MAIN CONTENTS

Chapter 5: Abortion care

contents

contents (continued)

1. Introduction

Ensuring good health and moving towards the realization of human rights for all requires that individuals have access to quality healthcare, which includes comprehensive abortion care – comprising information, management of the abortion process, and post-abortion care. Lack of access to safe, timely, affordable, and respectful abortion care poses not only physical risks, but also mental and social ones, which affect the well-being of those seeking abortion.

The objective of this chapter is to provide evidence-based recommendations regarding the entire abortion process, including the pre-abortion period, the abortion process itself, and post-abortion care.

1.1 Definition

Abortion can be spontaneous (also called miscarriage) or induced. Abortion can be induced surgically (e.g. by vacuum aspiration, or dilatation and evacuation [D&E]) or medically (e.g. using an antiprogestogen with prostaglandins or prostaglandins alone).

Induced abortion is a common procedure throughout the world and one of the safest medical procedures when performed by trained individuals using the proper equipment or quality-assured medical abortion drugs, the correct technique, and sanitary standards. According to the World Health Organization (WHO), medical abortion can also be self-managed by clients safely and effectively, without the supervision of a healthcare provider [1].

Each year, an estimated 25 million unsafe abortions take place globally, almost all of them in low- and middle-income countries. Between 4.7 per cent and 13.2 per cent of maternal deaths can be attributed to unsafe abortion [2].

Acronyms

D&E	dilatation and evacuation
EVA	electric vacuum aspiration
FGM	female genital mutilation
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
MVA	manual vacuum aspiration
NSAIDs	non-steroidal anti-inflammatory drugs
SGBV	sexual and gender-based violence
STI	sexually transmitted infection
WHO	World Health Organization

Comprehensive abortion care can be provided through various pathways, including in-clinic care as well as through out-of-clinic care models. Out-of-clinic pathways to care include, for example, through digital health interventions, home provision of medical abortion, or supported self-care. In a growing number of countries, guidance no longer restricts the provision of abortion care to registered facilities, enabling health workers, clinics, and organizations to innovate and use new models of care to increase reach and access to a greater number of clients, in particular those who may have difficulty accessing in-clinic care due to geographical location or other challenges. Adapting existing healthcare delivery models and introducing new pathways to care allow for a more person-centred approach to abortion care, enabling women and girls and people who can get pregnant* to end a pregnancy through a pathway that is most suited to their personal situations and preferences (see *Chapter 1: Guiding principles and approaches* for more information on inclusivity).

* These guidelines are inclusive of women and girls and all people who can become pregnant, including intersex people, transgender men and boys, and people with diverse gender identities that may have the reproductive capacity to become pregnant and have abortions. For the purposes of these guidelines, references to 'women and girls' refer to all people who have the capacity to become pregnant.

Comprehensive abortion care includes:

- Planning of care that is sustainable, accessible, decentralized and closer to clients, affordable and acceptable, and addresses the needs of young people and other groups; this should include the implementation of different pathways to care including in-clinic care, telehealth, home-based care, and support for self-care.
- Care structured with the individual at the centre and offered based on human rights and gender equality principles; in addition, healthcare provision efforts must be gender transformative and non-stigmatizing.
- Empathetic counselling and support, addressing physical and psychological needs, including access to other sexual and reproductive healthcare, such as screening (e.g. sexually transmitted infections [STIs], gender-based violence), contraceptive counselling and provision to allow immediate post-abortion start, if requested.
- Competent abortion providers using safe technologies such as vacuum aspiration or medical regimens to ensure successful abortion and management of complications, including referral to other healthcare, as appropriate.
- Follow-up care, if needed or wanted, including contraception (if not provided at the time of the abortion care) and management of complications in line with current evidence-based recommendations.

1.2 Legal considerations

The vast majority of women live in countries where abortion is legally available for at least one indication. As of 2019:

- 5 per cent of women (90 million) live in countries that prohibit abortion under any circumstances
- 36 per cent of women (596 million) live in countries where abortion is only indicated to save a woman's life or preserve health
- 59 per cent of women (976 million) live in countries where abortion is allowed on broad social or economic grounds or on request [3]

In countries where abortions are permitted at the request of the pregnant individual, most adopt gestational age limits.

In countries that legally permit abortion only for specific indications, these include:

- to save the life of the pregnant individual (in some countries, this is the only indication for legal abortion)
- to preserve the health of the pregnant individual (mostly physical and/or mental health)
- pregnancy resulting from rape or incest
- fetal abnormality
- economic and social grounds

In some countries or settings, abortion is legal but access to abortion care is restricted, meaning that complex administrative procedures or legally mandated over-medicalized clinical guidelines must be followed before the abortion can be carried out, even if the basic grounds for legality are met. These types of restrictions can decrease and delay access to abortion care. They can include a mandatory waiting period, a requirement to have an ultrasound examination, the provider's right to refuse to provide abortion, and mandated third-party authorization (e.g. spousal, parental, or judicial). In addition, healthcare delivery limitations can restrict access to legal abortion, such as the need for inpatient care, limitation on the types of providers who can provide abortion care, and need for specialized infrastructure or equipment.

These requirements are often outdated, not evidence based, and do not contribute to the safety of the abortion, but instead further the stigmatization of abortion. As abortions are safer when carried out earlier in pregnancy, all unnecessary requirements that delay care may increase complications [4,5]. Additionally, they may contribute to delay and may preclude access to legal care, due to gestational age limits.

WHO guidelines recommend the full decriminalization of abortion, that abortion be available on the request of the individual without the authorization of any other individual, and that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection. WHO guidelines also recommend against laws and other regulations that restrict abortion by grounds and those that prohibit abortion based on gestational age limits; the guidelines also recommend against mandatory waiting periods, and against regulation on who can provide and manage abortion that is inconsistent with WHO guidance [1].

1.3 Guiding principles

The International Planned Parenthood Federation (IPPF) is committed to a rights-based, person-centred approach to ensure full access to safe abortion care as part of an integrated sexual and reproductive health package, and to thus reduce the entirely preventable maternal morbidity and mortality associated with unsafe abortion. Therefore, IPPF upholds:

- the right of all individuals to decide the number and spacing of children
- the right of a pregnant individual to determine the outcome of their pregnancy, including access to safe abortion and post-abortion care

IPPF supports the provision of comprehensive abortion care according to the most liberal interpretation of national laws and policies. Accordingly:

- Healthcare providers should make every effort to make full use of the law in the country where they work through a liberal, rights-based, client-centred approach and translate it into practice. Healthcare providers should aim to reduce or remove all unnecessary barriers that are not evidence based to improve the access and guarantee the safety and overall quality of care received by clients.
- Clients have a right to accurate, evidence-based information about their health and treatment to best inform their decision-making about their health. In some settings, accurate information may form a 'harm reduction' approach to care.
- In all countries, the provision of post-abortion care – including treatment for incomplete abortion – is legal, and therefore healthcare providers should, at a minimum, provide post-abortion care.

Concerning access to abortion care:

- Pregnant individuals should have access to full and accurate information and counselling on all possible options for their pregnancy and support to make choices that are best for their circumstances.
- When an individual has decided to have an abortion, it should be provided as early as possible and without delay (this is because the earlier care is accessed, more medical and surgical options can be offered, the risk of falling outside legal restrictions on gestational age is lower, and the procedure is safer).
- The available pathways to abortion care and the safety and quality of the methods of abortion are explained to the client and adequate opportunity for questions, discussion, and clarifications is provided.
- Abortion care is provided through a person-centred approach, the client's choice of method and pathway for abortion care is respected, and the utmost is done to provide and/or facilitate that abortion care.
- Referral pathways for where abortion care can be provided – if it is not locally available – should be clear for healthcare providers, as should procedures for managing complications.

Where national guidelines exist, all efforts must be made to incorporate evidence and best practices, to increase access and ensure safety, while simplifying the healthcare delivered when possible. IPPF supports task-sharing, with the aim of demedicalizing abortion and optimizing the use of available human resources to ensure that clients receive timely and high-quality abortion care.

