NATIONAL SERVICE DELIVERY STANDARDS AND GUIDELINES FOR HIGH-QUALITY SAFE UTERINE EVACUATION/POST-ABORTION CARE

Ministry of National Health Services, Regulations and Coordination

Government of Pakistan
Islamabad

March 2018

Cover Inside

Government of Pakistan

Ministry of National Health Services Regulations and Coordination

LG&RD Complex, Sector G/5/2, Islamabad

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Islamabad, the 30th March, 2018

NOTIFICATION

F.No.3-2/2018-Ipas/DD(PIII) The Ministry of National Health Services, Regulations and Coordination, Government of Pakistan, Islamabad, is pleased to approve the National Service Delivery Standards and Guidelines for High Quality Safe Uterine Evacuation and Post Abortion Care, for implementation and further dissemination to the relevant stakeholders , with immediate effect.

2. The approved National Service Delivery Standards and Guidelines for High Quality Safe Uterine Evacuation and Post Abortion Care are attached herewith.

Director General

Ministry of National Health Services

Regulations and Coordination

Copy of the above is forwarded for information and necessary action to:

1. The Secretary,Department of Health,Government of Punjab, KPK,Sindh,Baluchistan,GB,AJK
2. The Secretary,Department of Population Welfare,Government of Punjab,KPK,Sindh,Baluchistan, GB,AJK
3. The Chief Commissioner, Islamabad Capital Territory,Islamabad
4. The Director General, Population Program Wing, MoNHSR&C
5. The Director Technical, Population Program Wing, MoNHSR&C
6. The Director General Health Services, Department of Health,Government of Punjab, KPK, Sindh, Baluchistan,AJK
7. The Director Health Services,Department of Health,FATA, GB
8. The Director General,Population Welfare Department, Government of Punjab, KPK, Sindh, Baluchistan,AJK,GB
9. The Provincial Coordinator, LHW/RMNCAH Program, Punjab,KPK,Sindh,Baluchistan FATA,AJK,GB,ICT
10. The District Health Officer,Islamabad Capital Territory, Islamabad
11. The Executive Director, Health Services Academy, Islamabad
12. The President/Registrar,Pakistan Medical and Dental Council,Islamabad

13. The President/Registrar,Pakistan Nursing Council,Islamabad
14. The President, College of Physicians and Surgeons Pakistan, Karachi
15. The Chief Executive Officer, Drug Regulatory Authority Pakistan(DRAP), Islamabad
16. The Heads of Teaching Hospitals and MCH Department under the Federal Government
17. The President, Society of Obstetricians and Gynecologists of Pakistan(SOGP), Karachi
18. The President , Midwifery Association of Pakistan,Karachi
19. The Country Director, Ipas, Pakistan

MESSAGE FROM THE SECRETARY

As we all know, health sector is one of the most important sectors for socio economic development of any country. This is unfortunate that in Pakistan six percent of maternal mortality is associated with unsafe abortions which are one of the most easily preventable among all the causes of maternal mortality. These preventable deaths represent enormous gap in demand and need met for family planning services and other shortcomings in the delivery of essential health and contraceptive services delivery system.

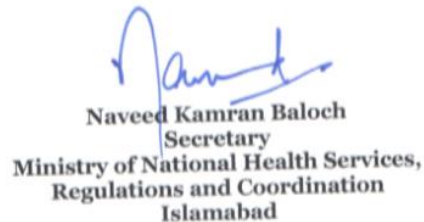
With the efforts of Govt of Pakistan and different stakeholders working in health sector, general guidelines for different sub-components of the healthcare service delivery existed but there was a strong need for updated and comprehensive guidelines on safe uterine evacuation/post abortion care based on global best practices and Pakistan's local context. To address this, Department of Health Punjab developed and endorsed Service Delivery Standards and Guidelines (S&Gs) for high quality Safe Uterine Evacuation/Postabortion Care in 2015 after consultation with key stakeholders. The objective of these S&Gs was to provide health workers with prerequisites and guidance during service delivery, improving service quality and to provide health managers with standards to evaluate quality of care through checklists for monitoring and supervision.

Realizing the benefits of use of these S&Gs and the enormous interest among the teaching and service delivery institutions, and providers in Punjab, the Ministry of National Health Services, Regulation and Coordination (M/o NHSR&C) and stakeholders felt need to upscale these standards and guidelines at national level. After a series of consultative and consensus building meetings led by M/o NHSR&C) in Sep-Oct 2017, and with the technical and collaborative efforts of Ipas and Health Services Academy, and other Government and Non-Government Organizations (NGOs) across the country, draft of S&Gs was developed and finalized in December 2017.

I appreciate and thank representatives of Departments of Health, Pakistan Nursing Council, Society of Obstetricians and Gynecologists (SOGP), Midwifery Association of Pakistan, member organizations of Pakistan Alliance for Postabortion Care (PAPAC), Private Sector, Civil Society, and International and National Non-Governmental organizations for their active participation and contribution to finalization of these S&Gs. I also acknowledge and thank HSA and Ipas Pakistan and US staff, for their technical support and collaborative efforts to make this happen.

I want to take this opportunity to encourage all provincial Departments of Health and partners to strategize implementation and ensure an effective use of these guidelines across the teaching and service delivery institutions, health and population facilities and providers in Public, Private and NGO sectors, leading to improved health sector specifically maternal health outcome indicators in Pakistan.

