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Acknowledgments

In 2010, the United States Agency for International Development (USAID) Postabortion Care (PAC) Working Group supported development of the first edition of the global PAC Curriculum under the leadership of Carolyn Curtis, a certified nurse midwife, American College of Nurse-Midwives fellow, and public health specialist with a master of science in nursing. Frances Ganges (consultant, Jhpiego) co-authored the first edition. Members of the PAC Working Group who served during the development of the 2010 curriculum include: Mary Vandenbergroucke, Sarah Harbison, Gary Cook, Lily Kak, Mary Ellen Stanton, Patricia Stephenson, Willa Pressman, Sandra Jordan, Marguerite Farrell, Lindsay Stewart, Maureen Norton, Shawn Malarcher, Lois Schaefer, Patricia MacDonald, Rushina Ravji, Beverly Johnston, Dana Vogel, Michal Avni, Erin Mielke, Margaret D’Adamo, Jewel Gausman, Jennifer Mason, Megan Matthews, Ishrat Husain, Chelsea Smart, Emily Roseman, and Jeff Spieler.

Rocio Lara (USAID/Bolivia), Betty Farrell (EngenderHealth), Melinda Pavin (EngenderHealth), Didar Ouladi (EngenderHealth), Jose del Barco (EngenderHealth), Gloria Metcalfe, (consultant, EngenderHealth), Pierre Mercier (USAID/Haiti),* Lucito Jeannis (Jhpiego), Jean Bernard Fevrier (Jhpiego), and Gérard Evens Lucien (consultant) supported field-testing of the first edition. Their comments and contributions were invaluable in strengthening the original curriculum.

Stembile Mugore (Evidence to Action/IntraHealth), Ricky Lu (Jhpiego), Leonard Tibyehabwa (EngenderHealth), Juliana Bantambya (EngenderHealth), Lawrenca Ngoso (EngenderHealth), Rehema Kahando (EngenderHealth), Nester Moyo (International Confederation of Midwives), Carolyn Curtis (USAID), Erin Mielke (USAID), Meridith Mikulich (USAID), Emma Clark (USAID), Bethany Arnold (USAID), Premila Bartlett (USAID), Deborah Armbruster (USAID), Jennifer Mason (USAID), Kate Dieringer (USAID), Kimberly Ocheltree (USAID), Evie Schumann (USAID), Gyasi Gomez (USAID), and Betty Farrell (consultant) provided guidance for development of the revised curriculum. The EngenderHealth-led Postabortion Care Family Planning and the MOMENTUM Safe Surgery in Family Planning and Obstetrics projects also supported the review process; this included Grace Lusiola, Rehema Kahando, Ominde Japhet Achola, Sara Malakoff, and Renae Stafford. We also extend appreciation to Mustafa Kudrati (EngenderHealth) and Candace Lew (EngenderHealth) for their review of the original curriculum and support with the revision.

Sara Malakoff, Ominde Japhet Achola, and Renae Stafford substantially revised the curriculum to reflect reviewers’ feedback and to update and finalize the content of the 2024 version of the curriculum. This included removing outdated practices, incorporating critical clinical updates, and streamlining the narrative to improve understanding and better support skills acquisition. Sincere thanks to Amy Agarwal (EngenderHealth) who further strengthened this version of the curriculum through additional rewriting and editing for clarity, concision, and consistency and who provided graphic design support for the full suite of materials.

The Postabortion Care Family Planning project and the MOMENTUM Safe Surgery in Family Planning and Obstetrics project, both led by EngenderHealth, with the generous support from the American people through USAID under Cooperative Agreements No. AID-OAA-A-00050 and 7200AA20CA00011, respectively, managed the review of this global training curriculum. The content in this curriculum reflects the views of the reviewers, which are the responsibility of EngenderHealth and do not necessarily reflect the views of USAID.

*Deceased, October 27, 2010
Module 1: Postabortion Care
Module 1, Session 1: Issues Surrounding Miscarriage, Induced Abortion, and the Delivery of Postabortion Care

Summary
This introductory session is a brief orientation to postabortion care (PAC). It begins by describing the magnitude of maternal mortality and morbidity, factors that may cause a spontaneous abortion (also known as a miscarriage), reasons why clients may choose to have an induced abortion, and why clients may delay seeking PAC. This is followed by a brief review of national legislation and service delivery guidelines related to the provision of PAC.

Learning Objectives
At the end of this session, participants will be able to:
1. Define the term “abortion.”
2. Discuss the magnitude of maternal mortality worldwide and nationally (if known).
3. Explain possible reasons for a spontaneous abortion or miscarriage.
4. Explain possible reasons a client may choose to have an induced abortion.
5. Describe national abortion laws and regulations and discuss how they impact PAC.
6. Describe facility policies for PAC (at participant’s place of employment) and how they impact service delivery.

Defining Terms
Throughout this document, the word “abortion” refers to the loss or termination of pregnancy, including spontaneous abortion (also known as miscarriage) or induced abortion. Note that in this document, the terms “miscarriage” and “spontaneous abortion” are used interchangeably. Another important term is “incomplete abortion,” which typically involves vaginal bleeding, contractions and associated cramping, cervical dilation, and incomplete passage of the products of conception. An induced abortion is defined as “unsafe” when it is performed by persons without the necessary skills and/or in an environment lacking medical standards; in these situations, safety is compromised and complications are more likely to occur.

Magnitude of Maternal Mortality and Morbidity
The World Health Organization (WHO) estimated that in 2020:
- Approximately 800 maternal deaths occurred each day from preventable conditions related to pregnancy and childbirth.1
- More than 287,000 maternal deaths occurred worldwide.2
- Almost 95% of maternal deaths occurred in low- and lower middle-income countries.3
- For every maternal death, approximately 20 to 30 pregnant people experience maternal morbidity.4

At the International Conference on Population and Development in 1994, there was consensus that contraception must be readily available to prevent unplanned pregnancies. In the years since, global stakeholders have strengthened commitments to addressing maternal health issues, including PAC. From 2000 to 2020, the global maternal mortality ratio declined by 34%.5 However, current maternal mortality ratios in some regions remain alarming, as shown in the table on the following page. Review the statistics in the Estimated Maternal Mortality Ratios table included on the following page and compare with your own country.

---

2 Ibid.
<table>
<thead>
<tr>
<th>Region†</th>
<th>Estimated Maternal Mortality Ratio</th>
<th>Range of Uncertainty on Estimates (80% Uncertainty Interval)</th>
<th>Number of Maternal Deaths</th>
<th>Lifetime Risk of Maternal Death</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower Estimate</td>
<td>Upper Estimate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Worldwide</td>
<td>223</td>
<td>202</td>
<td>255</td>
<td>287,000</td>
</tr>
<tr>
<td>Europe &amp; North America</td>
<td>13</td>
<td>11</td>
<td>15</td>
<td>1,400</td>
</tr>
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<td>Least Developed Countries</td>
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<td>388</td>
<td>431</td>
<td>120,000</td>
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<td>Northern Africa</td>
<td>103</td>
<td>76</td>
<td>144</td>
<td>5,900</td>
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<tr>
<td>Sub-Saharan Africa</td>
<td>545</td>
<td>477</td>
<td>654</td>
<td>202,000</td>
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<tr>
<td>Eastern Asia</td>
<td>24</td>
<td>20</td>
<td>29</td>
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<tr>
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<td>21</td>
<td>30</td>
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<tr>
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<td>118</td>
<td>155</td>
<td>47,000</td>
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<td>176</td>
<td>15,000</td>
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<tr>
<td>Western Asia</td>
<td>63</td>
<td>49</td>
<td>82</td>
<td>3,500</td>
</tr>
<tr>
<td>Latin America &amp; the Caribbean</td>
<td>88</td>
<td>79</td>
<td>99</td>
<td>8,400</td>
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<tr>
<td>Oceania (excluding Australia &amp; New Zealand)</td>
<td>173</td>
<td>120</td>
<td>255</td>
<td>540</td>
</tr>
</tbody>
</table>

†Explanations of which countries are included in select regional groupings are available from the United Nations at https://unstats.un.org/sdgs/indicators/regional-groups.
Maternal Mortality and Morbidity: The Impact of Abortion

From 2015 to 2019, approximately 121 million unintended pregnancies occurred globally each year, corresponding to 64 unintended pregnancies per 1,000 women aged 15 to 49 years.6 A total of 73.3 million pregnancies—61% of the unintended pregnancies—ended in abortion; this corresponds to 39 abortions per 1,000 women aged 15 to 49 years.7 Approximately 45% of the abortions were unsafe; 97% of these occurred in developing countries.8 Between 4.7% to 13.2% of maternal deaths can be attributed to unsafe abortions each year.9 Among adolescents aged 15 to 19, 55% of unintended pregnancies ended in abortions.10

### Percentage of Pregnancies Ending in Abortion, by Region and Time*

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<thead>
<tr>
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<tr>
<td>Sub-Saharan Africa</td>
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<td>31</td>
<td>32</td>
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<tr>
<td>Central &amp; South Asia</td>
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<td>29</td>
</tr>
<tr>
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<td>37</td>
<td>32</td>
<td>27</td>
<td>23</td>
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<tr>
<td>Oceania</td>
<td>18</td>
<td>19</td>
<td>19</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Worldwide</td>
<td>25</td>
<td>25</td>
<td>26</td>
<td>28</td>
<td>29</td>
<td>29</td>
</tr>
</tbody>
</table>


Between 10% and 20% of recognized pregnancies will end in spontaneous abortions or miscarriages.11 Some spontaneous abortions will also result in complications, such as retained products of conception, that necessitate emergency treatment. Further, many spontaneous abortions will result in long-term health problems, including chronic pelvic pain and pelvic inflammatory disease (PID), tubal blockage, and secondary infertility. Additionally, a client who has had a spontaneous abortion also has an increased risk of other problems including:

- Ectopic pregnancy
- Spontaneous abortion and premature delivery in subsequent pregnancies
- Psychological trauma
- Maternal death

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7 Ibid.


9 Ibid.


Moreover, children who have lost their mothers are up to 10 times more likely to die prematurely than those with living mothers. Additionally, newborns and children whose mothers died from maternal causes frequently face nutrition deficits (for instance, due to lack of breastfeeding) and are often less likely to receive the healthcare they need to thrive (including failing to receive critical immunizations or experiencing delays in healthcare when sick).

**Value of Postabortion Care, Including Contraceptive Care**

PAC is internationally recognized as an important intervention to address complications related to induced and spontaneous abortions. Comprehensive PAC integrates public health interventions, including community engagement and mobilization, with various service delivery interventions, such as emergency obstetric care, family planning (FP), and other reproductive health services.

PAC is an essential component of maternal and newborn healthcare programming. Indeed, many maternal health programs include PAC as part of emergency obstetric care, which is focused on reducing maternal mortalities and often incorporates interventions to prevent, recognize, and/or treat common obstetric complications.

Unmet need for FP is a key underlying cause of induced abortion. Therefore, contraceptive care is an integral part of comprehensive PAC—critical for addressing unmet need for FP and reducing the potential for subsequent unplanned pregnancies. Comprehensive contraceptive care includes provision of counseling and FP methods. However, services such as FP may unfortunately be omitted, thereby limiting PAC to the provision of emergency treatment (usually uterine evacuation) only. Ideally, contraceptive care is available in the same place as emergency treatment for abortion.

Integrating comprehensive PAC (including contraceptive care), into emergency obstetric care programs can (1) help clients determine healthy timing and spacing of future pregnancies, (2) address unmet demand for FP, and (3) help prevent additional unplanned pregnancies and abortions. Comprehensive PAC can significantly reduce maternal mortalities—thereby assisting countries in meeting target 3.1 of the United Nations Sustainable Development Goal 3, which aims to achieve a 70% reduction in maternal mortality by 2030.