1.4 Requirements for abortion providers

Each facility manager/director and each healthcare provider should be aware of:

- local and national laws, policies, regulations, and guidelines for abortion care, including which safe methods of abortion are available (which also depends on provider skills and available facilities/equipment and training) and the pathways to care permitted (e.g. in-clinic, telemedicine, self-administration at home)
- organizational and professional bodies' policies, procedures, standards, and best practices for healthcare provision, documentation, reporting, auditing, and tracking of referrals
- organizational policy
- when and how to detect, refer, and follow-up with a client who requires specialist or higher-level abortion care, e.g. operative interventions, serious complications

1.4.1 Staff requirements

At a healthcare facility that provides abortion care, adequate numbers of staff with a suitable mix of skills should be trained and assessed as competent for:

- counselling
- determining eligibility for abortion method and contraception (gestational dating and clinical conditions)
- clinical and laboratory examination, when needed
- performing and/or knowing when to refer for ultrasound evaluation, when needed
- surgical and/or medical abortion procedures
- pain management
- infection control and instrument processing
- post-abortion care
- identification and management of medical emergencies
- follow-up care for clients

2. Pre-abortion care

2.1 History-taking and examination

The first task for the healthcare provider is to develop a rapport with the client, to find out what care they are seeking, and to perform a clinical assessment (see *Chapter 2: Facility requirements and client history/examination* and *Chapter 3: Counselling*).

In addition to the routine history-taking and examination recommended for all healthcare, the following steps should be covered during the clinical assessment:

1. Correct assessment of gestational age: this informs the management method and preparation for abortion (see *Box 1* and *Table 2*):
    - Confirm pregnancy if the client is not sure (use procedure described in *Chapter 9: Maternal health, Appendix 2*).
    - Determine gestational age – this can usually be done based on the first day of the last menstrual period alone or in combination with the use of

BOX 1: Why correct assessment of gestational age is important prior to abortion

- Risk of abortion complications increases with gestational age.
- Providers require additional competencies and equipment for higher gestational age.
- Dosing regimens for medical abortion need to be adjusted for gestational age to reduce the chances of a failed procedure (due to insufficient doses) or uterine overstimulation (due to high doses of misoprostol) (see *Table 3* for dosing regimens).
- Surgical abortion over 12–14 weeks of gestation requires per-procedure cervical preparation. However, cervical preparation may be considered for surgical abortions earlier than 12 weeks in clients with specific conditions (e.g. young age and nulliparity, previous cervical procedures, overall higher risk for abortion complications) or when performed by a less experienced provider.

a validation tool. If the last menstrual period is uncertain, physical exam (abdominal/bimanual examination) can be used. The routine use of ultrasound is not required or recommended to provide induced abortion care [1]. However, in certain clinical situations, additional investigations including ultrasound and/or serum beta human chorionic gonadotropin (hCG) may be needed to determine location of pregnancy and/or gestational age (see *Section 2.2*).

2. Identification of any co-existing medical issues that may result in additional care being considered, or one type of procedure being recommended over another:

   - Take the client's medical and obstetric history, history of any gynaecological pathology, and history of any surgical procedures. In particular, note the following:

     - A previous caesarean delivery is not a contraindication for induced abortion. Previous caesarean deliveries or classical uterine scars require additional care under the following circumstances: (a) during surgical evacuations, especially at higher gestational age due to a risk of perforation; and (b) during medical procedures, due to increased risk of uterine rupture. Multiple prior caesarean deliveries can increase risks for either surgical or medical abortion due to risk of implantation in the uterine scar leading to risk of haemorrhage.

     - Fibroids may increase uterine size on examination and affect reliable assessment of gestational age. There is also a small chance that submucosal fibroids can distort the uterine cavity making surgical procedures more difficult.

     - In the presence of uterine malformations or severe distortions of the uterine cavity, a medical abortion may be preferable to surgical evacuation or a surgical procedure may require ultrasound guidance.

     - A history of cervical procedures may make cervical dilatation more difficult and require additional preparation (see information on cervical preparation in *Box 1* – previous page).

     - History of or presence of conditions that increase the risk of an ectopic implantation, including prior ectopic pregnancies, history of pelvic inflammatory disease or abdominal surgeries, pregnancy with an intrauterine device (IUD) in place, or symptoms such as vaginal bleeding/spotting or one-sided pelvic pain.

   - Make note of any co-existing medical conditions such as diabetes, hypertension, asthma, heart disease, coagulation disorder, porphyria, or a history of allergy to medicines.

3. Other points to cover during the clinical assessment:

   - *Current risk of STIs including HIV*: Provide information on the benefits of testing. If the client consents to testing and there is an active STI or a positive HIV test result, provide treatment with information on the benefits, but do not delay the provision of an abortion. If the client has an active STI, treating the STI first before performing a surgical procedure can avoid ascending infection (see *Chapter 6: Sexually transmitted infections* and *Chapter 7: HIV*) but the procedure should not be delayed if access to abortion is difficult and treatment can be started on the day of the procedure.

   - *Current use of contraception, if any*: It may be that the client has been using a method correctly, but it has failed. This is an opportunity to discuss contraceptive options. If an IUD is in place, it must be removed prior to a medical abortion.

   - *Sexual and gender-based violence (SGBV) and female genital mutilation (FGM)*: Any contact with a provider at a sexual and reproductive health clinic is an opportunity to identify people affected by SGBV. The provider should therefore be aware of signs of SGBV. For clients with FGM type III, deinfibulation should be suggested. This can be performed at the same time as surgical abortion, if that is the procedure of choice (see *Chapter 10: Sexual and gender-based violence*).

- *Medications and allergies*:
  - Allergies to mifepristone or misoprostol should be excluded. If allergy is confirmed, a surgical procedure should be considered and/or an alternative medical regimen or cervical preparation, if required.
  - Medications to treat epilepsy and tuberculosis, antiretrovirals, or corticosteroids may reduce the effectiveness of mifepristone if they are taken regularly.

2.2 Other investigations

No other routine investigations are needed for the provision of safe abortion in the first trimester, but the following additional testing can be offered:

- Rhesus status should be established, if possible, and anti-D prescribed for clients with rhesus negative blood type who are having a surgical evacuation or medical abortion over 12 weeks. The procedure should not be withheld, however, if these resources (rhesus testing and anti-D) are not available.
- Blood tests to check haemoglobin can be done if there is a clinical suspicion of anaemia. If the client's haemoglobin level is found to be below 8 g/dl, consideration should be given to treating or referring to a higher-level facility.
- Ultrasound is not recommended or routinely required unless there are concerns or the need to confirm gestational age, such as in the situations listed below. Ensure that the procedure is not unduly delayed because of this.
  - The client does not remember the date of their last menstrual period or has irregular menses, e.g. due to use of progestogen-only contraceptives or breastfeeding, and gestational age cannot be determined by physical examination.
  - There is discrepancy between gestational age as determined by the date of the last menstrual period versus uterine size by bimanual examination.
  - There is suspicion of ectopic pregnancy based on risk factors or small-for-gestational-age uterus.
  - Other conditions (e.g. fibroids).

Post-abortion contraception

Healthcare providers should discuss post-abortion contraception with the client. Clients should be made aware that fertility can return as soon as 8 days after early abortion, with ovulation occurring within 1 month of first-trimester abortions in 90 per cent of clients (see *Section 5: Post-abortion contraception*). If the client chooses a method of contraception, the contraceptive method or a prescription, placement, or appointment for placement if needed, should be provided. However, acceptance of post-abortion contraception should never be a requirement for providing abortion care.

2.3 Information, counselling, and informed consent

2.3.1 Information and counselling

As with any procedure or care, informed consent must be obtained (see *Chapter 3: Counselling*).