Thank you!



Naveed Kamran Baloch
Secretary
Ministry of National Health Services,
Regulations and Coordination
Islamabad

Date, MARCH 30, 2018

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FOREWORD

Health is one of the most important social sectors, and healthy performance indicators in the health sector are among the major positive contributing factors in the overall economy of the country. It is unfortunate that six percent of maternal morta lity in our country is associated with unsafe abortions which are one of the most easily preventable among all the causes of maternal mortality. Therefore, providing high-quality, safe uterine evacuation/postabortion care is one of the key elements of our reproductive health strategy.

While guidelines pertaining to different components of maternal health care are in existence, there was a strong need felt by service providers and health managers for updated and comprehensive guidelines on safe uterine evacuation/postabortion care. Recognizing this need, in 2015, the Department of Health Punjab developed and endorsed Service Delivery Standards and Guidelines (S&Gs) for high quality Safe Uterine Evacuation/Postabortion Care after consultation with key stakeholders. This local guidance was adapted from WHO's policy and technical guidance-2012 on safe abortion/postabortion care. The guidelines were developed to provide health workers with prerequisites and guidance for reference during service delivery, improving service quality as well as to provide health administrators/managers with standards to evaluate quality of care as well as checklists for monitoring and supervision.

In March 2017, Ministry of National Health Services, Regulations and Coordination (M/o NHSR&C) and stakeholders felt the need to upscale these standards and guideline (Punjab 2015) at the national level. With Ipas' technical support, M/o NHSR&C tasked the Health Services Academy to take up the review process with all the provinces, regions and stakeholders include representatives of Departments of Health, Pakistan Nursing Council (PNC), Society of Obstetricians & Gynecologists (SoGP), Midwifery Association of Pakistan (MAP), WHO, UNFPA, Pakistan Alliance for Postabortion Care (PAPAC), Private Sector, Civil Society and International and National Non-Governmental organizations and develop national S&Gs. Subsequently, national S&Gs were finalized during the stakeholders' consensus building meetings in Islamabad and Karachi on September 22 and October 19, 2017 respectively and submitted to the M/o NHSR&C for approval.

The M/o NHSR&C is pleased to approve and notify the national S&Gs for dissemination and use across the teaching, training and service delivery institutions and service providers across the country. The national S&Gs will help generate ownership and improve applicability and use in standardization and sustained improvement in UE/PAC training and service delivery at all levels of the healthcare system in the country.

We, at the M/o NHSR&C Islamabad, consider these Service Delivery Standards and Guidelines for the provision of high-quality safe uterine evacuation/postabortion care as a dynamic document that needs continuous updating and improving to keep pace with changes in medical technology and global best practices. We envision that these guidelines would not only be a resource for the healthcare providers, but will also be useful for policymakers & program managers in implementing effective and high-quality services for safe uterine evacuation/postabortion care at every level of health care service delivery.

Prof. Dr. Assad Hafeez
Director General Health,
Ministry of National Health Services,
Regulations and Coordination,
Government of Pakistan, Islamabad.

Date: March 30, 2018

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ACKNOWLEDGEMENTS

The Ministry of Health Services, Regulations & Coordination, Islamabad would like to express its gratitude to all provincial and regional Departments of Health of Pakistan and key stakeholders for their invaluable support throughout the development of this document.

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Since the Guidelines would not have been possible without the dedicated and painstaking work of the reviewers, apart from the authors and contributors, we are grateful to the several experts in the field with extensive experience in reproductive health especially in Postabortion Care for providing their valuable inputs particularly acknowledging the valuable technical contributions by the following organizations/representatives of the Government, Development Sector, Donors, I/NGOs, Civil society and Private sector;

- Director General Health Services Sindh, Khyber Pakhtunkhwa (KP), Gilgit Baltistan (GB), Azad Jammu Kashmir (AJK), Federally Administered Tribal Area (FATA), and District health officer Islamabad Capital Territory (ICT), and Population Welfare Department Sindh;
- Director General Health, and Provincial Coordinators MNCH and LHW program Balochistan were also among the S&Gs' draft reviewers, however they could not participate in-person due to cancellation of flight at the last moment.
- Technical Specialist Policy and Strategic Planning Unit (PSPU), Punjab; Provincial Coordinators MNCH/IRMNCH Sindh, KP, GB, AJK, FATA, ICT; and Provincial Coordinators LHW program Sindh, KP, GB and AJK;
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- Pakistan Nursing Council; Secretary General, Senior Vice President, and Executive Council members of Society of Obstetricians & Gynecologists of Pakistan (SOGP); Midwifery Association of Pakistan (MAP); National Commission on the Status of Women (NCSW);
- World Health Organization and United Nations Population Fund;
- Senior Public Health Specialists of the development sector from ICT/Punjab, Hyderabad and Karachi;
- Pakistan Alliance for Postabortion Care (PAPAC) Steering Committee members/organizations- The David and Lucile Packard Foundation, National Committee for Maternal & Neonatal Health, Rahnuma-Family Planning Association of Pakistan , Association for Mothers and Newborns, Marie Stopes Society, Save the Children, Health Policy Plus Sindh, Sukh Initiative/Aman foundation, Youth Advocacy Network, Aware Girls, Aahung, HANDS, Shirkat Gah, Jhpiego, Pathfinder International, Rutgers, White Ribbon Alliance, DKT, Girls Women Health Initiative (GWHI) and Ipas Pakistan;