**Spontaneous Loss Of Pregnancy**

The WHO defines a spontaneous abortion (or miscarriage) as the spontaneous loss of a clinical pregnancy before 20 completed weeks of gestation or, if gestational age is unknown, a weight of 500 grams or less. As of 2019, the WHO estimates that, worldwide, up to 39 abortions (spontaneous and induced) occur each year per 1,000 women aged 15 to 49 years. Most reported abortions are induced; however, an estimated 23 million spontaneous abortions occur each year, translating to 44 pregnancies lost every minute. Most miscarriages occur between the 6th and 12th weeks of pregnancy and can result in complete or incomplete expulsion of the products of conception. Caring for clients experiencing a miscarriage may require specific counseling and support, particularly

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for those grieving the loss of a pregnancy and/or experiencing anxiety concerning future fertility.\textsuperscript{18,19} The exact cause of a spontaneous abortion in many cases may not be clear, even after obtaining a thorough history and completing a physical examination. However, clients who experience multiple miscarriages should undergo further evaluation. Some known factors that contribute to miscarriages include:

- Genetic factors
- Hormonal factors, including:
  - Hypothyroidism
  - Polycystic ovarian syndrome
  - Poorly controlled diabetes (and other blood sugar metabolism disorders)
- Infections, including:
  - Bacterial, fungal, parasitic, and viral infections
  - Malaria (there is a strong association between malaria during pregnancy and an increased risk of spontaneous abortion)\textsuperscript{20}
  - Sexually transmitted infections (STIs) (prompt treatment of STIs during pregnancy can reduce the risk of spontaneous abortion) (Note: HIV status in the era of combination antiretroviral therapy does not demonstrate a risk of miscarriage.\textsuperscript{21})
- Gender-based violence (physical violence during pregnancy is linked with higher rates of miscarriage)\textsuperscript{22}
- Other contributing factors:
  - Environment
  - Medications
  - Other medical illnesses
  - Placental abnormalities
  - Smoking

\textbf{Induced Abortion—Why Clients Seek Abortion Services}

There are multiple reasons why clients seek abortion services when experiencing unplanned pregnancies. Some may have become pregnant due to a lack of power to negotiate sexual activity and/or use of contraception. The cultural and social environment in which a client lives, the dominant religion, and their personal beliefs can all contribute to the decisions they make about an unintended pregnancy and the services they seek.

In addition, providers may indirectly influence whether clients seek care. For example, the sociocultural perspectives and religious beliefs of health workers affect their attitudes toward clients seeking abortion services. If these attitudes are negative, clients may be reluctant to access care in a timely manner.

It is important to remember that every client’s situation is different and the factors that lead a client to seek abortion care vary widely. Knowing the reason for a client’s decision can assist providers in individualizing counseling, care, and referrals. Possible reasons why clients seek abortion are listed below.

- Economic problems, such as:
  - Inadequate income to care for a child
  - Lack of employment


• Social and cultural problems, such as:
  » A pregnancy outside of marriage
  » Cultural and religious stigma
  » Preference for a male child (if the fetus is a female)
  » Pressure or coercion to have an abortion
• Medical problems, such as:
  » A history of medical problems during pregnancy
  » A history of obstetric complications
  » Knowledge that the child will be born with serious health problems
• Unintended pregnancy, due to:
  » Lack of access to contraception
  » Contraceptive method failure
  » Rape or incest
• Other reasons, such as:
  » Desire to delay pregnancy for personal circumstances
  » Desire to limit or space pregnancies
  » School enrollment status

Factors that Affect whether Clients Seek Postabortion Care

Various sociocultural factors can affect whether clients seek PAC. Many of these factors are interrelated and affect clients’ abilities to make informed decisions concerning care.

• **Ability and willingness to seek care promptly:** Clients may need permission (and potentially financial support) from their partners or spouses (or parents or guardians, particularly in cases of adolescent clients) before seeking health services. For many clients, accessing PAC can lead to ostracism and even rejection by family and community members; this often leads to delays in seeking care.

• **Access to PAC:** Access to PAC within a client’s immediate area may be limited and, due to the personal nature of and the stigma surrounding PAC (noted previously), clients may be reluctant to visit local facilities where family, friends, or neighbors may recognize them.

• **Importance of fertility:** In many societies, fertility is central to community acceptance. Clients who experience spontaneous abortions may be blamed (or fear being blamed) for failing to demonstrate their fertility; this can negatively impact decisions to seek care. Additionally, clients may be unwilling to use modern contraception due to myths and misconceptions that contraception can be harmful to fertility.

• **Providers’ attitudes:** Provider attitudes toward PAC clients can affect clients’ decisions to seek care.23,24 Demonstrating empathy and providing support improves the quality of and associated demand for PAC.

To foster an environment that encourages care-seeking, providers should be respectful, gentle, and supportive. Further, clinic and hospital staff should be aware of and sympathetic to clients from diverse age groups, marital statuses, and sociocultural groups who visit the facility for PAC as well as any other healthcare issue.

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Delays in Seeking Care
Factors affecting whether clients seek care are also related to preventable delays. These include delays in the following.

Recognizing that a Problem Exists
- Many clients feel that certain problems—such as bleeding during pregnancy—are normal.
- Some clients may not know they are pregnant (especially adolescents and others who are pregnant for the first time) and therefore may be unaware that an issue they are experiencing may be pregnancy-related.

Deciding to Seek Care
- Gender and family roles may dictate who decides when a client seeks care—with spouses, parents, or other relatives preventing clients from seeking care.
- Clients who have received poor-quality care previously may be reluctant to seek care.
- Clients experiencing abortion-related complications may fear being ostracized by family, friends, and the community if they are discovered seeking care.
- The cost of services may deter clients from seeking care.

Reaching Care
- Clients may lack transportation access and roads may be poor, especially in rural areas and during rainy seasons.
- Clients may not have funds to cover the cost of transportation.

Receiving Quality Care Once They Arrive at the Facility
- Many facilities do not offer comprehensive PAC, leading to clients needing to seek care at other facilities or to return during available service hours.
- Lack of a triage system within facilities may result in delayed treatment of PAC clients.
- Treatment delays may occur in facilities that are under-staffed and/or insufficiently equipped.
- Service providers may have negative and punitive attitudes toward PAC clients, particularly youth and unmarried women, which may lead to delays in care.25,26

Understanding National Policies Regarding the Provision of Postabortion Care
PAC is a lifesaving intervention that should be available to all who need it. All clients have the right to the highest quality of PAC possible, whether experiencing an induced or spontaneous abortion. Medical professionals have an ethical responsibility to provide PAC, including FP counseling and services, to all clients seeking such care; this care is essential to saving lives and reducing future unplanned pregnancies and abortions.

Every country has laws, policies, protocols, and/or regulations on induced abortion and PAC. These laws, policies, protocols, and regulations directly affect providers and clients and it is important that providers offer care in alignment with these established standards and guidelines. However, providers and clients may not always be familiar with or understand laws regarding the legal status of abortion and/or the legality of PAC, which can result in barriers to accessing or providing competent PAC. For instance, in countries where induced abortion is illegal, people may be unaware that emergency PAC is a medical requirement in nearly every instance, regardless of whether the abortion is induced or spontaneous. As a result, clients needing PAC may be reluctant to seek care, even for spontaneous abortions, fearing potential consequences, and providers may similarly fear providing care. Concerns about stigma and criminal prosecution, for instance, can result in a failure to seek or provide care. Provision of PAC should not lead to punishment of the provider or client, but can occur if policies are not widely understood and supported.

To address this issue, regulating bodies should promote understanding of laws and policies affecting PAC among providers and the public. Providers must receive training in emergency obstetric procedures as well as FP counseling and service provision—and undergo regular updates, as needed. It is also important to engage community leaders to generate awareness and to incorporate other interventions to educate the public.

Think about your facility and community and what local laws and policies may be affecting PAC demand and provision. If your country’s policies are unavailable, consider examples from other countries, included in the Examples of National Postabortion Care Policies and Guidelines table below.

<table>
<thead>
<tr>
<th>Examples of National Postabortion Care Policies and Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bolivia</strong></td>
</tr>
<tr>
<td>• Supreme Decree #25265 (1998): Addresses basic healthcare that promotes preventive and curative services to reduce maternal and infant morbidity and mortality</td>
</tr>
<tr>
<td>• Ministerial Resolution #0133 (1999): Sets the scope of the government’s obligation to protect the health and well-being of the Bolivian population</td>
</tr>
<tr>
<td>• Law #1788, Article 11 of the Bolivia Health Code: Details the norms, supervision, and evaluation of the national health system for improving service quality in line with the government’s Strategic Health Plan</td>
</tr>
<tr>
<td>• Supreme Decree #26874 (2002): Describes the universal maternal and infant health insurance scheme</td>
</tr>
<tr>
<td>• Law #2426 (2002): Details planning, acquisition, and maintenance of equipment in sufficient quantities for clients seeking treatment for a hemorrhage during the first half of pregnancy</td>
</tr>
<tr>
<td><strong>Kenya</strong></td>
</tr>
<tr>
<td>• National Guidelines for Quality Obstetrics and Perinatal Care (n.d.): Ministry of Public Health and Sanitation and Ministry of Medical Services guidelines for maternal and newborn health, including guidance for PAC and contraception</td>
</tr>
<tr>
<td><strong>Nepal</strong></td>
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<tr>
<td>• National Medical Standard for Reproductive Health, Volume 1, Contraceptive Services (2020): Ministry of Health and Population standards, Chapter 14, including PAC guidance</td>
</tr>
<tr>
<td><strong>Philippines</strong></td>
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<tr>
<td>• Administrative Order No. 2016–0041, National Policy on Prevention and Management of Abortion Complications (2016): Department of Health guidelines, including the scope of PAC, PAC procedures and responsibilities at each level of the healthcare system, and a general statement on quality assurance</td>
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<tr>
<td><strong>Sri Lanka</strong></td>
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<tr>
<td><strong>Tanzania (Zanzibar)</strong></td>
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<tr>
<td>• Guideline for Post Abortion Care Service Delivery (2019): Zanzibar Ministry of Health guidelines</td>
</tr>
<tr>
<td><strong>Uganda</strong></td>
</tr>
<tr>
<td>• Clinical Guidelines, National Guidelines for Management of Common Conditions (2016): Ministry of Health guidelines, including PAC and contraception</td>
</tr>
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Module 1, Session 2: The Postabortion Care Model

Summary

Postabortion care (PAC) is a package of services provided to a client who has experienced an induced or spontaneous abortion. PAC comprises three core components that should be implemented systematically. This session will focus on defining PAC, explaining the rationale for PAC programs, introducing the core components of the PAC model established by the United States Agency for International Development (USAID), and introducing the benefits of postabortion family planning (FP) counseling and services.

Learning Objectives

At the end of this session, participants will be able to:
1. Define the term “postabortion care.”
2. Explain why counseling should be integrated throughout all components of PAC.
3. Outline the three components of the USAID PAC model and the main elements of each.
4. Explain the difference between emergency obstetric care and PAC.
5. Explain three benefits associated with PAC.

Postabortion Care

PAC is an important intervention to address complications related to spontaneous and induced abortions by improving treatment and linking clients to contraceptive care and other reproductive health services. PAC, as a part of a larger reproductive health strategy, can be vital in reducing the unmet need for FP, which can prevent future unintended (including unplanned and/or mistimed) pregnancies, decrease the incidence of subsequent abortions and miscarriages, and decrease maternal morbidity and mortality rates.

Definition of Postabortion Care

PAC is a package of integrated services provided to clients who have had miscarriages, induced abortions, or are experiencing abortion-related complications. USAID developed an updated PAC model that comprises three core components to be implemented systematically. The three core components of the model are:

1. Emergency treatment for complications of spontaneous or induced abortions
2. Provision of contraceptive counseling and method of choice; assessment of risk for STIs, including HIV; referral for STI management and/or HIV counseling and testing
3. Community empowerment via awareness generation and mobilization activities

Benefits of Providing Postabortion Care

PAC benefits both clients and health programs.