Counselling must never be imposed; however, every individual considering abortion should have access to comprehensive, non-directive, and supportive counselling that is responsive to personal needs, circumstances, and cultural background. Clients should always be given access to correct and unbiased information.

The healthcare provider should take time to talk with the client about the available options and not expect an immediate decision (see *Section 2.3.1.1*). If necessary, make it clear that the client can return at another time. However, most clients will have decided firmly not to move through a full pregnancy before seeking assistance from the healthcare provider and should receive care without requiring another visit. The key information in *Section 2.3.1.1* should be provided to a client regardless of where abortion care is taking place (e.g. clinic or by telemedicine).

2.3.1.1 Key information to be provided for informed consent

For all abortion procedures:

- Provide the client with information on all available options for the current pregnancy and clearly document the client's independent decision.

- Inform clients who are eligible for medical or surgical procedures about the characteristics of each mode of treatment (see *Table 2*).
- Explain what the client should expect before, during, and after the procedure, and ensure that the client is made aware of when they may feel discomfort, how long this may last, and what medications will be available to treat it.

For medical abortion:

- Explain the possibility of heavy bleeding with clots, passage of the products of conception, and pain that may be significantly stronger than normal menstrual cramps for some clients; explain that pain relief is available (see *Section 2.4*).
- Explain that medical abortion is a process that typically takes 2–3 days and that bleeding can continue afterwards for 2–3 weeks.

For surgical abortion:

- Explain that an internal examination/instrumentation with a speculum will be needed to insert cervical dilators (if required) as well as an aspirator cannula.
- Explain to the client that they may experience discomfort as the cervix is dilated, painful abdominal cramps during and after the procedure, and that pain relief will be available.
- Explain that for vacuum aspiration the procedure will typically take 5 minutes. D&E procedures may take longer (up to 20–30 minutes).
- The side effects of any analgesia should be discussed and appropriate options for the management of side effects should be offered to all clients.

Regarding risks and complications [6]:

- Inform the client that serious complications following safe medical and surgical abortion are rare (<1 per cent).
- The risk of the following complications is lower for first-trimester abortion than for second- or third-trimester abortion: severe bleeding, uterine rupture, cervical trauma, and uterine perforation.
- For medical abortion at higher gestational age, clients with uterine scars have a low risk of scar dehiscence.
- For surgical abortion, there is a low risk of the following complications that may require transfer to another facility and additional procedures including laparotomy: haemorrhage, uterine perforation, infection, damage to bladder and bowel (<1 per cent).
- Make the client aware of the signs of the following rare complications, so that they can seek appropriate care promptly:
  - Incomplete abortion: This may necessitate additional doses of misoprostol or a surgical intervention to complete the abortion.
  - Infection: This is more common with surgical abortion than with medical abortion and may require antibiotic treatment or transfer to an inpatient facility for additional treatment, if severe.
  - Continuing pregnancy: Continuing symptoms of pregnancy after a failed manual vacuum aspiration (MVA) or medical abortion may also indicate an ectopic location of pregnancy. This will need confirmatory tests and corresponding care (see *Section 4.3.1* and *Chapter 9: Maternal health*).

2.4 Pain management

The two key sources of pain during an abortion are cervical dilatation and uterine contractions. It is important that providers understand the timing of expected pain during the procedure in order to ideally prevent it and to time anaesthesia/analgesia accordingly. Pain relief should be offered to all clients undergoing medical and surgical abortion, and an individualized pain management plan should be made before initiating the abortion. Key points for healthcare providers regarding pain management are given in *Section 2.4.1* and a summary of pain management options can be found in *Table 1* (next page).

2.4.1 Key points for healthcare providers [7]

- Non-pharmacological methods to reduce pain and anxiety for abortion procedures are essential. These include preparing the client during pre-procedural counselling and discussion of what might be

expected and providing verbal reassurance and support throughout the entire process.

- Reducing discomfort for the client may also reduce time taken to perform the procedure.
- In most cases, analgesics such as non-steroidal anti-inflammatory drugs (NSAIDs), local anaesthesia, and/or conscious sedation supplemented by verbal reassurance are sufficient.
- Prophylactic NSAIDs, at sufficient doses, are the first-line analgesics of choice and may reduce the need for narcotic analgesia during surgical abortion. They should also be offered if misoprostol is used for cervical priming.
- To ensure that oral medications (NSAIDs and analgesics) will be most effective at the time of the procedure, administer them 30–45 minutes before the procedure.
- The need for pain management increases with gestational age; narcotic analgesia (with or without anxiolytics) may be required for D&E.
- Local anaesthesia, such as paracervical block using lidocaine, will alleviate discomfort from surgical procedures and should be routinely provided if available (*Appendix 1*).
- Paracetamol (oral or rectal) is ineffective for reducing pain during both surgical and medical abortion but can be used to treat fever and in addition to NSAIDs or, in case of allergy, replace NSAIDs.
- General anaesthesia is not recommended for routine abortion procedures, including routine D&E, as it has been associated with higher rates of complications than analgesia and local anaesthesia.

TABLE 1: Summary of pain management options

	Surgical abortion	Medical abortion
Non-pharmacological methods	• Respectful, non-judgemental communication • Verbal support and reassurance • Thorough explanation of what to expect • The presence of a support person who can remain with the client during the process (if the client desires it) • Hot water bottle or heating pad • Advance notice of each step of the procedure (if the client desires it) • Gentle, smooth operative technique • Encouraging deep controlled breathing • Listening to music	• Respectful, non-judgemental communication • Verbal support and reassurance • Thorough explanation of what to expect • The presence of a support person who can remain with the client during the process (if the client desires it) • Hot water bottle or heating pad • Moving helps to reduce pain (as during labour) • Encouraging deep controlled breathing • Listening to music

Pharmacological methods	• Analgesia (NSAIDs, e.g. ibuprofen 400–800 mg)
	• Anxiolytics/sedatives (e.g. diazepam 5–10 mg)
	• Local anaesthetic (paracervical block using lidocaine, usually 20 ml of 1 per cent or 10 ml of 2 per cent)
	• Conscious sedation (a combination of a sedative to relax and an anaesthetic to block pain) where available
		• Analgesia (NSAIDs, e.g. ibuprofen 400–800 mg)
		• Adjuvant medications may also be provided for side effects of misoprostol (e.g. loperamide for diarrhoea)
		> 12 weeks of gestation
		• Offer at least one of the following other options:
		  ◦ oral opioids (e.g. tramadol)
		  ◦ intramuscular or intravenous opioids
		  ◦ epidural anaesthesia (for higher gestational ages)

Source: WHO [1], Ipas [6].

3. Methods of abortion

3.1 Recommended options for medical and surgical abortion

Abortion can be carried out with medications – using a combined regimen of mifepristone plus misoprostol, or misoprostol alone – or surgically, using vacuum aspiration for gestational ages before 14 weeks or using D&E at or after 14 weeks of gestation.

The following methods are recommended for abortion up to 12 weeks of gestation:

- surgical methods: MVA or electric vacuum aspiration (EVA)
- medical methods:
  - combined medical abortion (oral mifepristone followed by misoprostol)
  - misoprostol alone in repeat doses, where mifepristone is not available

Dilatation and curettage (D&C) is an obsolete method of surgical abortion and should be replaced by vacuum aspiration and/or medical methods [1,8].

The following methods are recommended for abortion at or after 12 weeks of gestation:

- medical methods:
  - combined medical abortion (oral mifepristone followed by repeated doses of misoprostol)
  - misoprostol alone, in repeated doses, where mifepristone is not available
- surgical method: MVA or EVA up to 14 weeks of gestation and D&E using vacuum aspiration and forceps after 14 weeks of gestation

Healthcare providers should ensure that they stay updated on current evidence-based practice and how to provide it in a safe, dignified, and respectful environment. This helps to ensure that clients are empowered to make the best decision on what type of abortion procedure they prefer, including when they choose abortion self-care.

Further details regarding medical and surgical procedures can be found in the next sections and in *Tables 2, 3, and 4*.