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LIST OF ACRONYMS

CMW - Community Midwife

D&C - Dilatation and Curettage

EVA – Electric Vacuum Aspiration

HIV - Human Immunodeficiency Virus

IEC - Information, Education and Communication

IPC - Interpersonal Communication

IUD - Intrauterine Device

IV - Intravenous

LHW - Lady Health Worker

LHV - Lady Health Visitor

LMP - Last Menstrual Period

MW - Midwife

MVA - Manual Vacuum Aspirator

N-MW - Nurse Midwife

PAC - Postabortion Care

PAFP - Postabortion Family Planning

STIs - Sexually Transmitted Infections

UE - Uterine Evacuation

UNFPA - United Nations Population Fund

WHO - World Health Organization

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INTRODUCTION:

WHO defines unsafe abortion as a procedure for termination of a pregnancy done by an individual who does not have the necessary skills or in an environment not conforming to minimal medical standards or both. According to a recent study by WHO and the Guttmacher Institute, 25.1 million unsafe abortions (45.1% of all abortions) occurred every year between 2010 and 2014 worldwide and majority of the unsafe abortions (97%) occurred in developing countries in Africa, Asia and Latin America. The proportion of unsafe abortions was significantly higher in developing countries than developed countries (49·5% vs 12·5%). When grouped by the legal status of abortion, the proportion of unsafe abortions was significantly higher in countries with highly restrictive abortion laws than in those with less restrictive laws.

The deaths and disabilities due to unsafe abortion are almost entirely avoidable: contraception can greatly reduce the need for abortion, and when properly performed, abortion is extremely safe. As such, these preventable deaths represent enormous shortcomings in the delivery of essential health and contraceptive services and the failure of laws, policies, healthcare system and societies to respond to women's needs. Vulnerable women are most affected by unsafe abortion – poor rural women, women in refugee and displaced settings, women who have experienced violence, and women with low levels of education. Unsafe abortion constitutes a global public health crisis, a social injustice and a violation of women's human rights and dignity.

Effectively addressing the provision of high-quality, safe, accessible uterine evacuation care is essential to ensuring fewer maternal deaths and better reproductive health outcomes for women and girls in Pakistan. High levels of unmet need for contraception and low levels of contraceptive use put women and girls at particular risk for unintended pregnancies. Given high levels of stigma, service cost barriers and the lack of clarity in interpreting law by both women/girls and healthcare providers, many women and girls experiencing an unintended pregnancy in Pakistan resort to clandestine and unsafe abortion procedures. A national study released by the Population Council in 2013 found that an estimated 696,000 women were treated for postabortion complications in healthcare facilities across the country. The primary reason for abortion is poor socio-economic status.

Following a 1989 decision of the Pakistan Supreme Court, which held that part of the Penal Code of 1860 dealing with offences against the human body was invalid because it was repugnant to the injunctions of Islam Pakistan, the abortion law was revised. The revised law, now in conjunction with Islamic principles came into effect provisionally in 1990 and became permanent law in 1997. Abortion is legal in Pakistan for expanded indications in early pregnancy, generally accepted by Islamic legal scholars as up to 120 days of pregnancy, when the abortion is caused in good faith to save the woman's life and to provide "necessary treatment". After 120 days of pregnancy, abortion is legal only to save a woman's life.

Clearly, serious complications and morbidity from unsafe abortion have a substantial impact on women's health, on their families, on the communities to which they belong, and on the healthcare system. Government at every level must strive to prevent unintended pregnancies and to mainstream and institutionalize safe uterine evacuation care in the health system within a supportive policy environment, so that women and girls can safely exercise their sexual and reproductive rights.

The service delivery standards and guidelines in this document aim to set the standard of care and provide guidance to healthcare workers on the provision of high-quality, comprehensive uterine evacuation care for the first trimester. There are other important documents supporting healthcare delivery, include clinical protocols and training curricula. The standards and guidelines in this document should be individualized to each woman and girl, with emphasis on her clinical status and the specific method of uterine evacuation to be used, while considering each woman and girl's preferences for care. The target audience for this guidance is policymakers, program managers and healthcare providers in Pakistan.

SERVICE DELIVERY STANDARDS AND GUIDELINES:

1. Uterine Evacuation Care Methods

Standard 1: WHO-recommended methods to be used for first trimester uterine evacuation care are vacuum aspiration (electric or manual) and medical methods (mifepristone followed by misoprostol or misoprostol only where mifepristone is not available).

Guidelines:

1. Healthcare providers need to take the following factors into consideration in deciding which uterine evacuation method to use:
   a. Women and girls' personal preferences
   b. clinical condition
   c. uterine size/gestational age
   d. availability of equipment, supplies and skilled staff, and
   e. currently available scientific and medical evidence.
2. Sharp curettage is not recommended because it is less safe than other methods.
3. The use of medical methods of uterine evacuation requires the back-up of vacuum aspiration either on-site or through referral to another healthcare facility in case of failed or incomplete abortion.
4. Providers should explain the difference between all available options and help the woman/girl explore which option is best for her.
5. Providers should discuss the possible benefits, risks and what to expect with each method.

