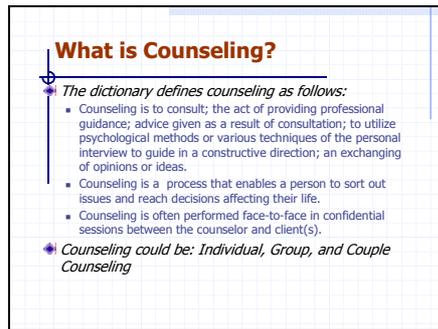
PowerPoint Presentations

1. Postabortion Family Planning and Counseling
2. Referral

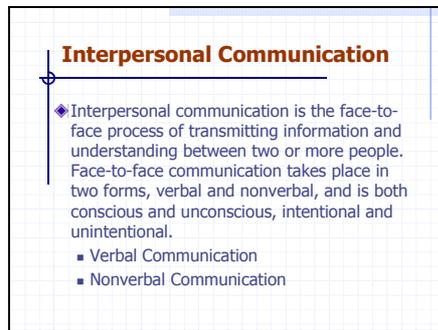
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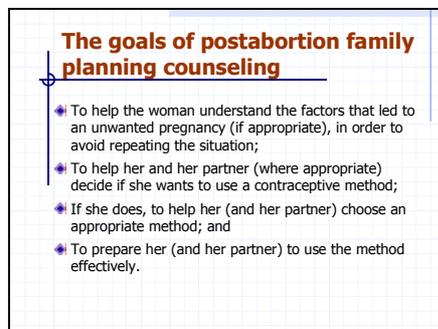
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Slide 3



Slide 4



Slide 5

Free and informed choice

- ◆ Free and informed choice means that the client chooses a method voluntarily without coercion or pressure.
- ◆ It is based on a clear understanding of the benefits and limitations of the methods that are available.
- ◆ The client should understand that almost all methods can be used safely and effectively immediately after treatment of an incomplete abortion and that she can choose another method later if she wishes to change.

Slide 6

General Approach to Counseling

- ◆ Counseling is a two-way communication process
- ◆ Counseling is an ongoing process and must be part of every client-provider interaction in health care delivery.
- ◆ Counseling should take place in a private, quiet place.
- ◆ Confidentiality must be ensured, both in the process of counseling and the handling of client records.
- ◆ It is essential that counseling take place in a non-judgmental, accepting and caring atmosphere.

Slide 7

General Approach to Counseling (Cont.)

- ◆ The client should be able to understand the language the provider uses.
- ◆ Clinic staff must use good interpersonal communication skills, including the ability to question effectively, listen actively, summarize and paraphrase clients' comments or problems and adopt a non-judgmental, helpful manner.
- ◆ The client should not be overwhelmed with information.
- ◆ Use audiovisual aids and contraceptive samples
- ◆ Always verify that the client has understood what has been discussed.

Slide 8

Specific Approach for Counteracting Rumors and Misinformation

- ◆ Always listen politely. Don't laugh.
- ◆ Define what a rumor or misconception is.
- ◆ Find out where the rumor came from and talk with the people who started it or repeated it.
- ◆ Explain the facts.
- ◆ Use strong scientific facts to counteract misinformation.
- ◆ Always tell the truth.
- ◆ Clarify information with the use of demonstrations and visual aids.
- ◆ Reassure the client by examining her and telling her your findings.