TABLE 2: Characteristics of medical and surgical abortion procedures by gestational age range

Medical abortion	Surgical abortion
Gestation <12 weeks	**Gestation <14 weeks**

• Mifepristone + misoprostol (combined medical abortion) or misoprostol alone
• Avoids surgery
• May take place in a healthcare facility OR may be self-managed at home/elsewhere (with access to accurate information, quality medications, and access to a healthcare provider if needed)
• Takes time (hours to days) to complete the abortion, and the timing may not be predictable
• Mimics the process of miscarriage
• Clients experience bleeding and cramping, and potentially some other side effects (nausea, vomiting, slight fever, chills, and diarrhoea)
• Contraceptive options that can be initiated at the time of medical abortion are limited to hormonal methods
• May be preferred in the following situations:
  ◦ client wants to avoid surgical intervention
  ◦ client wishes to administer medication themself (up to 12 weeks)
  ◦ pelvic instrumentation is not feasible or not wanted
  ◦ client is severely obese
  ◦ client has uterine malformations or fibroids
• **Complications** are rare (<5 per cent) but may include: infection, excessive bleeding, continued pregnancy and need for a surgical procedure if abortion fails or is incomplete
	• Vacuum aspiration (manual or electric)
	• Requires instrumentation of the uterus
	• Takes place in a healthcare facility
	• Quick procedure – timing of abortion controlled by the facility and provider
	• Complete abortion easily verified by evaluation of aspirated products of conception
	• All contraceptive methods including tubal occlusion or placement of an intrauterine device (IUD) may be performed at the same time as the procedure
	• May be preferred in the following situations:
	  ◦ contraindications to medical abortion
	  ◦ constraints for the timing of the abortion
	• **Complications** are rare (<1 per cent) but may include: infection, excessive bleeding, cervical trauma, perforation of uterus, bladder, and bowel, continued pregnancy and need for an additional surgical procedure if abortion fails

continued

Medical abortion	Surgical abortion
Gestation ≥12 weeks	**Gestation ≥14 weeks**

• Mifepristone + misoprostol (combined regimen) or misoprostol alone
• Avoids surgery
• Takes place in a healthcare facility; clients remain in the facility until expulsion of the pregnancy is complete (usually day care)
• Takes time (hours to days) to complete the abortion, and the timing may not be predictable
• Mimics the process of miscarriage
• Clients experience bleeding and cramping, and potentially some other side effects (nausea, vomiting, slight fever, chills, and diarrhoea)
• Complete abortion easily verified by inspection of expelled products of conception
• All hormonal contraceptive methods can be started immediately; IUD placement or tubal occlusion can be performed immediately after expulsion
• May be preferred or necessary in the following situations:
  ◦ client wants to avoid surgical intervention
  ◦ client is severely obese
  ◦ client has uterine malformations or fibroids, or has had previous cervical surgery
  ◦ if surgical procedure is unsuccessful
• **Complications** are rare but may include: infection, excessive bleeding, uterine rupture, incomplete abortion or continued pregnancy (more common in early gestations). Retained placenta can occur in at least 10 per cent of cases, which requires intervention with manual removal or an aspiration procedure
	• Dilatation and evacuation (D&E)
	• Requires uterine instrumentation, and requires cervical preparation prior to the procedure
	• Takes place in a healthcare facility
	• Relatively shorter procedure than medical abortion, once cervical preparation is adequate; timing of abortion controlled by the facility and provider
	• Complete abortion easily verified by evaluation of evacuated products of conception
	• All contraceptive methods including tubal occlusion or placement of an IUD may be performed at the same time as the procedure
	• May be preferred or necessary in the following situations:
	  ◦ client has an allergy to mifepristone or misoprostol
	  ◦ constraints for the timing of the abortion
	  ◦ if medical abortion is prolonged or unsuccessful
	• **Complications** are rare but may include: infection, excessive bleeding, perforation of uterus, bladder, and bowel, cervical trauma, incomplete abortion or continued pregnancy

Source: WHO [1], RCOG [9].

3.2 Medical abortion [1]

Medical management of induced abortion at all gestations is most effective when a combination of mifepristone and misoprostol is used (*Box 2*). This regimen also shortens the induction-to-abortion interval and reduces side effects compared with the misoprostol-only regimen. Therefore, for induced abortion (and for cases of intrauterine embryonic or fetal demise), the combined regimen should always be the first choice if mifepristone is available, whereas the misoprostol-only regimen is the alternate choice. For treatment of incomplete abortion, the misoprostol-only regimen is the only recommended regimen. Misoprostol can be administered through a variety of routes (vaginal, sublingual, or buccal), whereas mifepristone is always given orally. See *Table 3* for further details on regimens, doses, and routes of administration for a range of indications.

3.2.1 Self-management of medical abortion

IPPF understands abortion self-care as the right of individuals to lead, in part or entirely, their abortion process, with or without support from healthcare providers. WHO recommendations state that individuals who have access to accurate information, quality-assured medicines, and a trained healthcare provider can self-manage the medical abortion process up to 12 weeks of gestation, including self-assessment of eligibility, self-administration of abortion medicines outside of a healthcare facility, and self-assessing the success of the abortion process using pregnancy tests (at 2–4 weeks post-abortion) and/or checklists.† The self-management of medical abortion is often a preferred alternative for some individuals due to affordability, reduced transportation needs, improved privacy, reduced stigma, comfort, and easier access for people with restricted mobility.

Abortion self-care places the person firmly at the centre of the abortion process; however, multiple stakeholders can also play a role in enabling this and facilitating this approach. The self-management of medical abortion is most effective when individuals have access to accurate information, quality medical abortion pills, and to a trained and empathetic facilitator or provider if needed or desired at any point during the process.

Healthcare providers should recognize self-managed abortion as a valid approach and be ready to play a supportive and enabling role, by acting on three components of support for abortion self-care:

1. **Delivery of accurate and accessible information** on abortion and, particularly, on medical abortion including what to expect, dosage, side effects, and signs of complications. Information can be provided through various strategies including hotlines, peer

BOX 2: Key information about mifepristone and misoprostol and effectiveness of medical abortion regimens

- Mifepristone works by blocking the effects of progesterone and thus inhibiting hormonal and vascular support of pregnancy, inducing cervical ripening and uterine contractions. It also increases the sensitivity of the myometrium to prostaglandins.
- Misoprostol is a prostaglandin analogue that causes uterine contractions and cervical softening (cervical ripening) to allow passage of the pregnancy.
- A combined regimen of mifepristone and misoprostol is recommended for medical abortion; where mifepristone is not available, the misoprostol-only regimen may be used.
- A combined regimen of mifepristone and misoprostol is effective and safe with success rates over 95 per cent, continuing pregnancy rates of less than 2 per cent, and complication rates of less than 1 per cent up to 10 weeks of gestation. Between 10 and 13 weeks, the success rate of mifepristone combined with misoprostol is over 95 per cent, with a continuing pregnancy rate around 2 per cent and complication rate of 3 per cent.
- A misoprostol-only regimen has lower success rates of about 80–85 per cent, with continuing pregnancy rates of 3–10 per cent and complication rates of 1–4 per cent up to 13 weeks of gestation.

Source: Ipas [6].

† There are limited data between 10 and 11 weeks and no comparative data regarding home use of misoprostol as part of a combined regimen after 11 weeks of gestation [6].

provision, websites, or referral to other reliable sources of information and support.

2. **Access to quality medical abortion pills**. People who choose to self-manage abortion can be supported to access quality medical abortion pills, for example by providing digital prescriptions, partnership with pharmacists, and sending pills by post or dispensed by community health workers.
3. **Providing supportive care during the self-care process**. Healthcare providers should ensure readiness to meet the needs of the individual at any point in their abortion process. This includes, for example, providing on-demand abortion counselling when requested and setting up referral networks in case of doubts or for treatment of complications, for post-abortion care, or other relevant care, as needed.