- PAC helps reduce incidences of morbidity and mortality associated with abortions.
- PAC contributes to higher contraceptive uptake rates.
  - When postabortion FP counseling and services are available at the same time and in the same location as emergency treatment, clients are more likely to voluntarily adopt contraception.27,28
  - Providing FP counseling increases the proportion of clients who voluntarily adopt a contraceptive method before leaving the PAC facility.29

29 Ibid.
• PAC increases access to contraceptive care and informed method choice. Improving providers’ FP counseling and clinical skills can increase the proportion of PAC clients who can access a method of choice.  

• PAC that includes FP counseling and services enables clients to achieve their reproductive intentions by deciding on whether and when to have a future pregnancy.

• PAC can generate cost savings to facilities and clients; using misoprostol or vacuum aspiration (VA) for PAC can support savings for the facility (for example, with lower costs associated with fewer personnel, laboratory services, medications, and anesthesia) and for clients (for instance, with less expensive medications and reduced time required at the facility).

• PAC mitigates subsequent abortions by providing voluntary contraception that can reduce the number of future unintended pregnancies.

Components of the USAID Postabortion Care Model

The USAID PAC model includes three primary components, as illustrated in the figure below.

USAID PAC Model (2004)

Component 1: Emergency Treatment

The first component of PAC involves triage and emergency treatment based on the level of the healthcare facility and staff. This includes prompt treatment of abortion complications, such as addressing retained products of conception (that may result in hemorrhage and/or infection), injury to internal organs, and other related problems (such as shock). The specific aspects of emergency treatment required depend on the individual client’s condition, but often include client evaluation, stabilization, uterine evacuation, and management of pain, bleeding, and infection.

Removal of retained products of conception is one of the signal functions of emergency obstetric care. PAC includes the removal of retained products of conception as part of emergency treatment, but also integrates FP counseling and services. Community

Integrating Counseling

PAC includes emergency and preventive services. While not all facilities may be able to support provision of all PAC components, trained PAC providers can offer counseling and preventive care. Counseling is an integral part of all components of PAC, with specific counseling topics for each of the three key components of PAC. However, providers should leverage all appropriate opportunities for initiating counseling on the various subjects. Provision of FP counseling should begin as soon as possible, to support FP service provision for PAC clients prior to discharge. In addition to giving clients critical information, providers should offer emotional support and respectful care, including by encouraging clients to ask questions or express concerns throughout the visit.


empowerment is another integral component of PAC, but it is not a signal function of emergency obstetric care. The figure below illustrates the difference between PAC and emergency obstetric care.

**PAC versus Emergency Obstetric Care**

<table>
<thead>
<tr>
<th>Emergency Obstetric Care</th>
<th>= Uterine Evacuation</th>
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<tbody>
<tr>
<td>Postabortion Care</td>
<td>= Uterine Evacuation + FP Counseling and Services + Community Mobilization</td>
</tr>
</tbody>
</table>

**Component 2: Provision of Contraceptive Counseling and Method of Choice; Assessment of Risk for STIs, Including HIV; Referral for STI Management and/or HIV Counseling and Testing**

For many clients, PAC may be one of the few contacts they have with the healthcare system; it is therefore critical to provide comprehensive reproductive care and initiate referrals to appropriate services, as needed. The second component of PAC comprises FP counseling and service provision, as well as other reproductive health services, such as assessment of risk for STIs, including HIV, and referral for STI management and/or HIV counseling and testing. Provision of STI and HIV services and referrals is particularly relevant where there is notable disease prevalence but is dependent on available resources.

Postabortion FP is an evidence-based high-impact practice, with recent studies demonstrating an increase in voluntary postabortion FP uptake when services are available in the same place as emergency treatment and when couples receive joint FP counseling (with the PAC client’s consent).

While timely emergency treatment is vital to reducing maternal mortality, voluntary postabortion FP is the preventative care aspect of PAC that is essential for mitigating future unplanned and mistimed pregnancies, subsequent abortions, and related complications. Postabortion FP also assists in addressing general unmet need for FP, which is often an underlying cause of induced abortion.

The WHO recommends that clients who have miscarried or have undergone an induced abortion wait at least six months before conceiving again in order to increase the chances of a healthy future pregnancy and decrease the risk of low birth weight, maternal anemia, and preterm delivery. *Note: Systematic review and meta-analysis primarily comprising studies from high-income countries suggests that an interval of less than six months following miscarriage is not associated with adverse outcome.* Providers should support PAC clients to make voluntary and informed choices about contraception based on their reproductive and fertility intentions. All clients should receive appropriate counseling—regardless of the type of treatment required and even when the full range of contraceptive methods or services are not available on-site. For PAC sites that do not offer comprehensive FP services, linkages with referral sites that offer comprehensive contraceptive care are critical. For instance, if a client wishes to adopt a long-acting or permanent method that is not available at the site where emergency treatment is offered, providers should offer referrals for the desired method. Providers should also offer short-acting methods (such as condoms) and emergency contraception—as interim methods for clients who require referrals to other service sites or who wish to have more time to select another method.

Clients who experience unintended pregnancies may also be exposed to STIs, which if untreated, may lead to future spontaneous abortions, infertility, PID, and other reproductive health problems. Similarly, clients who are exposed to or are living with HIV require specialized care, counseling, and support. Countries with high incidences of STIs and HIV should therefore consider including STI and HIV counseling, evaluation, treatment, and/or referrals within PAC, if resources allow.

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Component 3: Community Empowerment through Awareness Generation and Mobilization

Effective awareness generation and mobilization interventions are needed to ensure communities are able to demand high-quality, safe, and effective postabortion services. In this context, the term “community” includes government agencies (e.g., ministries of health and education), nongovernmental organizations, community associations, faith-based organizations, private voluntary organizations, professional organizations, women’s groups, traditional and religious leaders, traditional healers, community-based distributors, development partners, and other relevant stakeholders in the local context. PAC community mobilization using the community action cycle—as implemented in Bolivia, Egypt, Kenya, Peru, and Senegal—has resulted in increased voluntary FP uptake, not only for PAC clients, but also for the community at-large.

To support awareness of and access to PAC, communities should:

- Identify health needs related to PAC.
- Plan for resources necessary to meet identified health needs.
- Determine how to make care accessible in the community.
- Work with stakeholders to mobilize resources to ensure availability and access to PAC.
- Educate community members about risks associated with unsafe abortion, signs of a spontaneous abortion, and risks of delaying care.
- Establish relationships with healthcare providers and facilities at all levels to ensure comprehensive service delivery for PAC.

The table on the following pages outlines the three core components of PAC by level of healthcare facility and provider cadres.
### Provision of Core Postabortion Care Components, by Healthcare Level and Provider Cadre*

<table>
<thead>
<tr>
<th>Healthcare Level</th>
<th>Provider Cadre</th>
<th>Core PAC Components</th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Community &lt;br&gt; health workers &lt;br&gt; and volunteers,† &lt;br&gt; traditional birth &lt;br&gt; attendants, healers</td>
<td>- Recognition of signs and symptoms of abortion and postabortion complications &lt;br&gt;- Referral to facilities where treatment is available</td>
<td>- Counseling and information sharing &lt;br&gt;- Provision of condoms, diaphragms, spermicides, oral contraceptives, emergency contraception, patch, injectable contraceptives, and implants‡ &lt;br&gt;- Referral and follow-up for these and other methods</td>
<td>- Community ownership and leading the community empowerment efforts &lt;br&gt;- Identification of champions</td>
<td></td>
</tr>
<tr>
<td>Drug shops and pharmacies</td>
<td>Drug shop &lt;br&gt; attendants, pharmacists, &lt;br&gt; pharmaceutical technologists</td>
<td>- Recognition of symptoms of abortion-related complications &lt;br&gt;- Referral to facilities where treatment is available &lt;br&gt;- Medical treatment of uncomplicated incomplete abortion less than 14 weeks gestation</td>
<td>- Counseling and information sharing &lt;br&gt;- Provision of condoms, diaphragms, spermicides, oral contraceptives, emergency contraception, patch, injectable contraceptives, and implants‡ &lt;br&gt;- Referral and follow-up for these and other methods</td>
<td>Not Applicable (N/A)</td>
<td></td>
</tr>
<tr>
<td>Alternative medicine clinics</td>
<td>Alternative medicine practitioners</td>
<td>- Recognition of symptoms of abortion-related complications &lt;br&gt;- Referral to facilities where treatment is available &lt;br&gt;- Medical treatment of uncomplicated incomplete abortion less than 14 weeks gestation</td>
<td>- Counseling and information sharing &lt;br&gt;- Provision of condoms, diaphragms, spermicides, oral contraceptives, emergency contraception, patch, injectable contraceptives, and implants‡ &lt;br&gt;- Referral and follow-up for these and other methods</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
### Provision of Core Postabortion Care Components, by Healthcare Level and Provider Cadre (continued)

<table>
<thead>
<tr>
<th>Healthcare Level</th>
<th>Provider Cadre</th>
<th>Core PAC Components</th>
</tr>
</thead>
</table>
| Primary level: Primary health clinics, FP clinics, polyclinics | Health workers, nurse aids, attendants, nurses, trained midwives, general practitioners | 1. Emergency Treatment All primary-level facilities—all above activities plus:  
- Diagnosis based on medical history and physical exam  
- Resuscitation and prep for treatment or transfer  
- Tetanus vaccination  
If trained staff and appropriate equipment are available—all above activities plus:  
- Counseling on treatment options; emotional support  
- Obtaining consent for VA or medical treatment  
- Hematocrit and/or hemoglobin testing  
- STI evaluation and treatment  
- Initiation of emergency treatments (antibiotic therapy, intravenous fluid replacement, and oxytocics)  
- Uterine evacuation of uncomplicated first trimester cases  
- Appropriate pain control (analgesia and sedation and/or local anesthesia)  
- Referral of second trimester incomplete abortion, missed abortion, and genital and/or intra-abdominal injury  |
|                   |                | 2. Postabortion FP Counseling on the return of fertility following emergency treatment, self-care and emotional support, achieving fertility and reproductive intentions, using FP methods, and behaviors that increase risk of STIs and HIV  
- Provision of condoms, diaphragms, spermicides, oral contraceptives, emergency contraception, patch, injectable contraceptives, implants, intrauterine devices (IUD), and instructions on natural methods  
- Referral to community, primary, secondary, and tertiary resources offering FP counseling and services; emergency treatment services; and assessment of risk for STIs, including HIV, and referral for STI management and/or HIV counseling and testing  
- Referral and follow-up, as needed  
- Assessment of risk for STIs, including HIV, and referral for STI management and/or HIV counseling and testing  
- Referral for care for gender-based violence survivors and other psychological and emotional needs |
|                   |                | 3. Community Engagement  
- Educate community members about risks associated with unsafe abortion, signs of a spontaneous abortion, and risks of delayed care seeking (including maternal mortality risk)  
- Demonstrate linkages between the community and community, primary, secondary, and tertiary resources offering: FP counseling and services; emergency treatment services; and assessment of risk for STIs, including HIV, and referral for STI management and/or HIV counseling and testing  
- Facilitate community decisions about the type and number of PAC facilities needed in the community and transportation options for emergency treatment  
- Generate resources for PAC, including funding to support facilities and cover service, transportation, and equipment costs |
## Provision of Core Postabortion Care Components, by Healthcare Level and Provider Cadre (continued)

<table>
<thead>
<tr>
<th>Healthcare Level</th>
<th>Provider Cadre</th>
<th>Core PAC Components</th>
<th>2. Postabortion FP</th>
<th>3. Community Engagement</th>
</tr>
</thead>
</table>
| First referral level: Hospital | Nurses, trained midwives, general practitioners, obstetrician/gynecologists, specialists | All above activities plus:  
• Emergency evacuation for fetal death through second trimester  
• Treatment of most postabortion complications  
• Use conscious sedation, analgesics, local or general anesthesia  
• Diagnosis and referral for severe complications (including septicemia, peritonitis, and renal failure)  
• Laparotomy and indicated surgery (including for ectopic pregnancies)  
• Blood cross-match and transfusion | All above activities plus voluntary sterilization | N/A |
| Secondary and tertiary levels: Regional and referral hospitals | Nurses, trained midwives, general practitioners, obstetrician/gynecologists, specialists | All above activities plus:  
• Uterine evacuation as indicated for all cases  
• Treatment of severe complications (including bowel injury, severe sepsis, renal failure)  
• Treatment of bleeding and clotting disorders | All above activities | N/A |


† This includes community members with basic health training and community-based distributors.