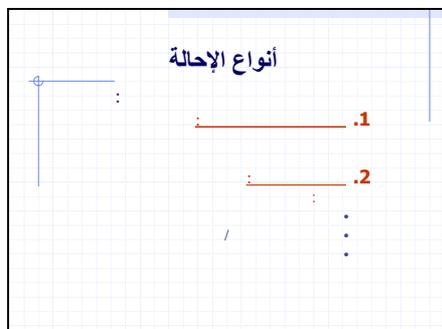
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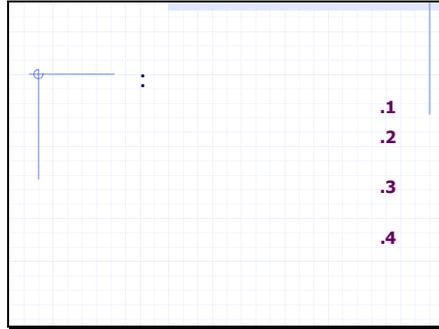
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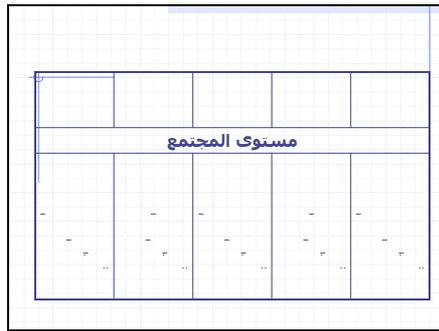
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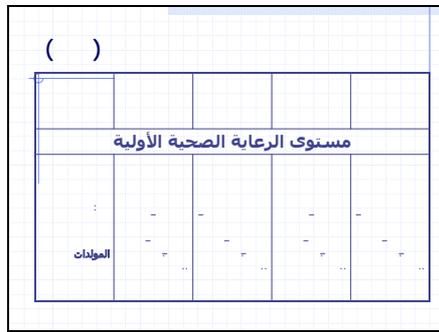
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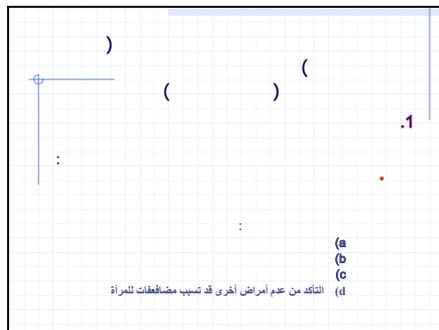
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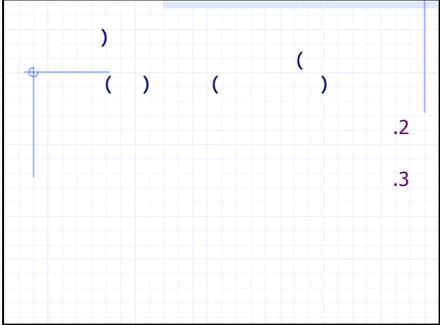
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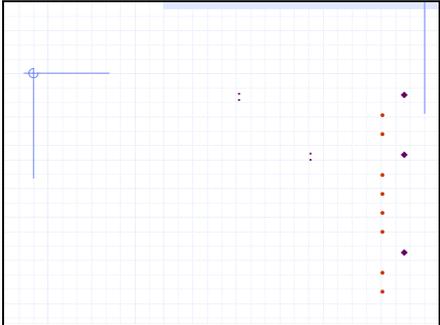
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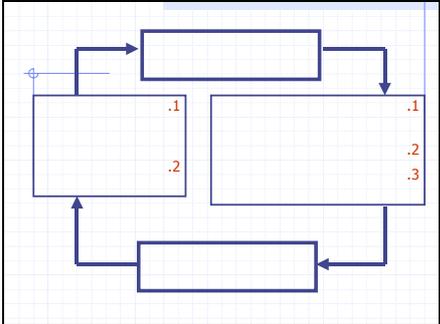
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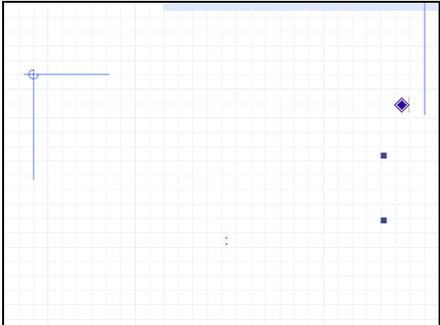
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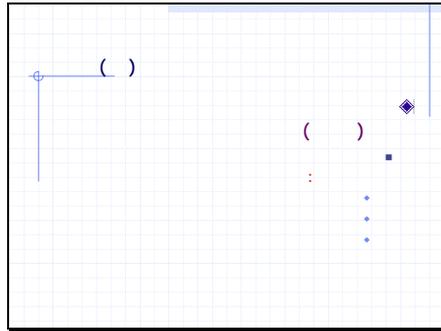
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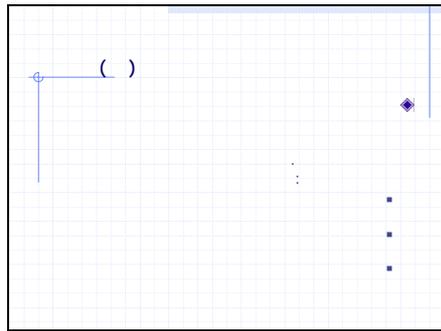
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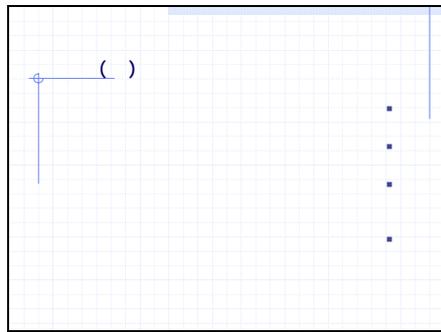
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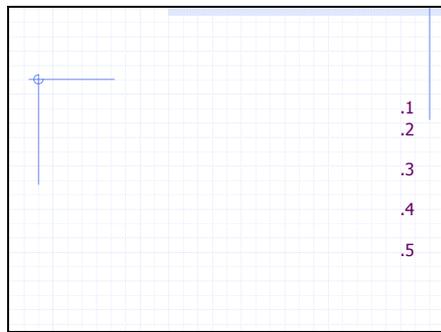
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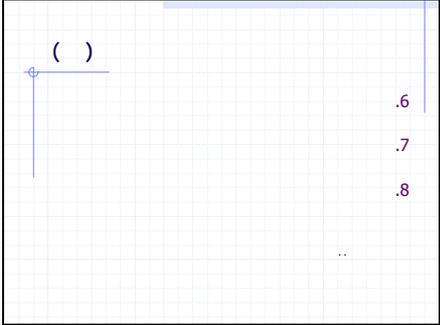
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