3.2.2 Additional information for care of medical abortion clients

Routine prophylactic antibiotics are **NOT** required for medical abortion at any gestational age if no instrumentation of the cervix or uterus is undertaken nor manual removal of the placenta in second-trimester medical abortions.

For both medical and surgical abortions at less than 12 weeks, WHO recommend against administration of anti-D immunoglobulin to prevent Rh-isoimmunization in Rh-negative clients [1]. At beyond 12 weeks, if available, anti-D immunoglobulin should be given by injection into the deltoid muscle to all Rh-negative clients at surgical abortion or within 72 hours following medical abortion; however, abortion care should not be refused or delayed if this is not possible (see *Section 3.3* for information on surgical abortion).

Regardless of gestational age or which regimen is used (combined or misoprostol only), repeated doses of misoprostol can be considered. Most medical abortions up to 10 weeks will be successful with only one dose of misoprostol, while abortions between 10 and 13 weeks will usually require two doses; above 13 weeks, 3–5 doses may be needed. The WHO abortion care guidelines do not set a maximum number of doses of misoprostol but encourages healthcare providers to use caution and clinical judgement when making this decision [1]. According to WHO recommendations: "Health-care providers should use caution and clinical judgement to decide the maximum number of doses of misoprostol in pregnant individuals with prior uterine incision. Uterine rupture is a rare complication; clinical judgement and health system preparedness for emergency management of uterine rupture must be considered with later gestational age" [1].

Ensure the client has access to pain relief, sanitary pads, and private toilets while awaiting pregnancy expulsion following medical abortion, whether at the healthcare facility or at home.

TABLE 3: Medical management of abortion: WHO recommended regimens

Recommendations	Combination regimen (Recommended) Mifepristone >>1–2 days>> Misoprostol		Misoprostol only (Alternate)
	Mifepristone	Misoprostol	Misoprostol[1]
Induced abortion <12 weeks	200 mg PO once	800 µg B, PV, or SL[2]	800 µg B, PV, or SL every 3 hours[3]
Induced abortion ≥12 weeks	200 mg PO once	400 µg B, PV, or SL every 3 hours[4,5]	400 µg B, PV, or SL every 3 hours[4,5]
Intrauterine fetal demise ≥14–28 weeks	200 mg PO once	400 µg PV or SL every 4–6 hours[4,5]	400 µg SL (preferred) or PV every 4–6 hours[4,5]

Abbreviations: B, buccal (between gum and inside cheek); PO, oral; PV, vaginal; SL, sublingual.

Source: WHO [1], Ipas [6].

1 If the uterine size is 22 weeks AND the client has a history of previous caesarean delivery or 13–22 weeks with more than one previous caesarean delivery), consider lowering the dosage of misoprostol with or without increasing dosing interval.

2 If bleeding does not begin within 24 hours, or if it is unclear whether the abortion has worked, the client can be given four more pills of misoprostol, to be taken in the same way as the initial dose (e.g. buccally, sublingually, or vaginally). It is common for clients to require two doses of misoprostol for pregnancies between 10 and 13 weeks of gestation. If bleeding has not begun within 24 hours of the second dose of misoprostol, consider and evaluate for ectopic pregnancy (see *Chapter 9: Maternal health, Section 4.3.1*) or failed abortion.

3 While some clients may require additional doses of misoprostol to complete an abortion, if bleeding does not begin within 24 hours of the third dose of misoprostol, or if it is unclear if the abortion has worked, consider and evaluate for the possibility of ectopic pregnancy (see *Chapter 9: Maternal health, Section 4.3*) or failed abortion.

4 Refer to information regarding repeat doses of misoprostol above.

5 If the client is stable, providers should allow at least 4 hours after fetal expulsion for passage of the placenta.

3.3 Surgical abortion

3.3.1 Prophylactic antibiotics

To reduce the risk of post-procedure infection, it is recommended that prophylactic antibiotics should be initiated preoperatively or perioperatively, whether the client has requested STI screening or not. Facilities offering surgical abortion should make efforts to secure adequate antibiotic supplies. If antibiotics are not available, however, abortion may still be performed.

3.3.2 Cervical preparation

Adequate cervical preparation decreases the morbidity associated with surgical abortion after 13 weeks, including the risk of cervical injury, uterine perforation, and incomplete abortion. Therefore, cervical preparation before surgical abortion is recommended for all clients with pregnancies beyond 12 weeks and may be considered in specific circumstances for earlier gestations (see *Box 1*). Pharmacologic agents and osmotic dilators can be used for cervical preparation (*Table 4* – next page).

TABLE 4: Cervical preparation for surgical abortion

Up to 14 weeks of gestation	Over 14 weeks of gestation
Misoprostol 400 µg administered vaginally or buccally 2–3 hours prior to the procedure. Misoprostol 400 µg sublingually 12 hours prior to the procedure	**Misoprostol** 400 µg administered vaginally 3 hours prior to the procedure. Misoprostol 400 µg sublingually 1–3 hours before the procedure
Mifepristone 200 mg taken orally 24–48 hours prior to the procedure	**Mifepristone** 200 mg taken orally 24–48 hours prior to the procedure
NOTE: Vaginal administration of misoprostol provides equally effective dilatation with fewer systemic side effects than sublingual administration but needs 3 hours to be effective	**Osmotic dilator** (e.g. laminaria) placed within the cervical canal 6–24 hours before the procedure; if the pregnancy is <18 weeks of gestion, an osmotic dilator will be effective if placed 3–4 hours before the procedure
	For surgical abortion at ≥19 weeks: Recommend cervical priming with an osmotic dilator plus medication (mifepristone, misoprostol, or a combination of both)
	NOTE: Use of misoprostol results in less dilatation than osmotic dilators but has the advantage of being a 1-day procedure for most clients

Source: WHO [1], Ipas [6], RCOG [9].

Analgesics such as ibuprofen and/or narcotics, as well as oral anxiolytics, as needed, should be administered around the time of cervical preparation and repeated, as needed, in advance of the procedure to maximize their effectiveness. Paracervical block can also be used when placing osmotic dilators. For further information on pain management, see *Section 2.4*.

3.3.3 Surgical abortion up to 14 weeks of gestation: vacuum aspiration

Vacuum aspiration is the only recommended surgical method for abortion up to gestations of 14 weeks, with successful abortion rates of over 98 per cent [6].

Either MVA or EVA can be used. MVA does not require a power supply and is quieter for the client. EVA may be more convenient for high-volume sites.

MVA uses a hand-held aspirator to generate a vacuum. The aspirator is attached to cannulas ranging from 4–16 mm in diameter and can be used in multiple settings, including those without electricity.

EVA uses an electric pump to generate a vacuum and can accommodate cannulas ranging from 6–16 mm in diameter, depending on gestational age, with larger-diameter tubing or an adapter required for cannulas larger than 12 mm.

For gestations between 12 and 14 weeks of gestation, MVA can be performed if providers have the appropriate level of competence and the correct equipment, including the appropriate cannula size.

Sharp uterine curettage, including a 'check' routine curettage, is **NOT** recommended for uterine evacuation nor for checking the success of MVA/EVA surgical abortion at any gestation as it has not been shown to decrease rates of incomplete abortion and can increase the potential for complications.

The steps for vacuum aspiration for gestational ages up to 14 weeks are summarized in *Appendix 2*.

3.3.4 Surgical abortion at and above 14 weeks of gestation: dilatation and evacuation (D&E)

D&E involves cervical preparation (see *Section 3.3.2*) and use of aspiration and blunt forceps, as needed, to remove fetal parts. The steps for performing D&E are summarized in *Appendix 3*.

D&E is the only recommended surgical method for pregnancies above 14 weeks of gestation and it is generally safe and effective; however, trained and skilled providers and specific equipment must be available. D&E can usually be performed on an outpatient basis but is associated with more pain for the client than surgical evacuation up to 14 weeks of gestation. Information on pain management is provided in *Section 2.4*.