‡ Specific method provision allowable may vary by country. For instance, in some countries, select providers (such as community health extension workers and pharmacists) who receive additional training and can provide contraceptive implants.
Module 1, Session 3: Values and Attitudes

Note: The content contained within this session is adapted from Counseling the Postabortion Client: A Training Curriculum.37

Summary
This session will discuss values and attitudes and their importance in delivering PAC. While many providers come from similar backgrounds, they may have vastly different experiences leading to different assumptions that affect their daily work interactions or how they address common issues. Awareness of one's values and attitudes can help healthcare professionals offer care in a respectful and nonjudgmental manner, regardless of a client's personal situation, social status, or values.

Learning Objectives
At the end of this session, participants will be able to:

1. Define the terms “value” and “attitude.”
2. Explain the importance of being aware of our own values and attitudes.
3. Explain the importance of unconditional respect and protecting and fulfilling the human rights of all clients, regardless of their values, social status, or personal situations.
4. Demonstrate respect during counseling sessions and/or classroom activities.

Values and Attitudes about Postabortion Care
A value is a belief that is important to an individual. Values and beliefs can be influenced by culture, education, religion, and various personal experiences. Our values are often so ingrained that we may be unaware of them until we are confronted with a situation that challenges them. Our values shape our attitudes, or the way that we think about and act toward various people and ideas.

How we communicate our attitudes and values (verbally and nonverbally) is an important part of our interactions with clients. Every interaction between a client and healthcare provider, from the time the client enters the healthcare system until discharge, affects the client's satisfaction with care, their recovery time, and how well they care for themselves after leaving the facility. Our attitudes, biases, feelings, and values affect how we treat clients. For example, our feelings about a client's age, appearance, culture, economic status, marital status, parity, religion, and/or other social characteristic can affect the gentleness or harshness with which we perform procedures, the delay that we impose on clients, and whether we respond to the full range of healthcare needs of the client. This may result in biased treatment of clients presenting with a spontaneous or induced abortion as well as unequal treatment of young and unmarried clients presenting with an induced abortion versus married adolescent clients presenting with a miscarriage.

In some settings, provider attitudes about clients with abortion-related complications may be influenced by community and social norms outside the health system. For example, providers may fear community and/or legal repercussions for treating postabortion clients despite explicit laws and policies that allow for the provision of PAC.

Being self-aware helps ensure that we do not impose our beliefs on clients. It is not always easy to keep our personal attitudes and values separate from our professional responsibilities, but it is our duty to do so.

Remember, two people from similar experiences and backgrounds may see things differently. What do you see in the image, a woman or a musician?


Responding to Client Needs

Effective communication with clients requires providers to understand the feelings and experiences of clients. While healthcare workers are not obligated to resolve clients’ feelings, it is often helpful to demonstrate an understanding of their feelings. Further, the provider’s expertise is often not the primary determining factor when clients rate quality of care. Instead, clients are more likely to respond favorably to providers who express genuine interest and concern. Consider, for instance, the following examples when caring for PAC clients:

- The client may be experiencing a miscarriage of a desired pregnancy, including as a result of physical violence, malaria, or other factors.
- The client may have induced an abortion for an unintended pregnancy resulting from gender-based violence (for instance, the pregnancy may be the result of reproductive coercion, sexual violence, child marriage, rape, forced sex work, or forced sexual debut). Further, the client may be experiencing or may have experienced intimate partner violence previously. Clients experiencing such violence are more likely to experience unintended pregnancies and there is an association between violence and pregnancy termination.38,39
- The client may have been forced to have an abortion.
- The client, particularly in the case of an adolescent client, may be feeling guilty, isolated, and/or sad and may be concerned about stigma and/or risks of criminalization.40

It is normal for providers to experience a range of emotions during the potential life-and-death encounters of clinical emergencies. Therefore, providers must be aware of their emotional responses and how their thoughts and actions can convey empathy and support the client, including by encouraging effective two-way communication and providing reassurances.

Emotional Response of Postabortion Clients

PAC clients may experience a range of emotions. Many factors may influence a client’s emotional state, including their feelings about the pregnancy loss or abortion, concern over their medical condition, beliefs about their medical treatment, lack of familiarity with the hospital setting, and the amount of time they waited for treatment. Approximately 40% to 45% of abortion clients experience significant anxiety before the procedure. For many, this distress declines after the procedure; however, approximately 25% of these clients report anxiety and depression from one month to two years after the procedure.41 Grief after a miscarriage is also common as are feelings of anxiety and/or depression. Miscarriage clients may perceive themselves as being failures for not carrying their babies to term and/or may be worried about future pregnancies.42,43 Some clients also worry about how their in-laws or other relatives will perceive their pregnancy loss.44,45,46 Evidence indicates stronger emotional reactions

among clients who experience miscarriages than those who undergo an induced abortion.\textsuperscript{47,48} Reports show long-term psychological outcomes are similar between clients who have had a live birth and those who have had an induced abortion.\textsuperscript{49} This indicates a need for greater counseling and support for clients who have had a miscarriage.

Recognizing these data, providers should consider that PAC clients may experience a diversity of feelings (including depression, guilt, regret, and sadness) following a miscarriage or induced abortion, particularly in cases of unintended pregnancies, including those that may have resulted from violence, and/or in cases in which clients needed to make decisions based on health issues or socioeconomic factors. Acknowledging clients’ fears and concerns and providing clients with information about their conditions, about their rights to care (including confidential treatment with dignity), about treatment options for their conditions (including aspects of self-care), and about the importance of consent to care (verbal or written) are all paramount to the provision of high-quality, respectful healthcare. High-quality PAC also requires providers to be empathetic, including by asking clients how they are feeling and about their prior experiences with the healthcare system, reassuring the client (as needed), and respecting the client and their partner’s and/or family member’s beliefs and cultures while providing care.

Clients may delay seeking care due to gender-based violence, lack of agency in decision-making, sexual coercion, and/or restrictions and limitations related to stigma and other social norms. Similarly, clients may be reluctant to tell the health provider how they feel. In such cases, healthcare providers should encourage the client to share by asking questions and demonstrating a nonjudgmental attitude. Help the client feel more comfortable by asking, “Tell me, what is your biggest worry?” or “What can I do to help you?” A client may say, “I feel horrible” or “I want to leave” and you may feel inclined to respond with phrases such as, “You will feel better soon,” or “Your situation is not that bad.” Responses like these fail to acknowledge the client’s perspective and instead diminish their feelings, which may cause them to feel more uncomfortable sharing further. Providers should instead validate the client’s feelings and ask the client to share more, for instance, by saying, “I think many clients feel the same way in this situation,” or “We understand and we’re here to help you.” Sympathy and empathy are two ways that one can support clients to share their feelings (see text box below).

Regardless of the circumstances that caused a client to seek PAC, the provider must offer professional, nonjudgmental, respectful care. PAC training therefore includes both clinical skills training as well as opportunities for providers to examine and reflect on their personal values, attitudes, and experiences in order to provide more empathetic care to clients. Values clarification and reflection exercises aim to help eliminate punitive attitudes toward postabortion clients and ensure high-quality PAC.

Empathy is the ability to imagine, understand, and/or be sensitive to another person’s experiences and feelings. Being empathetic means understanding a person’s feelings without necessarily having experienced them yourself. Empathy is not just feeling sorry for someone; it means demonstrating understanding, concern, and a desire to help in a way that encourages open, honest communication.

Sympathy is the ability to share another person’s emotions, especially of sorrow or anguish. Sympathy can be shown by expressing compassion (in culturally appropriate ways), for instance, by consoling or reassuring a client experiencing a range of challenging emotions.


Considerations for Working with Young People

Nearly one third of the global population—approximately 2.4 billion people—are youth aged 10 to 29. Further, adolescents and youth make up a large share of the populations of low- and middle-income countries, accounting for 30% to 70% of national populations. By 2050, 9 of 10 young people will live in Africa or South Asia and Sub-Saharan Africa will account for nearly half of the world population growth over the coming decades. As of 2019, adolescents aged 15 to 19 in these countries experienced an estimated 21 million pregnancies each year. Further, 55% of the unintended pregnancies among these adolescents ended in abortions, which are often unsafe. Unintended pregnancy tends to be higher among those with less education and those of lower socioeconomic status. Other factors contributing to adolescent pregnancy rates include unsafe sex, early sexual debut, early and forced marriages and unions, sexual abuse, and intimate partner violence. One WHO report estimated that 120 million girls under 20 years of age have experienced some form of forced sexual contact. Such abuse is deeply rooted in gender inequality, affecting girls more than boys, although many boys are also affected.

Pregnant adolescents face many risks, including risks associated with pregnancy complications, unsafe abortions, and increased maternal mortalities. Young people also face many barriers to accessing essential health services, including PAC. As a result, young people often present at health facilities for the first time only after becoming unintentionally pregnant or experiencing complications from an unsafe abortion. Therefore, it is important to use this visit as an opportunity to provide comprehensive sexual reproductive health services to address a full range of healthcare needs.

Young people seeking PAC are not a homogenous group; they may be at different stages of physical and psychosocial development, they may be married or unmarried, they may or not be living with HIV, they may be in or out-of-school, and they may be employed or unemployed. These clients may also be gender-based violence survivors; for instance, a young person may be a victim of coercion, child marriage, forced sexual debut or sex work.

Barriers to care for young people, include:

- Limited understanding of bodies and reproduction
- Concerns that providers will be hostile or judgmental, or that services will lack privacy and confidentiality
- Fears of contraceptive methods based on myths and misconceptions
- Fears of being stigmatized and ostracized by family members, friends, and communities (especially for clients who are experiencing violence)
- Lack of necessary financial resources to pay for services or transportation costs
- Lack of decision-making power to seek health services (especially among young people who are financially dependent on family members and/or experiencing violence)

53 Ibid.
57 Ibid.
Essential minimum standards for high-quality PAC for young people include:\(^{58}\)

- Policies that do not restrict services based on age, marital status, gender, or another person's approval (for instance, approval of a partner, parent, or other family member)
- Trained providers who are respectful and nonjudgmental
- Assurance of privacy and confidentiality
- Availability of a wide range of sexual and reproductive health services and contraceptive methods
- Youth involvement in service design and provision of feedback

Other recommendations include:

- Ensure service costs are not a barrier.
- Provide service delivery options that will not require the client to wait a long time for admission at the facility.
- Use appropriately sized instruments, such as a smaller speculum for examination.
- Allow extra time for counseling and care, as young people may not immediately feel comfortable revealing their problems or expressing their concerns.
- Tailor counseling to the specific needs and characteristics of each young client—use language that they can understand with respect to contraceptive options and explain how each method can help prevent future unintended pregnancies.