2. Healthcare Providers (See Appendix C)

Standard 2: Uterine evacuation care can be safely provided by any properly trained health care provider, including doctors and a range of non-physician and midlevel providers such as Midwives, Nurse-Midwives, Lady Health Visitors and Community Midwives, who are trained to provide basic clinical procedures related to reproductive health, including bimanual pelvic examination to determine the age of pregnancy and positioning of the uterus, uterine sounding and other trans-cervical procedures.

3. Provider Skills and Performance

Standard 3: Healthcare workers must be trained, technically competent and use appropriate clinical technologies in order to provide high-quality medical and MVA uterine evacuation care.

Standard 4: Uterine evacuation care training programs (both pre-and in-service) must be competency based which may require a wide range of number of cases for different trainees and conducted in facilities that have sufficient patient flow to provide all trainees with the requisite supervised practice, including practice in managing abortion complications. Sites with low case flow may avail other facilities for clinical practice to ensure adequate practice for trainees.

Guidelines:

1. Training programs should use a variety of teaching methodologies and should address both technical and clinical skills. All staff should receive periodic updating in these skills.
2. Training should address healthcare provider's attitudes and beliefs about sexual and reproductive health, including abortion, safeguarding privacy and confidentiality, treating all women and girls with dignity and respect, and attending the special needs of the rape survivors and those who may be vulnerable for other health or socioeconomic reasons.
3. In addition to skills training, participating in values clarification exercises can help providers differentiate their own personal beliefs and attitudes from the needs of women and girls seeking uterine evacuation care.
4. Training curricula may vary in content, as well as length of training depending on the skills the healthcare provider has on entry into the training program.
5. Trained providers need support following training to put skills into practice, and need to work in an environment that ensures adequate drugs, equipment, infrastructure, remuneration and professional development to support the provision of safe uterine evacuation care services.

Standard 5: The service system must ensure that trained providers receive supportive and facilitative supervision and oversight along with commodities and supplies to ensure that service delivery meets norms and standards, satisfies clients' needs and respects their rights. An important tool for supervision can be a checklist of items that supervisors are to monitor regularly.

Standard 6: Where certification of uterine evacuation care providers (such as CMWs) is required, the purpose must be to ensure that providers are clinically competent for safe provision of care.

Certification and licensing requirements must not be used to exclude categories of health professionals, or impose excessive requirements for sophisticated equipment, infrastructure or staff that are not essential to the provision of safe uterine evacuation care and would unnecessarily restrict access.

4. Healthcare Levels (see Appendix A)

Standard 7: Properly trained community-based healthcare providers (including skilled birth attendants and all midlevel cadres) play an important role in helping women and girls avoid unintended pregnancy by providing contraceptive information, counseling and methods, and informing , women, girls and men about the risks of unsafe abortion. They can also provide women and girls with misoprostol for uterine evacuation care and inform them about how to use the medications, what to expect and when to seek additional care. They also inform them about how and where to obtain safe vacuum aspiration; and can refer women and girls with complications from unsafe abortion to emergency care.
Community level support by Lady Health Workers (LHWs) is very important. LHWs have a key role in providing counseling in safe uterine evacuation/postabortion care and family planning services, and making referrals to the health facilities when required.

Standard 8: Both vacuum aspiration and medical methods may be considered at the primary-care level, but where capacity to provide high-quality uterine evacuation care services does not exist, referral to services at higher levels is essential.

Standard 9: District hospitals should offer all primary-care level uterine evacuation care services on an outpatient basis, and be equipped and prepared to manage the complications of abortion; they should therefore be prepared to accept abortion-related referrals from healthcare facilities throughout the catchment area.

Standard 10: Secondary and tertiary-care level hospitals should have staff and facility capacity to perform uterine evacuation care in all circumstances permitted by law and to manage all complications of unsafe abortion.

Standard 11: The provision of uterine evacuation care at teaching hospitals is particularly important to ensure that relevant cadres of health professionals develop competence in safe uterine evacuation service delivery, including provision of medical methods and MVA during clinical training rotations.

Standard 12: Most of the supplies, equipment and infrastructure needed for uterine evacuation care are same as those needed for gynecological care and for clinical contraception. A detailed list of equipment and supplies for the provision of MVA and medical methods is included in Appendix-B. These instruments and medications must be routinely included in the planning, budget procurement, and distribution and management systems.

Standard 13: Health facility budgets must include sufficient funds for the following types of costs (equipment, medications and supplies required to provide safe uterine evacuation care; staff time;

training programs and supervisions; infrastructure upgrades; record-keeping; monitoring and evaluation).

Standard 14: A well-functioning referral system must be in place for the provision of safe uterine evacuation care services. All health centers, clinics or hospital staff must be able to direct women and girls to appropriate services if they are not available on site.

Guidelines:

1. Referral and transport arrangements among various levels of the healthcare system are necessary to ensure that:
   a. women and girls who need services can obtain them in a timely manner and;
   b. women and girls who need care for complications of unsafe abortion receive treatment promptly and properly.

5. Infection Prevention

Standard 15: All clinical and support staff that provide uterine evacuation care services must understand and apply standard precautions (also known as universal precautions) for infection prevention, for both their own protection and that of their clients. Training of the support staff in infection prevention should be made mandatory as part of their basic training, and accordingly revision of their job description would help in ensuring the implementation.