D&E is the only recommended surgical method for pregnancies above 14 weeks of gestation; however, there is some flexibility between use of vacuum aspiration and D&E procedures between 12 and 16 weeks of gestation.

3.3.5 Confirmation of a complete procedure

A surgical abortion at any gestational age is not considered complete without examination of the products of conception:

- If there is no gestational sac or chorionic villi seen after evacuation, ectopic pregnancy should be considered (see *Chapter 9: Maternal health, Section 4.3.1*).
- If fetal tissues are observed, but the criteria are not met for the estimated gestational age, re-aspiration or follow-up ultrasound should be performed to rule out an incomplete procedure.

4. Post-abortion care

4.1 Post-procedure protocol

Each facility providing surgical abortion at or after 14 weeks or medical abortion beyond 12 weeks must have a discharge protocol, including the following:

- Mandatory recording of vital signs (pulse, blood pressure, volume of vaginal blood loss) taken by a provider assessed as competent.
- Monitoring of the client at the facility, with discharge by a named competent provider only when clinically stable, usually 20 minutes to 1 hour after the procedure.
- Monitoring of fever in the client. Healthcare providers need to be aware that misoprostol can also cause elevation of body temperature and feverish symptoms such as chills. If the fever lasts more than a few hours from the last misoprostol dose, another cause of fever should be suspected.
- Regular assessment of pain and analgesia offered after the procedure for as long as required.

4.2 Follow-up

Routine follow-up is not necessary following an uncomplicated surgical abortion. However, clients undergoing abortion should be informed that they can contact a healthcare provider if they have any questions or worries after leaving the facility. Information about how to contact the facility, what warning signs to look out for (*Box 3* – next page), and other available post-abortion care should be both written and verbal if feasible.

Clients should be informed of normal post-abortion signs and symptoms. Vaginal bleeding and uterine cramping similar to menstrual colic are to be expected for up to 2 weeks following surgical abortion and up to 4 weeks after medical abortion, within normal limits. To manage this, the client should be provided with pain relief to take home.

If the client did not initiate post-abortion contraception on the day of the abortion procedure, healthcare

BOX 3: Warning signs for complications in the immediate post-abortion period – seek medical attention!

- Bleeding complications (including incomplete abortion): prolonged or heavy bleeding (soaking more than two large pads per hour for two consecutive hours).
- Infectious complications: any fever after surgical abortion or fever lasting more than 24 hours after misoprostol administration; severe abdominal pain, unrelieved by pain medications.
- Ectopic pregnancy: continuing signs and symptoms of pregnancy after abortion and/or no bleeding after medical abortion; severe abdominal pain, unrelieved by pain medications.
- Traumatic complications (i.e. uterine perforation +/– bowel injury): severe abdominal pain after surgical abortion, unrelieved by pain medications.
- Unspecified complications: feeling generally unwell with malaise more than 24 hours after misoprostol administration.

providers should discuss post-abortion contraception with the client at the time of follow-up and provide them with a method of contraception, if chosen. The provider must ensure the client is aware that fertility can return as early as 8 days after abortion (see *Section 5: Post-abortion contraception*).

4.2.1 Routine follow-up

There is no need for routine follow-up for clients who have had an uncomplicated medical or surgical abortion.

For those using any medical abortion regimen (mifepristone plus misoprostol, or misoprostol alone) at home before 12 weeks of gestation, an in-person follow-up visit to assess the success of the abortion is not required if clinical signs/symptoms of pregnancy disappear and no warning signs are present. However, clients can be offered the option of a telephone follow-up at 7–14 days to answer any questions, reiterate instructions, and confirm absence of complications.

Any follow-up visit provides a good opportunity to discuss methods of contraception and provide adequate supplies where requested. The client may also need to access other sexual and reproductive healthcare, such as STI or HIV care, psychological support, or sexual and gender-based violence counselling and support.

4.2.2 Urgent follow-up

If an ectopic pregnancy is suspected post-procedure (see *Box 3* for warning signs), evaluate the client by performing a pelvic examination and/or ultrasound scan and/or human chorionic gonadotropin (hCG) test to determine uterine size, adnexal pain, and/or presence of adnexal mass. See *Chapter 9: Maternal health, Section 4.3.1* for additional information on diagnosis and management of ectopic pregnancy.

If uterine perforation and/or visceral damage is suspected, prompt investigation and treatment is required. See *Section 4.3: Management of complications*.

4.3 Management of complications

When clients present with signs or symptoms of complications following abortion, a routine clinical history and examination should be performed (see *Section 2.1* and *Chapter 2: Facility requirements and client history/examination*), which should be as comprehensive and efficient as possible depending on the urgency and condition of the client.

4.3.1 Incomplete abortion (without or with infection)

Incomplete abortion should be suspected if the client presents with:

- heavy bleeding
- pain
- signs of infection (see below)

When incomplete abortion is suspected, the healthcare provider needs to establish the uterine size, how much blood loss has occurred, and whether infection is present.

If the client shows signs of shock, heavy bleeding, or infection, an aspiration/uterine evacuation should be performed or urgent referral should be provided. If the client is clinically stable and no signs of infection are present, the uterus can be evacuated surgically using aspiration or medically using misoprostol (see *Table 5 and Table 3*).

TABLE 5: Summary of management of incomplete abortion (without/with infection)

Clinical assessment	Uterine size	Action	Note
No suspicion of infection	Uterine size ≤14 weeks	**Option 1**: Uterine evacuation using vacuum aspiration; antibiotic prophylaxis should be given before surgical evacuation: 200 mg doxycycline or 500 mg azithromycin within 2 hours before the procedure **Option 2**: One dose misoprostol 800 µg vaginally (if no significant vaginal bleeding), 600 µg orally, or 400 µg sublingually	The procedure should not be delayed if antibiotics are not available
	Uterine size >14 weeks	**Option 1**: Uterine evacuation using vacuum aspiration and blunt forceps if necessary; antibiotic prophylaxis as above **Option 2**: If the client is stable, misoprostol can be used: 14–28 weeks: misoprostol 400 µg buccally, sublingually or, in the absence of vaginal bleeding, vaginally every 3 hours until expulsion 28+ weeks: 25 µg vaginally 6-hourly or 25 µg orally 2-hourly	If the uterine size is 22 weeks AND the client has a history of previous caesarean delivery or 14–22 weeks with more than one previous caesarean delivery), consider lowering the dosage of misoprostol with or without increasing dosing interval
Infection is present	Regardless of uterine size, evacuation as soon as possible	Start broad-spectrum antibiotics immediately – intravenously if infection is severe Urgently transfer to a unit with the facilities for undertaking surgical evacuation if it cannot be done in the facility where the client presents	If the skills necessary for urgent surgical uterine evacuation are not available, misoprostol can be used while planning for a transfer: • 14–28 weeks: misoprostol 400 µg buccally, sublingually or, in the absence of vaginal bleeding, vaginally every 3 hours until expulsion • 28+ weeks: 25 µg vaginally 6-hourly or 25 µg orally 2-hourly

Source: Ipas [6], RCOG [9].

Complications of an unsafe abortion should be suspected if there is evidence of:

- vaginal or cervical laceration or injury
- presence of foreign material in the vagina or cervix
- systemic infection and vaginal bleeding in a previously pregnant client

4.3.2 Infection

Infection should be suspected if:

- the client's temperature is ≥37.5°C or <35.5°C
- there is localized or general abdominal tenderness, guarding, and rebound
- there is foul-smelling odour or pus in the cervical os or vaginal discharge
- the uterus is tender on palpation or bimanual examination

Infection should be treated promptly with evidence-based antibiotic regimens; evaluation should be performed to determine if uterine evacuation is needed due to retained products of conception (see *Table 5*).

4.3.3 Severe complications

While incomplete abortion and infection are the most common complications following abortion, healthcare providers should be able to recognize and treat or refer for the rare (<1 per cent) but life-threatening complications described in the following sections. Of note, these complications occur more commonly when unsafe methods of abortion are used.