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**Characteristics of Youth-Friendly Services*\(^\text{\textcircled{1}}\)**

<table>
<thead>
<tr>
<th>Provider Characteristics</th>
<th>Health Facility Characteristics</th>
<th>Health Program Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Specially trained to serve young people</td>
<td>• Adequate space to provide privacy</td>
<td>• Youth involvement in design and mechanisms for continuous feedback from young clients</td>
</tr>
<tr>
<td>• Nonjudgmental</td>
<td>• Convenient hours</td>
<td>• Youth representatives serve on health facility board or management committee</td>
</tr>
<tr>
<td>• Able to communicate with young people and support informed choice</td>
<td>• Convenient location</td>
<td>• Drop-in clients welcome</td>
</tr>
<tr>
<td>• Respectful of young people</td>
<td>• Separate space and/or special hours for serving young people</td>
<td>• Short waiting times</td>
</tr>
<tr>
<td>• Offers confidentiality and privacy</td>
<td>• Comfortable setting</td>
<td>• No or minimal fees for care</td>
</tr>
<tr>
<td>• Allows adequate time for client-provider interactions</td>
<td>• Peer counselors available on-site</td>
<td>• Publicity and recruitment activities that reassure youth</td>
</tr>
<tr>
<td></td>
<td>• Supportive policies that do not restrict services based on age, gender, marital status, or approval of partner, parent, or other family member</td>
<td>• All young people, regardless of gender or sexual orientation, welcomed and served</td>
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<tr>
<td></td>
<td>• Policies that allow young people to have a companion accompany them during counseling and services, if the client desires</td>
<td>• Wide range of sexual reproductive health services (including contraception, PAC, and STI and HIV services) and wide range of contraceptive methods available</td>
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<td></td>
<td>• Equipment, treatment, and pain management that consider the special needs of young people</td>
<td>• Referrals available, as necessary</td>
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<tr>
<td></td>
<td>• Policies allow providers to spend adequate time with young clients</td>
<td>• Education materials available on-site for clients to take home</td>
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Module 2, Session 1: Preparation and Client Assessment

Summary
Preparations for healthcare provision start long before the client arrives at the facility. First, facilities must organize health services to ensure readiness to provide the highest quality of care. This includes not only restructuring the environment but also ensuring that providers are trained in all PAC components and that a range of contraceptive methods are available at the service site, when possible. Paired with a supportive policy environment for PAC, reorganizing services can improve provider attitudes and skills and increase access to contraceptive methods and services. Then, when the client presents for care, the provider can assess their clinical condition in an environment that increases quality of care and client satisfaction. A thorough assessment is the first step in providing the most appropriate care and treatment. This session is an introduction to the emergency treatment component of PAC, and includes a brief discussion about rearranging service areas to enhance client privacy, followed by guidance on gathering information about the client’s history and conducting a physical examination.

Learning Objectives
At the end of this session, participants will be able to:
2. Describe how to rearrange service areas to ensure confidentiality, privacy, and the ability to counsel a client with a spouse or companion (as appropriate).
3. Perform a client assessment and examination according to standards, including:
   » Conducting a rapid assessment to rule out life-threatening conditions and to facilitate immediate management, as needed
   » Obtaining a complete history
   » Completing a physical examination, including abdominal and pelvic examinations
   » Determining and obtaining appropriate laboratory tests
4. Explain the different types of miscarriage and abortion, including major signs and symptoms.
5. Demonstrate the ability to integrate appropriate counseling in emergency treatment as indicated.

Integrating Counseling*
Before emergency treatment (but after ensuring the client is stable):
• Assess the client’s capacity to receive information.
• Explore the client’s needs and feelings.
• Discuss the client’s values and reproductive intentions.
• Based on the client’s condition, discuss the following:
  » Examinations and findings
  » Verbal and/or written informed consent
  » Treatment procedures and pain management
  » Possible side effects, complications, and risks
  » Human reproductive processes
  » Available contraceptive methods

Emergency Treatment

Emergency treatment is the prompt management of potentially life-threatening abortion-related complications, including hemorrhage and/or infection from retained products of conception, injury to internal organs, and shock. Components of emergency treatment include rapid client assessment, management of shock and related cardiorespiratory complications, uterine evacuation, antibiotic therapy, and other treatments. Delivery of appropriate and effective pain management support, including pharmacological methods (such as provision of nonsteroidal anti-inflammatory drugs and sedation) and non-pharmacological methods (such as counseling and distraction) may also be necessary. After completing the above, the provider should assist the client in making an informed and voluntary decision about treatment, including selecting a contraceptive method of choice. Providers should adhere to required infection prevention practices throughout all care and treatment.

The term “emergency treatment” may suggest that all postabortion situations are urgent and complex. However, PAC does not always involve complications and is not always life-threatening, and therefore immediate treatment is not always needed. Yet, timely evaluation, treatment, and referral are needed when an incomplete abortion is suspected, as delays in care can result in complications. Further, emergency treatment alone does not represent PAC. PAC is incomplete without appropriate contraceptive counseling and services, referral(s) for other reproductive health services, screening for STIs and HIV, and community empowerment through mobilization and engagement.

Components of Emergency Treatment

- Completion of client assessment, including:
  - Initial rapid assessment
  - Medical history, obtained from the client, or a family member or another person accompanying the client in cases where the client is unable to provide this history directly
  - Evaluation for shock and other life-threatening conditions

- Resuscitation and/or stabilization, as needed

- Preparation for treatment or transfer, as needed

- Continuing assessment and diagnosis, including:
  - Diagnosis of abortion-related complications based on presenting signs and symptoms
  - Collection of specimen(s) for laboratory testing and/or blood typing and cross-match, as needed

- Provision of emergency treatment and care, including:
  - Counseling and reassurance (integrated throughout all components of care)
  - Pain management (before, during, and after procedure), as needed
  - Uterine evacuation and related treatment, as needed
  - Treatment of other complications, as needed
  - Referral or transfer, as needed

Other components of care include informing persons accompanying the client of the situation (with the client’s consent), providing contraceptive care, discharge, and coordinating any necessary follow-up care.

The extent of emergency treatment to be provided depends on the level of care available at the facility, national treatment protocols for PAC, provider skills, availability of equipment, and referral systems in place (see Module 1, Session 2 for guidance on the provision of core PAC components by healthcare level and provider cadre). In addition, providing postabortion counseling and responding to clients’ questions or concerns about future pregnancies, incomplete abortion, treatment, and resumption of ovulation (return to fertility) are integral to emergency treatment, along with emotional support. Depending on the client’s physical condition, contraceptive care can begin at the time of admission and be completed before discharge from the facility, thus enabling the integration of contraceptive and emergency treatment services.59

Rapid Assessment

Rapid assessment and treatment includes immediately identifying the client’s specific problem and quickly acting. When clients present with pregnancy-related problems, assuming they are conscious, explain immediate treatment actions and seek their consent. For a semiconscious or unconscious client, quickly assess their condition to determine the appropriate level of treatment. In cases of life-threatening conditions, such as shock or severe hemorrhage, delay obtaining the client’s history and completing the physical assessment until the client is stable.

Conditions and postabortion complications that require immediate attention and treatment include:

- Shock
- Severe vaginal bleeding (hemorrhage)
- Signs of intra-abdominal injury, such as uterine perforation
- Sepsis or septic shock

Rapid Assessment Steps

- Obtain the history of the problem from the client, a family member, or another person accompanying the client
- Complete a rapid evaluation of the client’s general condition, including by checking vital signs (blood pressure, pulse, respiratory rate, and temperature) as well as checking for:
  - Signs of shock
  - Chills, fever, sweats, cold or sweaty extremities
- Assess the client’s level of consciousness, including if the client is awake, alert, oriented, confused, restless, semiconscious, or comatose
- Assess the client’s coloring, including checking for cyanosis and pallor
- Complete an initial assessment of any vaginal bleeding, including checking for:
  - Amount of bleeding
  - Evidence of active bleeding or recent bleeding, as determined by the presence of blood-soaked bedding, clothing, or pads or blood-stained lower extremities
  - Presence of clots or products of conception
- Assess for intra-abdominal injury
- Assess for sepsis

Some of the above steps can be completed simultaneously. For example, while obtaining a history of client’s problem, you can assess their color and level of consciousness.

After ruling out shock, quickly proceed to assessing for other serious complications, as listed above.

A summary of the major elements of rapid initial assessment are presented in the table on the following pages. Obtain consent to conduct the rapid assessment if the client is conscious and lucid before completing the assessment and explain each step of the process to the client. Otherwise, if the client is unable to provide consent (for instance, if they are unconscious or convulsing), obtain consent from client’s family member or companion to conduct the rapid assessment and explain each step of the process.

Reminder: If shock is suspected, begin treatment immediately. Shock can develop at any time, so careful monitoring throughout all PAC is important. Module 2, Session 7 provides additional guidance on assessment and treatment of shock and other emergency conditions.

## Major Elements of a Rapid Initial Assessment**

<table>
<thead>
<tr>
<th>Areas to Assess</th>
<th>Danger Signs</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airway and breathing</td>
<td><em>Look for:</em></td>
<td>• Asthma</td>
</tr>
<tr>
<td></td>
<td>• Increased respiratory rate</td>
<td>• Heart failure</td>
</tr>
<tr>
<td></td>
<td>• Pallor in mucous membranes (which may indicate cyanosis)</td>
<td>• Pneumonia</td>
</tr>
<tr>
<td></td>
<td>• Rapid shallow breathing</td>
<td>• Severe anemia</td>
</tr>
<tr>
<td></td>
<td><em>Examine:</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lungs: Wheezing, rales</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Skin: Pallor</td>
<td></td>
</tr>
<tr>
<td>Circulation</td>
<td><em>Examine:</em></td>
<td>• Shock</td>
</tr>
<tr>
<td>(signs of shock)</td>
<td>• Anxiousness, confusion, unconsciousness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Blood pressure: Low (systolic less than 90 mm Hg)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Body temperature: 38°C or more, less than 36°C</td>
<td></td>
</tr>
<tr>
<td></td>
<td>•Breathing: Rapid (30 breaths/minute or more)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pulse: Rapid (110 or higher) and weak</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Skin: Cool and clammy, sweaty</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Skin: Pallor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Urine output: Minimal (less than 30 ml per hour)</td>
<td></td>
</tr>
<tr>
<td>Vaginal bleeding</td>
<td><em>Ask the client about:</em></td>
<td>• Abortion</td>
</tr>
<tr>
<td>(early pregnancy)</td>
<td>• Pregnancy and length of gestation</td>
<td>• Ectopic pregnancy</td>
</tr>
<tr>
<td></td>
<td>• Vaginal bleeding, including how and when it started</td>
<td>• Injuries to external or internal reproductive organs</td>
</tr>
<tr>
<td></td>
<td><em>Examine:</em></td>
<td>• Trophoblastic disease</td>
</tr>
<tr>
<td></td>
<td>• Uterine size (correspondence to gestation)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Vulva: Amount of bleeding, obvious tears, protruding clots and products of conception, grape-like products</td>
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<tr>
<td></td>
<td>Proceed with a gentle speculum and bimanual exam if the history and exam indicate possible abnormal uterine bleeding, abortion, ectopic or molar pregnancy, intra-abdominal bleeding, or presence of adnexal mass</td>
<td></td>
</tr>
<tr>
<td>Unconscious or convulsing</td>
<td><em>Ask the client’s family member or companion about:</em></td>
<td>• Eclampsia</td>
</tr>
<tr>
<td></td>
<td>• Pregnancy and length of gestation</td>
<td>• Epilepsy</td>
</tr>
<tr>
<td></td>
<td><em>Examine:</em></td>
<td>• Malaria</td>
</tr>
<tr>
<td></td>
<td>• Blood pressure: High (diastolic 90 mm Hg or more)</td>
<td>• Meningitis</td>
</tr>
<tr>
<td></td>
<td>• Body temperature: 38°C or more</td>
<td>• Poisoning</td>
</tr>
<tr>
<td></td>
<td>• Presence of any signs or symptoms of infection</td>
<td>• Tetanus</td>
</tr>
</tbody>
</table>
### Major Elements of a Rapid Initial Assessment (continued)