Guidelines:

1. Standard precautions should be applied in all situations where healthcare workers anticipate contact with blood, secretions, excretions and other body fluids, non-intact skin, and mucous membranes.
2. The support staff should also be trained in infection prevention.
3. IEC material regarding infection prevention should be displayed in the facility.
4. The essential elements of infection prevention are hand washing, use of personal protective barriers, proper handling and processing of sharp instruments and items, proper handling and processing of instruments and materials, use of aseptic technique, environmental cleanliness and proper disposal of infectious waste.
5. During surgical procedures and when handling sterile instruments, it is essential to use a no-touch technique.
6. All infectious waste should be incinerated, or at the least, secured, contained and disposed of properly.
7. Protocols must be available, displayed and implemented at all places.
8. If a healthcare worker is exposed to blood or other body fluids, follow appropriate procedures for the management of occupational exposures as indicated in hospital waste management and infection prevention guidelines being locally implemented.
9. IPC should be included in pre-service curricula for medical students, LHVs, MWs and CMWs.

6. Community Linkages

Standard 16: Health systems will make safe uterine evacuation care available in communities where women and girls live and work.

Standard 17: Healthcare providers should be aware of their role in the community as role models and leaders, while working in partnership with community members to advance women and girls' health. LHWs in areas where they are appointed or working, or where the services of LHWs are utilized, should play an important role for building linkages between communities and providers. LHWs should be updated about the Referral Hospitals in the vicinity. Partnerships between health facility staff and communities play a key role in reducing maternal mortality and morbidity from unsafe abortion.

Standard 18: Health systems should partner closely with communities to help ensure that all women and girls with abortion-related emergencies can recognize signs and symptoms and access care in a timely manner.

7. Respect for Women and Girls' Informed and Voluntary Decision-Making, Autonomy, Confidentiality and Privacy

Standard 19: All women and girls have the right to high-quality, safe, comprehensive uterine evacuation care. Healthcare providers must provide high-quality care while protecting the human rights of their clients, including clients' rights to privacy and confidentiality, information, dignity and autonomy. High quality woman/girl-friendly care must be provided without discrimination, with special attention to equal treatment for marginalized groups such as young girls, poor women, and women with disabilities. Healthcare providers must be prepared to offer effective and compassionate interaction, communication, emotional support and, if desired, counseling that focuses on the women and girls' needs.

Standard 20: Healthcare providers must explain the woman/girl's condition and options to her in non-technical language and obtain her voluntary, informed consent prior to initiating care. She needs to be treated with respect and understanding and to be provided with information in a way that she can understand so that she can decide free of inducement, coercion or discrimination. In cases of shock or other life-threatening conditions, a complete clinical assessment and voluntary, informed consent may be deferred until after the woman/girl is stabilized. If a woman/girl is in extreme pain or emotional distress, counseling should be offered when she is stable and able to comprehend and communicate.

Standard 21: Healthcare providers must be trained to inform, counsel and treat all women and girls regarding the treatment and care options being offered.

Standard 22: Healthcare workers must support minors to identify what is in their best interest, including consulting parents or other trusted adults about their pregnancy, without bias, discrimination or coercion.

Standard 23: Confidentiality is a key principle of medical ethics and the right to privacy, and must be guaranteed.

Guidelines:

1. Healthcare providers have a duty to protect medical information against unauthorized disclosures.
2. Health service managers should ensure that facilities provide auditory and visual privacy for conversation between women/girls and providers, as well as for actual services. The woman/girl seeking treatment is entitled to counselling alone, if she desires.

Standard 24: Informed consent should be taken and documented.

Standard 25: Women and girls who are pregnant as a result of rape are in need of particularly sensitive treatment, and all levels of the health system should be able to offer appropriate care and support without requiring involvement of administrative or judicial procedures.

8. Conscientious Objection

Standard 26: Healthcare providers have a right to conscientious refusal to providing abortion, but that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women and girls, putting their health and life at risk. Where a healthcare provider refuses to provide uterine evacuation, they must refer the woman/girl to a willing and trained provider in their facility, or another easily accessible healthcare facility. Where referral is not possible, the healthcare provider who objects must provide safe abortion to save the woman/girl's life and to prevent serious injury to her health.

Standard 27: All women and girls who experience complications from an unsafe abortion must be treated urgently and respectfully, as any other emergency patient, without punitive, prejudiced or biased behaviors.

9. Contraceptive Services

Standard 28: All women and girls irrespective of their age or status receiving uterine evacuation care, must be offered comprehensive contraceptive information and counseling, and if they desire, a contraceptive method, including emergency contraception must be provided before leaving the healthcare facility.

Guidelines:

1. It is important for healthcare providers to discuss contraceptive and uterine evacuation options together because the uterine evacuation method selected has implications for whether and how certain contraceptive methods can be provided, for example: at the time of service versus at a return visit. For example, for a woman/girl who want an IUD, a vacuum aspiration procedure would allow her to have the IUD

inserted immediately, ensuring that she can leave the facility with her method of choice. However, a woman/girl who choose medical abortion and desire an IUD must return to a provider to have it inserted. Those who choose an implant can have it inserted immediately, whether they have a vacuum aspiration procedure or medical abortion.