4.3.3.1 Sepsis

Features suggestive of sepsis and indicating the need for emergency action include:

- hypotension
- tachycardia
- increased respiratory rate
- severe pain

If these features are present, start two intravenous lines with intravenous fluids (normal saline or compound sodium lactate solution) and start broad-spectrum antibiotics.

If there is a suspicion of retained products of conception, evacuation of the uterus should be considered.

If the situation is not stabilized or the client may need intensive care, transfer should be arranged.

4.3.3.2 Uterine perforation

Most perforations go undetected and resolve spontaneously without any need for intervention. However, uterine perforation should be suspected during surgical abortion if the cannula advances beyond the expected limits of the uterus (based on bimanual examination or ultrasound), or if fat or bowel is removed from the uterus.

If available, laparoscopy is the method of choice to investigate further. If laparoscopy is not available, or damage to organs or blood vessels is suspected, exploratory laparotomy should be performed. The healthcare provider should consider early transfer and resuscitation if a surgical approach cannot be performed in the facility.

4.3.3.3 Bowel damage

Late diagnosis of bowel perforation can lead to peritonitis and death. Healthcare providers of all cadres must be able to monitor vital signs and client condition after the procedure.

Clinical warning signs and symptoms of bowel perforation in the post-operative period include:

- abdominal pain or shoulder pain (a sign of fluid or blood in the abdomen causing irritation to the diaphragm)
- inability to tolerate oral fluids, nausea or vomiting
- distended abdomen with decreased bowel sounds and rebound tenderness
- fever and malaise
- rising pulse rate with lowering of blood pressure

Bowel injury most often presents 12–36 hours after a known surgical abortion (or suspected unsafe abortion), although it may not manifest until 5–7 days later. Facilities and staff should be aware of transfer protocols when bowel perforation is suspected. Clients should be kept nil by mouth if bowel injury is suspected. Clinical suspicion can be confirmed by X-ray (free intra-abdominal air), in which case a laparotomy is indicated for treatment.

5. Post-abortion contraception

Generally, almost all methods of contraception can be initiated immediately following a surgical or medical abortion.

If not started immediately, the method may be started if there is a reasonable certainty that the client is not pregnant. Need for additional contraception and its duration is based on when the method is started and the chosen contraceptive's mechanism of action (see *Chapter 4: Contraception*).

As with the initiation of any method of contraception, the client's medical eligibility for a method should be verified (see *Chapter 4: Contraception* and *Appendix 1* of that chapter for medical eligibility criteria summary tables).

Clients who do not choose to immediately start a contraceptive method should be offered follow-up contact to discuss this further and should be routinely supplied with condoms and emergency contraceptive pills.

Immediate start of contraception after surgical abortion refers to the same day as the procedure. Immediate start after medical abortion refers to the day the first pill of a medical abortion regimen is taken (mifepristone for the combined regimen or first dose of misoprostol for misoprostol-only regimens). With immediate start of contraception, no additional protection or abstinence is needed.

6. Harm reduction approach

In circumstances where abortion is legally permitted, providers should be trained and equipped to offer safe and accessible abortion care. However, in settings where abortion is severely legally restricted, a harm reduction approach with a view to improving the care of clients with unintended pregnancies can be implemented.

The harm reduction approach to preventing unsafe abortions is based on three principles, namely: **neutrality, humanism,** and **pragmatism**. It is grounded in ethical principles of the provider–client relationship and provides an inclusive approach for all people who can become pregnant, regardless of socioeconomic status or educational levels, while upholding confidentiality.

These principles can be used across countries even where abortion is restricted or illegal to provide information and supportive care in line with the law.

A harm reduction model provides abortion-related care to the full extent permitted by the law. That is, if the client requiring an abortion is eligible for a legal abortion, it is provided, or the client is referred to the relevant care (provided they accept and this is their preferred choice). If the client is not eligible for a legal abortion, they are provided with information and counselling to minimize potential harm to themselves, should they undertake efforts to opt out of the pregnancy.

A harm reduction approach acknowledges that in every abortion there are three stages, and care is provided accordingly:

1. The pre-abortion ('before') stage: Pre-abortion counselling and consultation is provided, including pregnancy options counselling and information on the safest methods of abortion available (i.e. the use of misoprostol).

2. The abortion ('during') stage: Individuals self-manage their abortion outside of the clinic setting.

    a. Tasks that can be undertaken to support a person in this stage, particularly to prevent least safe procedures, depend on local laws and a legal assessment.

3. The post-abortion ('after') stage: Post-abortion care is provided, offered via telephone/remote methods or in-person follow-up consultation. Complications, if any, are managed, and healthcare to prevent future unintended pregnancies and address other sexual and reproductive health concerns is provided.

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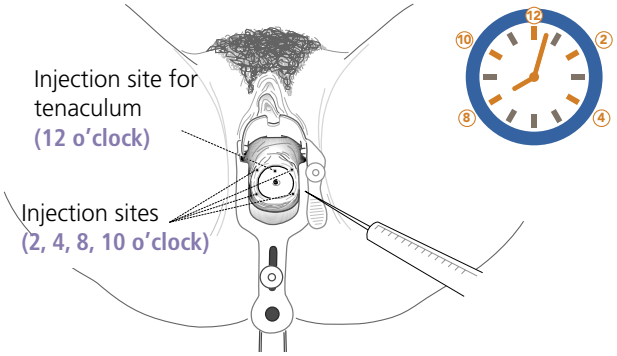
Appendices

Appendix 1: How to administer a paracervical block

Paracervical block technique



1. Prepare lidocaine syringe using 20mL of 1% lidocaine and a 3cm (1in) needle.
2. Place the speculum and perform cervical antiseptic prep.
3. Inject 2mL of lidocaine superficially into the anterior lip of the cervix where the tenaculum will be placed (12 o'clock).
4. Grasp cervix with the tenaculum at 12 o'clock.
5. Inject remaining lidocaine in equal amounts at the cervicovaginal junction, at 2, 4, 8 and 10 o'clock
6. Begin procedure without delay.

PRACTICE TIPS

- Do not exceed the lidocaine maximum dose of 4.5mg/kg or 200mg total.
- If 1% lidocaine is unavailable, 10mL of 2% may be substituted. A two-point paracervical block technique (injecting at 4 and 8 o'clock) may be used.
- Deep injection of lidocaine (3cm or 1in) provides more effective pain relief than superficial injection.
- Aspirate before injecting to prevent intravascular injection.
- Possible side effects seen with intravascular injection include peri-oral tingling, tinnitus, metallic taste, dizziness or irregular/slow pulse.
- Midlevel providers trained to provide paracervical block demonstrate similar safety and efficacy as physicians.
- Serious adverse events related to paracervical block are rare.

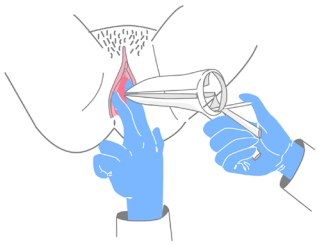
Source: Reproduced with permission from Ipas. Clinical Updates in Reproductive Health. North Carolina: Ipas; 2021. Available at: https://www.ipas.org/resource/clinical-updates-in-reproductive-health/

Appendix 2: How to perform vacuum aspiration

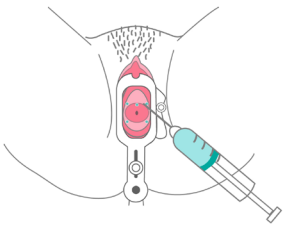
safe2choose

The vacuum aspiration abortion step-by-step

1. The procedure will begin with a **pelvic or speculum exam**.

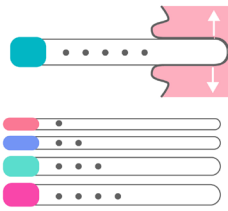


2. A local **anesthetic** is injected next to the cervix.



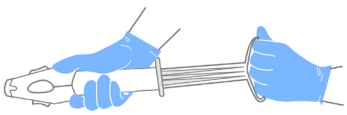
3. The clinician will **dilate the cervix** with instruments called cervical dilators.