<table>
<thead>
<tr>
<th>Areas to Assess</th>
<th>Danger Signs</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High fever or hypothermia</strong></td>
<td><em>Ask the client about:</em></td>
<td>• Breast infection</td>
</tr>
<tr>
<td></td>
<td>• Abdominal pain</td>
<td>• Complications of abortion</td>
</tr>
<tr>
<td></td>
<td>• Frequent and/or painful urination</td>
<td>• Malaria</td>
</tr>
<tr>
<td></td>
<td>• Pregnancy and length of gestation</td>
<td>• Meningitis</td>
</tr>
<tr>
<td></td>
<td>• Vaginal bleeding</td>
<td>• Metritis</td>
</tr>
<tr>
<td></td>
<td>• Vomiting</td>
<td>• Pelvic abscess</td>
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<tr>
<td></td>
<td><em>Examine:</em></td>
<td>• Peritonitis</td>
</tr>
<tr>
<td></td>
<td>• Abdomen: Adnexal tenderness, masses in lower abdomen, rebound tenderness,</td>
<td>• Pneumonia</td>
</tr>
<tr>
<td></td>
<td>rigidity</td>
<td>• Severe sepsis</td>
</tr>
<tr>
<td></td>
<td>• Breasts: Tenderness</td>
<td>• Urinary tract infection</td>
</tr>
<tr>
<td></td>
<td>• Body temperature: 38°C or more, less than 36°C</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Consciousness: Semicomconscious, unconscious</td>
<td></td>
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<tr>
<td></td>
<td>• Lungs: Consolidation, shallow breathing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Neck: Stiffness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Vulva: Purulent discharge, septic retained products of conception</td>
<td></td>
</tr>
<tr>
<td><strong>Abdominal pain and/ or distension</strong></td>
<td><em>Ask the client about:</em></td>
<td>• Amnionitis</td>
</tr>
<tr>
<td></td>
<td>• Abdominal distension and/or pain (location, nature)</td>
<td>• Appendicitis</td>
</tr>
<tr>
<td></td>
<td>• Bowel habits</td>
<td>• Ectopic pregnancy</td>
</tr>
<tr>
<td></td>
<td>• Pregnancy and length of gestation</td>
<td>• Ovarian cyst</td>
</tr>
<tr>
<td></td>
<td>• Shoulder pain (tip of shoulder)</td>
<td>• Placental abruption</td>
</tr>
<tr>
<td></td>
<td>• Vomiting</td>
<td>• Possible term or premature labor</td>
</tr>
<tr>
<td></td>
<td><em>Examine:</em></td>
<td>• Ruptured uterus</td>
</tr>
<tr>
<td></td>
<td>• Abdominal, pelvic, and uterine exam: Adnexal masses, distension and/or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>rigidity, foul-smelling discharge, localized pain, presence of amniotic</td>
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</tr>
<tr>
<td></td>
<td>fluid, presence of blood or fluid in peritoneum, rebound tenderness,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>uterus size (correspondence to gestation)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Blood pressure: Low (systolic less than 90 mm Hg)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Body temperature: 38°C or more</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pulse: Fast (110 or more)</td>
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</tbody>
</table>

*Note: This list does not include all possible problems a client may experience during the pregnancy, postabortion, or puerperium periods. It is meant only to identify the problems that put the client at a critical risk of maternal morbidity and mortality.

Presenting Signs and Symptoms

Regardless of the client’s contraceptive, menstrual, or obstetric history, healthcare providers should consider the possibility of an abortion-related condition in any client of reproductive age who presents with vaginal bleeding, passage of clots, and lower abdominal pain or cramping. The signs and symptoms of a possible miscarriage or induced abortion include the following:

- Amenorrhea, or the absence of menstruation (missing one or more menstrual periods)
- Known or suspected pregnancy
- Lower abdominal pain or cramping, similar to menstrual cramps or labor contractions
- Vaginal bleeding, which may be light or heavy (see Diagnosing Vaginal Bleeding in Early Pregnancy for assessment of bleeding) and which may be accompanied by the passage of clots or tissue fragments

Other gynecological or obstetric conditions that can result in abdominal pain, vaginal bleeding, and/or similar signs and symptoms include ectopic pregnancies, menstrual disorders, obstetric hemorrhage, PID, tumors (benign or malignant), and trophoblastic disease. Additionally, shock and loss of consciousness in a pregnant client may be caused by a variety of conditions unrelated to pregnancy, such as cerebral malaria or trauma.

Types of Abortion

Vaginal bleeding during pregnancy may present in different ways, which in most instances are referred to as an abortion or miscarriage. There are different types of abortion, as summarized below, that correspond to the viability of the fetus, the progression of the process of the expulsion of the products of conception (complete or partial expulsion), and if it is complicated with infection.

Complete Abortion
A “complete abortion” occurs when the conceptus, placenta, and membranes are expelled completely from the uterus. The abdominal pain subsides and signs of pregnancy regress. The uterus shrinks to become smaller than the size expected for the period of amenorrhea and is firmly contracted on palpation. The cervical os is closed with minimal bleeding. When the client is stable, they may require other components of PAC, such as counseling, contraceptive care, and screening for and treatment of STIs.

Incomplete Abortion
An “incomplete abortion” occurs when the products of conception are partially expelled from the uterus. Clients with incomplete abortions typically present with a history of amenorrhea (less than 28 weeks), lower abdominal pain, and vaginal bleeding (which may be excessive)—with or without signs and symptoms of shock. The uterine size may or may not correspond to the period of amenorrhea and the cervical os will remain open. An incomplete abortion is the most common abortion-related complication.

Induced Abortion
The term “induced abortion” refers to the voluntary termination of pregnancy before fetal viability. An induced abortion may also be categorized as unsafe. An unsafe abortion is one in which the procedure is performed in an environment lacking minimal medical standards, by persons lacking necessary skills, or both.

Inevitable Abortion or Miscarriage
An “inevitable abortion or miscarriage” occurs when the expulsion of the products of conception advances progressively until complete pregnancy loss. This typically presents as vaginal bleeding (potentially heavy bleeding and excessive blood loss) coupled with the expulsion of clots or the gestational sac containing the embryo or fetus. The pain during an inevitable abortion or miscarriage may be intermittently as intense as during labor. The uterine size may or may not shrink to be smaller than during the gestation period. If the pregnancy had advanced beyond the first trimester, the membranes may rupture and amniotic fluid may be visible. As the cervix progressively dilates, tissue or clots may be seen in the vagina or protruding through the os.
Missed Abortion

The term “missed abortion” refers to instances in which there is an intrauterine pregnancy with nonviable fetus before 28 weeks of gestation. Clients typically present with a history of amenorrhea, their uterine size will not correspond to dates, and symptoms of early pregnancy will cease. Embryo death usually occurs before eight weeks of gestation, but the pregnant person’s body does not recognize its demise. A brown discharge originating from the degeneration of placental tissue may present and a threatened abortion may be suspected.

Septic Abortion

The term “septic abortion” is used in cases in which the abortion is complicated, with an ascending infection. Clinically, the client will present with signs of an abortion and may also be experiencing fever, foul-smelling vaginal discharge, headache, nausea, and/or signs of shock. A septic abortion may present as either a localized infection in the uterine tubes and the uterine cavity or as generalized septicemia with peritonitis.

Threatened Abortion

The term “threatened abortion” refers to a situation in which there is vaginal bleeding early in the pregnancy. In these cases, the cervix remains closed, the uterus remains soft with no tenderness when palpated, blood loss may be minimal, and the pregnant person may or may not experience a backache and/or abdominal pain (similar to menstrual cramping). These symptoms may continue for a period. At this time, the pregnancy remains viable.

<table>
<thead>
<tr>
<th>Major Signs and Symptoms of Different Types of Abortion* **</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bleeding</strong></td>
</tr>
<tr>
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<tr>
<td><strong>Bleeding</strong></td>
</tr>
<tr>
<td><strong>Cervical os</strong></td>
</tr>
<tr>
<td><strong>Pain</strong></td>
</tr>
<tr>
<td><strong>Uterus (if palpable)</strong></td>
</tr>
<tr>
<td><strong>Additional signs and symptoms</strong></td>
</tr>
</tbody>
</table>

*Note: Remember to ensure confidentiality, dignity, and privacy while assessing a client’s symptoms.

Client Confidentiality, Privacy, and Dignity

Note: The content contained in this section is adapted from Family Planning: A Global Handbook for Providers.61

PAC clients, like all other healthcare clients, deserve to be treated respectfully and with dignity, particularly by ensuring their confidentiality and privacy, throughout all phases of care, including contraceptive care. Providers should respect and fulfill the nine elements of client rights (some of which are detailed below): confidentiality and privacy, dignity, voluntary and informed decision-making, high-quality and safe FP services, availability of FP information and services, accessibility to FP information and services, acceptability of FP information and services, participation (of the client, as well as their partner or spouse, if they desire), and accountability (of the provider, including through client and community feedback mechanisms).

Confidentiality

Providers should keep client information confidential. Confidentiality means not discussing a client’s personal information with their spouse or partner, family member(s), or other accompanying companions, or with staff members not directly involved in their treatment—except if required in a life-threatening emergency—unless the client provides permission to share such information (for instance, in cases in which the client wishes to involve a partner in decision-making). Personal information includes the client’s medical history, current conditions that prompted care-seeking, services provided, and any FP discussions or decisions.

Privacy

Ensuring privacy is critical to protecting client confidentiality. Privacy is also important for promoting client dignity, fostering a sense of security, and encouraging the client to communicate honestly. Ensuring privacy means ensuring that no one else can hear or see anything said or done during care. Simple changes to the client counseling and treatment areas can often improve privacy.

Dignity

Clients should receive respectful care and be treated with dignity throughout all phases of care. Dignity means that a client feels worthy regardless of their circumstances or condition. Ensuring privacy and confidentiality helps promote client dignity. Additionally, providers should employ empathetic language and abstain from any form of violence or other treatment that may force clients to respond in a particular way.

Ensuring Confidentiality, Privacy, and Dignity

The following may disturb a client’s confidentiality, privacy, and dignity:

- Leaving the client lying in a busy, open area
- Leaving the client in a room with their genitalia exposed
- Not using screens or curtains around the client
- Not adequately draping the client during a physical examination or procedure
- Openly discussing the client’s case with anyone who walks by
- Allowing people to enter the counseling and/or treatment areas freely
- Having casual conversations about the client with other staff during counseling and/or treatment
- Discussing care-related information and/or providing counseling in a busy, public space or in an area where others can easily see and hear the client and any client interactions

Simple adjustments at the facility level—such as those listed below—can often improve confidentiality, privacy, and dignity for clients.

- Allocate private areas for obtaining client history and counseling.
- Ensure availability of sufficient curtains, drapes, and screens in client exam areas.
- Position exam tables so that the foot of the table faces away from the entrance to the space.
- Store client records (electronic and paper) in a secure location that is only accessible to those providing care.

Youth-Friendly Services

Recommendations for providing youth-friendly services vary according to context. Ensuring service design responds to the needs of young people requires engaging them early and often. Facilitate meetings with youth leaders and adolescent groups, PAC providers, facility management, and other healthcare staff to identify appropriate approaches for making PAC more youth-friendly. Potential approaches are listed below.

- Adjust service hours—for example, by extending hours after school and on weekends—and post service hours in areas accessible to young people.
- Organize services to reduce wait times for young people.
- Create a separate clinic entrance for young clients to increase confidentiality.
- Provide a separate waiting area for young clients to increase confidentiality.
- Ensure the availability of appropriate tools and job aids (such as anatomical models, handouts, and pictures) and use simple language to help introduce and explain complex clinical terms and procedures.
- Ensure availability of variety of sizes of instruments to facilitate the comfort of clients of all ages and sizes.

Additional provider, health facility, and program design considerations are detailed in the table entitled “Characteristics of Youth-Friendly Services” included in Module 1, Session 3 of this manual.

Client-Centered Counseling: Addressing Postabortion Clients’ Emotions

PAC clients may experience a range of emotions; for instance, they may fear pain before, during, or after anticipated procedures. Clients who have experienced miscarriages may feel ashamed, disappointed, frustrated, and/or guilty over not having been able to carry the pregnancy to term. Similarly, clients who have undergone or are undergoing an induced abortion may fear that family, friends, or others in the community—including law enforcement officials—may become aware of their actions. The chart below (and continuing on the following page) provides examples of potential approaches to responding to different client emotions. Note, however, that there may be other appropriate approaches and other feelings that clients may experience, including anger, anxiety, embarrassment, relief, sadness, shyness, and worry.