Standard 29: Contraceptive services support the basic human right to decide whether and when to have children. Women and girls receiving contraceptive services have the right to privacy, confidentiality and informed choice.

Standard 30: Healthcare providers must establish trust, strive to understand a woman/girl's contraceptive preferences and needs, and tailor the counseling session to meet those needs.

Standard 31: Healthcare providers must ensure women and girls know they may ovulate within 10 days after uterine evacuation care and can become pregnant if they resume sexual intercourse without a modern contraceptive method.

Standard 32: Providers must be knowledgeable about the range of contraceptive methods and consider each woman/girl's medical eligibility for various methods, including emergency contraception.

10. Clinical Assessment

Standard 33: Clinical assessment for uterine evacuation care must include; taking a client history including LMP, history of IUD usage, previous history of ectopic pregnancy, estimate the duration of pregnancy, identify contraindications to vacuum aspiration or medical methods and risk factors for complications; a general physical exam, pelvic exam, speculum and bimanual exam; and if needed collection of specimens and ordering of any lab tests.

Standard 34: Laboratory testing and ultrasound are not required for routine uterine evacuation care services, but may be helpful if a woman/girl's pregnancy status and dating are unclear.

Standard 35: An assessment of the uterine size and position and gestational age must be completed before performing a uterine evacuation care procedure. In addition to estimating the duration of pregnancy, clinical history taking should serve to identify contraindications to vacuum aspiration or medical methods and to identify risk factors for complications.

Standard 36: A woman/girl presenting for postabortion care should be stabilized and then clinical assessment can focus on determining abortion-related complications and eligibility for vacuum aspiration or misoprostol. It may be necessary to refer to another facility if life-threatening complications or pre-existing conditions require additional resources.

Standard 37: Prophylactic antibiotics are not needed for medical methods. Lack of access to prophylactic antibiotics should not be a barrier to uterine evacuation care.

11. Uterine Evacuation Care with Manual Vacuum Aspirator (MVA)

Standard 38: All women and girls who present for uterine evacuation care must be offered pain medications (e.g. non-steroidal anti-inflammatory drugs) and non-pharmacologic approaches to treat pain and provided these services without delay.

Guidelines:

1. Providers should offer gentle, respectful care and provide appropriate information which can help women/girls stay calm and reduce anxiety.
2. Pain and discomfort during an MVA procedure can be reduced using a combination of verbal support, oral medications, paracervical block, gentle clinical technique and calming environment.
3. Prophylactic antibiotics should be administered prior to vacuum aspiration to help reduce the risk of post-procedure infection.
4. General anesthesia is not routinely recommended for MVA.

Standard 39: Evacuated tissue must be inspected for quantity and the presence of products of conception and signs of complete evacuation or molar pregnancy.

Guidelines:

1. If visual inspection is not conclusive, the material should be strained, immersed in water or vinegar, and viewed with light from beneath. If indicated, tissue specimen may also be sent to a pathology laboratory.

Standard 40: Post-procedure monitoring for at least 2 hours is conducted to ensure that the woman/girl is recovering well, to detect and manage any complications, to offer counseling and referrals and to provide the woman/girl with discharge instructions and information along with post-abortion family planning counseling.

12. Uterine Evacuation Care with Misoprostol

Standard 41: Counseling includes the discussion of: basic information about uterine evacuation care with misoprostol, risks and benefits, expected effects and possible side effects, the warning signs for potential complications, and when and where to seek medical help.

Standard 42: Preparation prior to administering misoprostol includes: counseling and obtaining informed consent; performing a client assessment, including physical, speculum and bimanual exam; ruling out ectopic pregnancy through clinical assessment; confirming that the woman/girl knows what to do, if there is an emergency; and discussing her contraceptive needs.

Guidelines:

1. Whenever possible, women/girls should be offered a choice of taking the misoprostol at home or in the healthcare facility, as different women/girls have different needs and desires.

For some women/girls, home may be a more private place but for others, the healthcare facility may afford a greater degree of privacy.

2. It is of great importance that only those women/girls are given the medicine to use at home, who can and will return at the time of emergency e.g., heavy bleeding. The distance from the health facility, support at home, transport and support, all should be carefully evaluated.
3. Healthcare providers should provide the following things to all women and girls taking misoprostol at home:
   - Misoprostol pills or a prescription for them;
   - Detailed information on number of tablets to be taken;
   - Details on the route of taking misoprostol;
   - Pain medicine, such as ibuprofen and/or mild narcotics with instructions about how to take it
   - Written and pictorial information on the uterine evacuation with misoprostol process, side effects and the warning signs, what signs indicate that the evacuation is complete, and information for follow-up contact, if desired;
   - Information on whom to contact, including a telephone number where possible, in case of questions, problems or complications, or the possibility of an unsuccessful evacuation, and where to go in the case of an emergency;
   - Other optional items: sanitary pads, cotton wool, contraceptive information and supplies;
   - The woman/girl should be counseled that the process may take as long as 10 days.

Standard 43: Thoroughly and accurately confirming the uterine size and gestational age and ruling out ectopic pregnancy is the key to safe, effective uterine evacuation care with misoprostol.

Standard 44: Both non-narcotic and narcotic analgesics can be used to treat pain associated with uterine evacuation with misoprostol.