These dilators gradually increase in size depending on the number of pregnancy weeks.



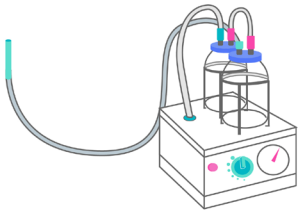
4. Once the desired dilation is achieved, the clinician will perform the **aspiration** and remove the pregnancy.

*A) with a silent, handheld suction device for **manual vacuum aspiration (MVA)**.*

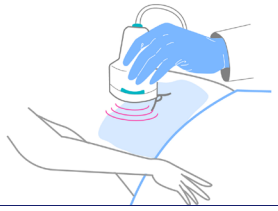


OR

*B) with an electrical machine for **electric vacuum aspiration (EVA)**.*



5. After removal of the pregnancy, the provider may choose to do an ultrasound, then the woman is allowed to **rest**.



Source: Source: Reproduced/translated/adapted with permission from Safe2Choose. Guide to a Safe Manual Vacuum Aspiration (MVA). London. Safe2choose; 2022. Available at: https://safe2choose.org/safe-abortion/inclinic-abortion/manual-vacuum-aspiration-mva-procedure

Appendix 3: How to perform dilatation and evacuation

Procedure step by step

- Perform safety and equipment check.
- Have the woman empty her bladder before entering the procedure room.
- Initiate any intravenous pain and/or antianxiolytics. Any oral medications should be given in advance of the procedure in order to perform the D&E at the time of their maximal effect.
- Perform bimanual exam to check uterine size and position as well as adequacy of cervical dilation. Remove and account for all osmotic dilators previously placed. If the cervix is not adequately prepared, give an additional dose of misoprostol and/or place another set of dilators.
- Place speculum.
- Clean cervix with an antiseptic solution, such as providone-iodine (Betadine).
- Perform paracervical block and place tenaculum.
- Place traction on the tenaculum to bring cervix down the vagina.
  - Ring/Foerster/sponge-holding/vulsellum forceps can be used in place of a tenaculum for later gestations, if desired.
- Recheck adequacy of dilation by attempting to pass the largest diameter dilator without using force.
- Mechanically dilate cervix, as needed, to achieve desired/necessary amount.
  - Dilators need to reach the internal os, without going higher into the uterus. Touching the fundus with the dilator is painful for the woman and increases the risk of perforation.
- Perform uterine aspiration with largest cannula available (12-16 mm) and aspirate the amniotic fluid (see Figure 1). Either electric or manual vacuum aspiration can be used.
  - Perform the suction as is done during a first-trimester aspiration abortion, rotating the cannula during suction. If using MVA, empty the aspirator when it is full and repeat as necessary. When nothing more can be suctioned, remove cannula from uterus.
  - For gestations up to 15 weeks, it may be possible to complete the abortion using aspiration only.
- Maintaining gentle traction on the tenaculum to straighten the cervical canal, pass the closed forceps through the cervix in a vertical direction (the jaw of the Bierer or Sopher forceps should open in an up-down direction, not horizontally) (see Figure 2).

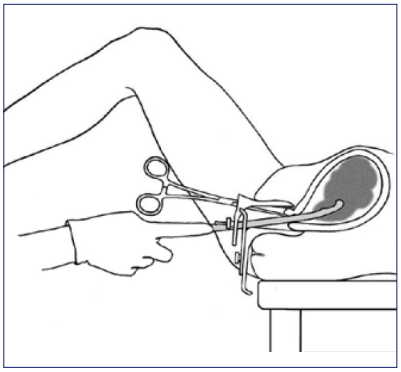


Figure 1. Aspirate the amniotic fluid.

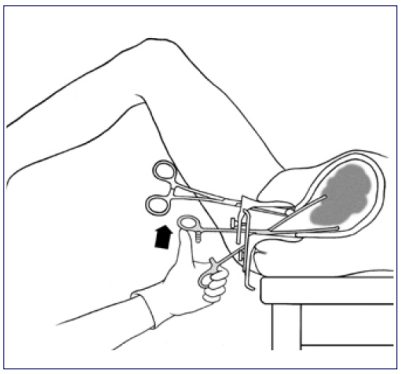


Figure 2. Open the forceps.

- As soon as the forceps pass through the internal os, gently open it as wide as possible. While opening the forceps, drop your hand and forceps in the direction of the floor to angle the jaws of the forceps into the anterior lower-uterine segment (see Figure 3).
  - A mid-trimester gravid uterus is usually positioned anteriorly, toward the anterior abdominal wall.
- To evacuate the tissue, close the forceps around the fetal tissue and rotate it 90 degrees to assist with disarticulation before withdrawing.
  - Be careful not to grasp the myometrium with the forceps.
  - Keep forceps within the lower to mid-uterine segment. There is usually no need to use the forceps near the fundus, which increases the risk of perforation (see Figure 4).
- Repeat until fetal removal is completed as is the majority or all of the placenta.
  - Attempt to remove tissue with each pass of the forceps.
    - If you cannot locate and move the fetus/fetal parts within 5-7 minutes, consider using ultrasound to visualize and direct the movement of the forceps.
    - If the tissue has moved upwards to the fundus from the lower segment of the uterus, use suction to bring the tissue down within grasp of the forceps or consider removing the speculum and tenaculum and massaging the uterus. If dilated sufficiently to allow passage of part of the provider's hand, the pregnancy can be repositioned internally. In the unlikely event that these maneuvers do not bring the tissue within reach of the forceps, administer misoprostol 400mcg (buccal) or high-dose oxytocin (200 units in 500mL normal saline or lactated ringers and run at 50mL/hour IV). The D&E procedure should be re-attempted in 30 minutes to 3 hours. The woman should be observed during this time.
- When all fetal tissue is removed, perform suction aspiration to ensure no tissue is remaining.
- Examine the fetal tissue to ensure that evacuation is complete:
  - Identify fetal parts (thorax, spine, calvarium, all 4 extremities and placenta, for all procedures 14 weeks and greater).
  - If it is unclear whether the evacuation is complete, an ultrasound or a digital exam of the uterine cavity may be used for confirmation.

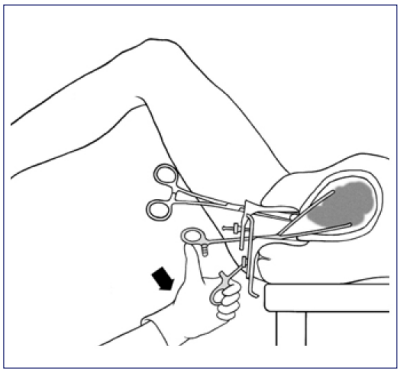


Figure 3. Pull the forceps handle down so graspers are in the anterior lower-uterine segment.

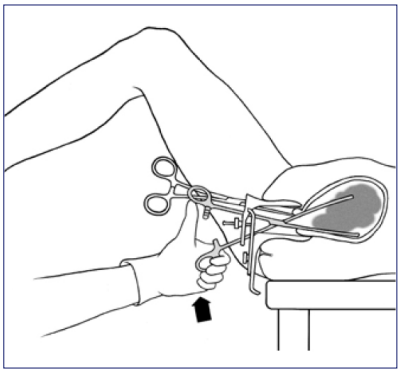


Figure 4. Evacuate from the lowest section of the uterine cavity.

Source: Reproduced with permission from Ipas. Edelman A, Kapp N. Dilatation & Evacuation (D&E) Reference Guide: Induced abortion and postabortion care at or after 13 weeks gestation ('second trimester'). Chapel Hill, NC: Ipas; 2018. Available at: https://www.ipas.org/resource/dilatation-evacuation-de-reference-guide-induced-abortion-and-postabortion-care-at-or-after-13-weeks-gestation-second-trim\ester/