<table>
<thead>
<tr>
<th>Emotion</th>
<th>Reasons</th>
<th>Responses</th>
</tr>
</thead>
</table>
| Fear    | • Fear of legal prosecution or criticism from health workers and/or family for illegally inducing abortion  
• Fear of dying or becoming disabled  
• Fear of the unknown (including what will happen at hospital)  
• Fear of being ostracized by peers, especially for young people  
• Anxiety about their future ability to have children | • Listen to the client’s concerns.  
• Reassure the client.  
• Tell the client what will happen before, during, and after the procedure.  
• Say, “I see you are uncomfortable. Please don’t hesitate to ask me any questions.”  
• Arrange for FP counseling, services, and/or referrals and let the client know that these are available.  
• Be aware of your own negative bias or appearing to “punish” the client.  
• Counsel and reassure the client that:  
  » Treatment is confidential.  
  » Treatment will help them get better.  
  » They will not get in trouble. |
| Grief   | • Sadness at losing pregnancy                                                                | • Be respectful of the client’s feelings.  
• Do not assume the abortion was induced.  
• Tell the client that feeling sad is common. |
Pain • Assess the client’s need for pain relief and offer medication, as appropriate. • Provide a comfortable area for the client to rest before and after the procedure. • Streamline processes to allow the client to be treated as soon as possible. • Help the client understand the value of delaying a future pregnancy and evaluate any repeated pregnancy loss.

### Obtaining the Client’s History

While obtaining the client’s history and assessing their physical signs and symptoms, it is important to respect the client’s needs and to provide unbiased care (see text box). To begin, the provider should collect and/or verify basic personal and sociodemographic data. If relevant client records or referral notes are available, the provider should carefully review these. If the client is unconscious or otherwise unable to provide information, it may be necessary to obtain information from the person or people accompanying the client.

After the initial intake, ask about or confirm information on the following topics.

**Present Condition**
- Presenting complaints
- Onset of symptoms
- Progression of the condition and any medication administered
- Date of last normal menstrual period
- Vaginal bleeding (amount and duration)
- Cramping (onset and severity)
- Fainting
- Fever, chills, or general malaise
- Abdominal or shoulder pain (may indicate intra-abdominal injury)

**Client-Provider Communication**

Due to the circumstances that may surround abortions, the accuracy and completeness of information that a client gives often depends on the quality of the provider-client interaction. For personal, sociocultural, and/or legal reasons, clients may be reluctant to provide information. For instance, some clients may have been compelled to have an abortion and may experience guilt and/or regret. Similarly, those who have experienced a spontaneous abortion or miscarriage may be experiencing grief and/or sadness. Throughout the process of obtaining the client’s history and providing counseling, it is important to use language that reflects the sensitivity of the client’s situation and to encourage the client to ask questions and express any feelings and concerns. For example, avoid language that may imply the failure to carry the pregnancy to term.

<table>
<thead>
<tr>
<th>Emotion</th>
<th>Reasons</th>
<th>Responses</th>
</tr>
</thead>
</table>
| Loneliness | • Hospital protocols do not allow family members to accompany clients  
• Transportation costs prohibit family or friends from accompanying clients  
• The client was afraid to tell anyone about the abortion or ask anyone to accompany them  
• The client does not have any emotional support | • Establish a waiting area for family and friends accompanying clients.  
• Counsel and reassure the client that they are not alone.  
• Tell the client that you are there to help and ask if they need anything. |
| Pain | • Abdominal cramping  
• Pain from an infection or other complications  
• Pain that intensified during transportation  
• Emotional pain, mourning loss of pregnancy | • Assess the client’s need for pain relief and offer medication, as appropriate.  
• Provide a comfortable area for the client to rest before and after the procedure.  
• Streamline processes to allow the client to be treated as soon as possible.  
• Help the client understand the value of delaying a future pregnancy and evaluate any repeated pregnancy loss. |

**Emotion Reasons Responses**

- **Loneliness**
  - Hospital protocols do not allow family members to accompany clients
  - Transportation costs prohibit family or friends from accompanying clients
  - The client was afraid to tell anyone about the abortion or ask anyone to accompany them
  - The client does not have any emotional support
  - Establish a waiting area for family and friends accompanying clients.
  - Counsel and reassure the client that they are not alone.
  - Tell the client that you are there to help and ask if they need anything.

- **Pain**
  - Abdominal cramping
  - Pain from an infection or other complications
  - Pain that intensified during transportation
  - Emotional pain, mourning loss of pregnancy
  - Assess the client’s need for pain relief and offer medication, as appropriate.
  - Provide a comfortable area for the client to rest before and after the procedure.
  - Streamline processes to allow the client to be treated as soon as possible.
  - Help the client understand the value of delaying a future pregnancy and evaluate any repeated pregnancy loss.

**Emotion Reasons Responses**

- **Emotional Reasons**
  - Responses
  - Loneliness
    - Establish a waiting area for family and friends accompanying clients.
    - Counsel and reassure the client that they are not alone.
    - Tell the client that you are there to help and ask if they need anything.
  - Hospital protocols do not allow family members to accompany clients
  - Transportation costs prohibit family or friends from accompanying clients
  - The client was afraid to tell anyone about the abortion or ask anyone to accompany them
  - The client does not have any emotional support

- **Client-Provider Communication**

  Due to the circumstances that may surround abortions, the accuracy and completeness of information that a client gives often depends on the quality of the provider-client interaction. For personal, sociocultural, and/or legal reasons, clients may be reluctant to provide information. For instance, some clients may have been compelled to have an abortion and may experience guilt and/or regret. Similarly, those who have experienced a spontaneous abortion or miscarriage may be experiencing grief and/or sadness. Throughout the process of obtaining the client’s history and providing counseling, it is important to use language that reflects the sensitivity of the client’s situation and to encourage the client to ask questions and express any feelings and concerns. For example, avoid language that may imply the failure to carry the pregnancy to term.
- Tetanus vaccination status and possible exposure to tetanus, including insertion of unclean instruments or other materials into the uterus
- General medical information, including drug allergies (especially related to antibiotics, local anesthetics, and pain management drugs)
- Bleeding disorders, including hemophilia, platelet disorders, sickle cell anemia, and thalassemia
- Current medications (such as corticosteroids)
- Recent ingestion of any herbs or herbal medicine (some of which may cause serious side effects)
- Other health conditions or problems, including diabetes, hypertension, and/or malaria (during pregnancy)
- Any other health concerns

Reproductive History

- Parity
- Outcomes of past pregnancies, including abortions and miscarriages (if applicable)
- Last delivery (if applicable)
- Age at menarche (first menstrual period)
- Menstrual cycle regularity and bleeding (amount and duration)
- Contraceptive method(s) used previously
- Sexual history
- History of STIs and reproductive tract infections
- History of partner violence or gender-based violence (see sample screening tool at the end of this session)

Past Medical History

- Previous admissions
- Previous surgeries
- Past treatment for any chronic condition(s)

Family and Social Status

- Marital or partnership status
- Number of people in the household and their relationships

Physical Examination

Assuming the vital signs are normal and the client does not require urgent care or an immediate referral, determining the cause of the vaginal bleeding is the priority. After obtaining a thorough reproductive history (as previously detailed), complete a physical exam and any necessary laboratory tests to make an accurate diagnosis and to confirm a treatment plan.

During the physical exam, remember to:
- Respect the client’s dignity, including by ensuring auditory and visual privacy (see text box).
- Prepare all necessary equipment and instruments in advance, to ensure availability and ability to serve the client in a timely manner.

Tips for Maintaining Client Privacy

No one should be able to see the client or hear your interactions with or about the client. Use the tips below to achieve client privacy.

- Close the door(s) to the exam room or secure the privacy curtains surrounding the client.
- Close any window curtains.
- Position the exam table so that the client’s feet are not facing the door.
- Ask the client for permission (and wait until permission is given) before entering the exam room, for instance by knocking before entering.
- Keep the client covered as much as possible, exposing only what is required for each part of the exam.
• Assess the client’s overall health, beyond specific presenting problems; for instance, by undertaking a systematic physical examination of the client’s heart, lungs, breasts, and extremities.
• Maintain established infection prevention precautions at all times.

**General Condition of Client**

Begin by observing the client’s general condition. Does the client look well or sickly? Consider the following when conducting a preliminary observation of the client.

- Degree of consciousness (does the client seem coherent, confused, restless, etc.?)
- Nutritional status and weight
- Skin condition (cyanosis and/or pallor)
- Vital signs, including blood pressure, pulse, respiratory rate, and temperature

**Abdominal Examination**

Complete an abdominal examination, focusing on the following:

- Distension with decreased bowel sounds
- Masses or gross abnormalities
- Pelvic or suprapubic tenderness
- Rebound tenderness with guarding
- Hernias and skin conditions, including lesions surgical scars

**Pelvic Examination**

Prior to initiating the pelvic examination, explain the purpose of the exam to the client and obtain verbal consent to proceed. Ask the client to empty their bladder and remove any undergarments before beginning the exam. As necessary, assist the client to lay on the examination table equipped with stirrups and to assume the lithotomy position; then cover the client with a clean cloth or drape to protect their dignity and privacy. Don new, undamaged examination gloves before beginning the bimanual and speculum examinations. Continuously update the client throughout the exam by stating what you are going to do (before you do it) and noting how it may feel to the client, including if the client may experience any discomfort or pain. Key steps for speculum and bimanual examinations are listed below.

**Speculum Examination**

- Before inserting the speculum, inspect the genital area for bleeding or discharge. If there is bleeding or discharge, check the odor and color and assess the volume.
- Part the labia and insert the speculum to examine the cervix. **Note:** It may be necessary to use a smaller speculum when examining adolescents.
- Remove any visible clots or products of conception from the vaginal canal or cervical os and set aside any tissue for further examination and testing.
- Confirm whether the cervix is open (dilated) and check for any cervical or vaginal anomalies, perforations, or tears.
- Check again for any foul-smelling discharge, for any pus in the cervix, and note the amount of bleeding.

**Note:** Cervical infections increase the chance of postoperative uterine infections, including acute PID. If an infection is present or suspected, obtain samples for bacteriological culture (if possible) and begin treatment with broad-spectrum antibiotics before performing the uterine evacuation procedure. Depending on national guidelines, if a septic abortion is suspected, it may be necessary to refer the client to a higher level facility for further treatment.
**Bimanual Examination**

- **Assess the uterus size** by comparing the actual size of the uterus with the gestational age calculated from the date of the client’s last menstrual period. Do not begin uterine evacuation until after determining the size of the uterus. If the uterus is retroverted or laterally displaced, if the client is overweight, or if the client has abdominal guarding (tensing the abdomen so that the uterus cannot be felt), the uterine size may be difficult to assess. If you experience problems determining uterine size, engage a more experienced clinician, if available, to assist. If there is any doubt, treat the client as if the pregnancy was advanced further than suspected initially.
  - A uterus that is smaller than expected may be an indication of an inevitable or missed abortion.
  - A uterus that is larger than expected may indicate a more advanced pregnancy than expected, a multiple pregnancy, a uterus filled with blood clots (postabortion syndrome), the presence of uterine fibroids, or a molar pregnancy (rare).

- **Assess the uterus shape, mobility, and position** next. Correctly determining the shape and position of the uterus is critical to the safety and success of any surgical treatment for abortion. The uterus may be anteverted, retroverted, or laterally displaced.
  - **Anteverted, or tilted forward (most common):** If the uterus is anteverted and anteflexed, the clinician must be especially careful because of the increased risk of perforation during surgical evacuation procedures.
  - **Retroverted, or tilted backwards:** A mildly retroverted uterus may be best palpated by recto-vaginal examination. Perforation may occur if the provider fails to recognize the condition and fails to follow the correct steps when inserting the cannula.
  - **Laterally displaced, or tilted to one side (least common):** If the uterus is laterally displaced, the clinician must be especially careful during the procedure or the risk of perforation may be increased.