Standard 45: Since different misoprostol products have varying quality and can degrade over time, healthcare providers should track medical abortion success rates to ensure that they are using an effective product. Misoprostol should be stored in a cool, dry place.[1]

13. Discharge and Follow-up

Standard 46: Healthcare providers must provide clear oral and written discharge instructions.

Standard 47: Healthcare providers must provide emotional support, if needed and refer to other services as determined by assessment of each woman/girl's individual needs, such as STI/HIV counseling. At discharge, the family planning method being practiced by the client should be documented. If no contraceptive method is being practiced, postabortion family planning (PAFP) counseling should be provided.

[1] To ensure the adequate drug efficacy, quality of purchased misoprostol should be in line with the recommended protocols.

Standard 48: Routine follow-up is not necessary but may be offered following an uncomplicated vacuum aspiration procedure, especially if no contraceptive was given. A routine follow-up visit within 7- 10 days is recommended in the case of medical methods with misoprostol to assess uterine evacuation success and serve as an additional opportunity to follow-up regarding contraceptive options e.g., IUD may be inserted then.

14. Complications

Standard 49: Healthcare staff must recognize and be able to treat or make the appropriate referral for complications that might occur during postabortion care, during a uterine evacuation procedure, in the recovery period or later. Complications may be presenting, procedural or pregnancy-related.

Standard 50: Women/girls with abortion complications must be closely monitored, informed about necessary follow-up care and counseled on any medical and emotional consequences.

Standard 51: Adverse events should be documented, reported and analyzed so that information learned can be used to improve care and client safety.

15. Monitoring, Quality Improvement and Evaluation

Standard 52: The accurate collection of service statistics and routine monitoring and evaluation at the healthcare facility level must be a key component of program management, and feedback based on analysis of this data must provide necessary information for improving access, maintaining and improving the quality of uterine evacuation care services delivered.

The facilities may have their own data reporting system but should also include a built-in system for data entry on medical and MVA uterine evacuation services, commodity supply (Misoprostol, and MVA), follow up as well as contraceptive counseling and contraceptive method uptake. (e.g., by adding an extra page to the registers)

Guidelines:

1. Monitoring should fit into the routine work of the facility, use simple indicators, be open and participatory, and be performed ethically.
2. When possible, monitoring should include input and participation of community members or clients who have received services, including women and girls.
3. Monitoring should be a simple, inclusive and rewarding (not punitive) process.
4. At the facility level, mechanisms for monitoring services may include analysis of routine service statistics, logbook reviews, case reviews, observation using checklists, facility assessments, maternal death and near-miss audits, and obtaining feedback from service users to improve the quality of care.
5. Routine uterine evacuation care service delivery information to be recorded in site logbooks may include:
   - Case number.

- Day/month/year of services.
- Age of client.
- Parity.
- Gestational age (# of weeks since LMP).
- Uterine size (in # of weeks).
- Diagnosis (induced abortion, incomplete abortion, other).
- Pain management (includes medical abortion): pain management given; prescription, information given; none given.
- Primary procedure method: MVA/EVA, misoprostol, sharp curettage/dilatation and curettage (D&C), other.
- Contraceptive methods received: implant/IUD/injectables/oral contraceptive pills/condoms/emergency contraceptive/sterilization (indicating if no method desired/method desired but no method received).
- Adverse events including what happened and what management was given?
- Was the woman/girl referred elsewhere?
- How the woman/girl learned about services?
- Provide name, initial or identification.
- All the above information should be made part of the District Health Information System (DHIS), and accordingly recorded and reported at all levels.

Standard 53: Quality assurance and improvement for uterine evacuation care must include planned and systematic processes for identifying measurable outcomes based on these standards and guidelines and the perspectives of health service users and healthcare providers, collecting data that reflect the extent to which the outcomes are achieved, and providing feedback to program managers and service providers.

Guidelines:

1. Quality improvement processes should attempt to identify and address both individual and organizational barriers to the achievement of good quality of care.
2. Quality improvement involves ongoing monitoring of routine service delivery, provider performance and patient outcomes, as well as periodic assessments conducted at the facility level.

Standard 54: Evaluation must include a systematic assessment of service delivery processes and outcomes.

Guidelines:

1. Comprehensive evaluation requires multiple data sources, including service statistics, feedback from healthcare providers and from women, girls and communities served, and financial records.
2. Program evaluators may focus their attention on three key areas related to policies, programs and services: access, availability, and quality of care.

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APPENDICES

Appendix A

TYPES OF UTERINE EVACUATION CARE SUITABLE TO EACH LEVEL OF THE HEALTHCARE DELIVERY SYSTEM (PUBLIC & PRIVATE SECTORS)

Community Level (Lady Health Visitors/Midwives/Community Midwives/Lady Health Workers):

- Public health education/information on reproductive health, including contraception and uterine evacuation care
- Community-based distribution of appropriate methods of contraception (condoms, pills, injectables and emergency contraceptives)
- All healthcare workers providing reproductive health services trained to provide counseling on contraception, unintended pregnancy and uterine evacuation care
- Lady Health Workers trained to provide information on, and referral to, pregnancy-detection and safe uterine evacuation services
- Lady Health Visitors/Midwives/Community Midwives trained to provide uterine evacuation with misoprostol and MVA.
- All healthcare workers trained to recognize abortion complications and promptly refer women/girls for treatment
- Transportation to services for management of complications of abortion
- All healthcare workers (and other key professionals such as police or teachers) trained to recognize signs of rape and to provide referral to healthcare or other social services

Primary Care Level (MCH centers/Basic Health Units/Rural Health Centers/Private Clinics/ NGOs' Clinics/Urban Health Units/Centers)

- All elements of care mentioned for the community level
- All healthcare workers providing reproductive health services trained to provide counseling on contraception, unintended pregnancy and uterine evacuation
- A broad range of contraceptive methods, including Implants, IUDs, injectables and emergency contraceptive pills.
- Manual vacuum aspiration for pregnancies of gestational age less than 13 weeks
- Medical methods of abortion for pregnancies of gestational age less than 13 weeks
- Clinical stabilization, provision of antibiotics, and uterine evacuation for women/girls with complications of abortion
- Vacuum aspiration or treatment with misoprostol for incomplete and missed abortion
- Prompt referral for women/girls needing services for abortion or for management of abortion complications that cannot be provided on-site

Referral Hospitals (Tehsil/District Headquarter/Tertiary/Teaching Hospitals- (Public/Private)

- All elements of uterine evacuation care mentioned for the primary-care level
- Provision of sterilization in addition to other contraceptive methods
- Uterine evacuation services for all circumstances and stages of pregnancy, as permitted by law
- Management of all abortion complications
- Information and outreach programs covering the full catchment area
- Training of all relevant cadres of healthcare professionals in uterine evacuation and postabortion contraception provision

Appendix B

EQUIPMENT AND SUPPLIES FOR UTERINE EVACUATION CARE WITH MVA

- Personal protective barriers such as gloves, face protection, apron
- Examination table with stirrups
- Bright light source
- MVA aspirator
- Silicone Lubricant for aspirators
- Selection of cannulae (4-12 mm)
- Simm's Specula, different sizes
- Tenaculum
- Tapered mechanical dilators (Pratt or Denn++iston)
- Sponge holding forceps
- Small bowl
- Sterile gauze pieces
- 10 - 20cc syringe
- #20 - 23-gauge spinal or hypodermic needle or needle from IV insertion set
- Betadine® or other non-alcohol based antiseptic
- 1 or 2% lidocaine without epinephrine (for paracervical block)
- Clear basin for specimen
- Strainer
- Fine-mesh metal strainer
- Glass dish to review POC
- Light box One
- Chlorine solution/bleach

MINIMUM REQUIREMENTS- UTERINE EVACUATION CARE WITH MISOPROSTOL

- **Infrastructure and furniture**
  - Counseling and examination room(s)
  - Light (electricity not required, can be a flashlight)
  - Toilet facilities
  - Clean water supply
- **Equipment and supplies**
  - Supplies for pelvic and bimanual exam, including speculum and gloves
  - Disinfection supplies for instruments and gloves
- **Drugs and contraceptive supplies**
  - Misoprostol or Mifepristone & Misoprostol (Combipack) if available
  - Analgesics and antipyretics (non-steroidal anti-inflammatory drugs)
  - Contraceptive supplies

Additional requirement for referral facilities:

- **Emergency treatment supplies**
  - Emergency resuscitation materials and drugs (including IV lines and fluids, IV antibiotics, blood transfusion and other surgical supplies)
  - MVA equipment
  - Other evacuation equipment if MVA is not available.

Appendix C

MATRIX SHOWING THE ROLE OF COMMUNITY AND FACILITY LEVEL HEALTH CARE PROVIDERS IN SAFE UTERINE EVACUATION/POSTABORTION COUNSELING & CONTRACEPTION (PUBLIC/PRIVATE SECTOR)

S#	Services	Cadres*					
		LHW	FWA	FWW	CMW	MW/ N-MW/ LHV	Doctor
1	Health Care Providers' skills for clinical assessment of client				√	√	√
2	Provide Confidentiality and Privacy to the client	√	√	√	√	√	√
3	Respect and provide support to Women's Informed and Voluntary Decision-Making and Autonomy	√	√	√	√	√	√
4	Community Linkages for Referral and Support	√	√	√	√	√	√
5	Conscientious Refusal	√	√	√	√	√	√
6	Uterine Evacuation Care with Misoprostol				√	√	√
7	Uterine Evacuation Care with Manual Vacuum Aspiration				√	√	√
8	Postabortion contraceptive counseling and service provision**	√	√	√	√	√	√
9	Client Follow-up	√	√	√	√	√	√
10	Complications Referral	√	√	√	√	√	√
11	Complications Treatment					√	√
12	Follow necessary Infection Prevention protocol for instruments cleaning and disinfecting	√	√	√	√	√	√
13	Maintain environmental Hygiene of UE services provision area and Health facility	√	√	√	√	√	√
14	Monitoring, Quality Improvement and Evaluation	√	√	√	√	√	√

* LHW Lady Health Worker; FWA Family Welfare Assistant; FWW Family Welfare Worker; CMW Community Midwife; MW Midwife; LHV Lady Health Visitor; NM Nurse Midwife

** WMO counseling and all FP methods including implant and Tubal ligation; MW/NM/LHV/FWW- FP counseling and method provision including condoms, pills, injections and IUDs, and referral for rest of the services; CMW/ LHW/FWA counseling and method provision including condoms, pills, injections, and referral for additional services.

Appendix D

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