- **Check adnexa and cervical motion tenderness.** Fullness and/or tenderness in adnexa and/or cervical motion tenderness may indicate other conditions, such as an ectopic pregnancy or a pelvic infection complicated with abscess formation.

- **Complete a rectal exam only if there is evidence of lacerations and injuries extending into the anus.**

**Provisional Diagnosis**

Make a provisional diagnosis after completing the abdominal and pelvic examinations; include two or three different diagnoses, as appropriate. Then, inform the client of your findings and next steps, including the need for any tests and the results.

**Laboratory Tests**

Obtain the client’s consent before collecting samples for laboratory testing. As applicable, inform the client of any costs associated with testing and treatment to support the client in making informed decisions. Perform the following recommended tests, with the client’s consent.

- Blood group and Rhesus status (provide or prescribe Rho(D) immune globulin to Rh-negative clients)
- Hemoglobin
- HIV counseling and testing
- Malaria and/or other relevant testing
Conduct any other necessary tests possible, for instance, to determine the viability of the pregnancy, to confirm a missed abortion, or to identify other conditions, such as obstruction. This may include conducting a point-of-care ultrasound or abdominal radiology or obtaining blood samples and swabs for culture. Provide relevant preventive measures, such as tetanus toxoid.

Vaginal Bleeding in Early Pregnancy

This section focuses on vaginal bleeding occurring during the first 28 weeks of pregnancy. Because vaginal bleeding can be an important danger sign of pregnancy or abortion, an accurate diagnosis is necessary to guide provision of timely, appropriate care or treatment. Determining the cause of the client’s vaginal bleeding is critical to determining the treatment plan. Taking a thorough reproductive history, performing careful abdominal and pelvic examinations, and (as necessary) obtaining appropriate laboratory tests are important steps in the process. However, it is important to determine gestational age before performing a pelvic exam on a pregnant client who presents with bleeding. Do not perform a pelvic exam on a client in later pregnancy (after 20 weeks) experiencing vaginal bleeding.

The following guidelines will help in assessing and managing vaginal bleeding.

- A rapid evaluation is the first step in assessing a client who presents with vaginal bleeding. If shock is suspected, immediately begin treatment.

- Consider an ectopic pregnancy in any client with:
  - A history of amenorrhea
  - A history of ectopic pregnancy or PID
  - A mass in the adnexa
  - Any unusual complaints about abdominal pain
  - A smaller uterus than expected (based on the client’s last menstrual period)
  - A suspected threatened abortion
  - Cervical motion tenderness
  - Fullness in the pouch of Douglas
  - Signs of shock

- Consider an incomplete abortion in any client with a history of a missed period, vaginal bleeding, and one or more of the following:
  - Cramping
  - Dilated cervix
  - Partial expulsion of products of conception

- Clients with other problems, such as menstrual disorders, may also present with severe vaginal bleeding.

- Remember that intravenous infusion is necessary for clients with severe vaginal bleeding as well as those with sepsis, shock, or any other related life-threatening condition(s).

The tables on the following page, which are adapted from Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors, and Myles Textbook for Midwives, may assist with assessing uterine size during the first trimester and diagnosing vaginal bleeding in early pregnancy.

---


### Assessing the Uterine Size in the First Trimester

<table>
<thead>
<tr>
<th>Weeks*</th>
<th>Cervical Signs</th>
<th>Uterine Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>None (not pregnant)</td>
<td>None</td>
<td>• Uterus is approximately 7 to 8 cm long, 4 to 6 cm wide</td>
</tr>
<tr>
<td>5 to 7 weeks</td>
<td>None</td>
<td>• Localized softening of the site of the placenta • Enlargement of the uterus • Uterus is not palpable</td>
</tr>
<tr>
<td>6 to 8 weeks</td>
<td>• Cervix is bluish due to increased blood supply (Chadwick’s sign) • Cervix is soft and can be compressed during bimanual exam</td>
<td>• Uterus is uniformly soft and round • Slight enlargement of the uterus</td>
</tr>
<tr>
<td>12 or more weeks</td>
<td>• Cervix is bluish and soft</td>
<td>• Uterus is soft and round • Uterus is palpable above pubic symphysis • Enlargement dependent on gestational age</td>
</tr>
</tbody>
</table>

*Weeks since last menstrual period

### Diagnosing Vaginal Bleeding in Early Pregnancy*

<table>
<thead>
<tr>
<th>Typical Signs and Symptoms</th>
<th>Occasional Signs and Symptoms</th>
<th>Probable Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Closed cervix • Light bleeding • Uterus size corresponds to dates</td>
<td>• Lower abdominal pain or cramping • Uterus softer than normal</td>
<td>Threatened abortion</td>
</tr>
<tr>
<td>• Abdominal pain • Closed cervix • Light bleeding • Uterus is slightly larger and/or softer than normal</td>
<td>• Amenorrhea • Cervical motion tenderness • Pain • Tender adnexal mass</td>
<td>Ectopic pregnancy</td>
</tr>
<tr>
<td>• Closed cervix • Light bleeding • Uterus is firmly contracted • Uterus is smaller than normal</td>
<td>• History of complete expulsion of conceptus, placenta, and membranes • Lower abdominal pain or cramping</td>
<td>Complete abortion</td>
</tr>
<tr>
<td>• Dilated cervix • Heavy bleeding • Uterus corresponds to dates</td>
<td>• Lower abdominal pain or cramping • Partial expulsion of products of conception</td>
<td>Inevitable abortion</td>
</tr>
<tr>
<td>• Amenorrhea • Dilated cervix • Heavy bleeding • Uterus corresponds to dates or is larger than expected • Expulsion of tissue</td>
<td>• Early onset preeclampsia • Lower abdominal pain or cramping • Nausea and/or vomiting • Ovarian cysts (easily ruptured) • Potential evidence of a fetus • Spontaneous abortion</td>
<td>Molar pregnancy</td>
</tr>
</tbody>
</table>

*Light bleeding takes longer than five minutes for a clean pad or cloth to be soaked. Heavy bleeding takes less than five minutes for a clean pad or cloth to be soaked.
Referrals

Providing emergency treatment and triaging care based upon the type of facility and available staff allows for timely client evaluation, stabilization, and referral (as needed). Follow the steps below for referring PAC clients to additional levels of care as needed.

- Explain the reason for the referral to the client. Include the client’s partner or spouse, family members, or other person(s) accompanying the client, as appropriate and with the client’s consent (if the client is conscious and able to consent).
- Arrange for the client’s transport and notify the referral facility.
- Prepare the client for transfer.
- Complete required forms for the referral, including by documenting:
  - Date and time of referral and transfer
  - Reason for referral
  - Treatments provided to the client prior to transfer
  - Findings from any examinations or laboratory tests completed prior to transfer
  - Name and signature of person completing the form(s)

If the referral is delayed or not possible, or if the client or the client’s partner, spouse, or other family member(s) (in the case of an unconscious client) refuse the referral:

- Be sure the client is clinically stable. This includes monitoring the client for signs of shock, providing treatment as required, and preparing an intravenous line for hydration and medication, as needed.
- Counsel and support the client and the client’s partner, spouse, or other family member(s), as appropriate, including by providing PAC, FP, and other reproductive healthcare counseling.
Sample Postabortion Care Client Information Form

Note: The basic elements for client evaluation included in this form are standard. However, different countries and programs may present this form differently, including in electronic or paper-based format.

Date: _________________________
Facility Name: _______________________________ Facility Location: ________________________________

Sociodemographic Data
Full Name: __________________________________________________________________________________
Address: ____________________________________________________________________________________
____________________________________________________________________________________
Age: _______________________________ Education Level: ________________________________
Marital Status:
☐ Married    ☐ Separated    ☐ Widowed    ☐ Single    ☐ Divorced
Partner / Spouse Name: ________________________________________________________________________
Partner / Spouse Occupation: ____________________________________________________________________
Number of Living Children: _____________________ Number of Deceased Children: _____________________
Age of Youngest Living Child: _______________________
Previous Contraception Practice: ☐ Yes    ☐ No    If Yes, Method Used: _____________________________
Date of Last Clinic Visit: _______________________

Medical History
Presenting Complaints: _________________________________________________________________________
Nature of Complaints: __________________________________________________________________________
Date of Last Menstrual Period: ______________________  Number of Days Bleeding: ______________________

Current Medical History
Any Current Illness: ☐ Yes    ☐ No
Current Medications (including traditional herbs): ☐ Yes    ☐ No

Past Medical History
Previous Admissions: ☐ Yes    ☐ No
Severe Headache: ☐ Yes    ☐ No
Severe Varicose Veins: ☐ Yes    ☐ No
Jaundice: □ Yes □ No
Renal Disease: □ Yes □ No
High Blood Pressure: □ Yes □ No
STI and HIV: □ Yes □ No
Epilepsy: □ Yes □ No
Tuberculosis: □ Yes □ No
Heart Problems: □ Yes □ No
Allergies: □ Yes □ No
Bleeding Disorders: □ Yes □ No

*(hemophilia, platelet disorder, sickle cell anemia, thalassemia)*

<table>
<thead>
<tr>
<th>Last Pap Smear:</th>
<th>Grade</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td></td>
<td></td>
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<tr>
<td>III</td>
<td></td>
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<tr>
<td>IV</td>
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</tr>
</tbody>
</table>

**Examination**

**Physical Examination**

Blood Pressure: _________________
Pulse: _________________
Respiration: _________________
Temperature: _________________
Weight: _________________
Pallor: □ Yes □ No

Breasts: ____________________________________________________________

Abdomen: __________________________________________________________

Heart: ____________________________________________________________
**Pelvic Examination**

External Genitalia: __________________________________________________________________________

**Speculum Exam**

Vagina: __________________________________________________________________________________

Cervix: __________________________________________________________________________________

Discharge: ___________________________ Type: ___________________________

Other: __________________________________________________________________________________

**Digital Exam**

Uterus: __________________________________________________________________________________

Size: ___________________________ Consistency: ___________________________

Adnexa: ___________________________ Cervical Dilation: ___________________________

Presence of Products of Conception:  ☐ Yes  ☐ No

Other: __________________________________________________________________________________

**Laboratory Tests**

Urine–Sugar: ___________________________ Urine–Albumin: ___________________________

Blood–Hemoglobin: _______________________ Blood–Group and Rhesus: ___________________

Pregnancy Test:  ☐ Positive  ☐ Negative

**Diagnosis**

Incomplete Abortion: __________________________________________________________________________

Complete Abortion: __________________________________________________________________________

Complications (specify): __________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

Other Diagnosis (specify): __________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

Method of Uterine Evacuation (in cases of abortion)

☐ Manual Vacuum Aspiration  ☐ Electric Vacuum Aspiration  ☐ Sharp Curettage

☐ Dilatation and Evacuation  ☐ Misoprostol (only)  ☐ Expectant Management

☐ Other (specify): ____________________________________________________________
Cadre of Provider: 

Pain Management:
- Yes *(specify)*: 
- No *(reason)*: 

### Management

#### Medications
- Given at the Facility: 
- Home Prescription: 
- Follow-Up Date: 

#### Counseling
- Specific Topics: 

### Contraceptive Care

- Counseling: □ Provided to Client □ Provided to Client with Partner or Spouse
- Method Accepted before Discharge: □ Yes □ No
- Method Voluntarily Adopted:
  - □ Condoms *(specify number issued)*: 
  - □ Contraceptive Implants *(specify type)*: 
  - □ Injectable Contraceptives *(specify type)*: 
  - □ Intrauterine Device *(specify type)*: 
  - □ Oral Contraceptives *(specify type and number of cycles)*: 
  - □ Tubal Ligation 
  - □ Other *(specify)*: 
  - □ None *(specify reason)*: 

None: *(specify reason)*:
Referral Information

Name of Referral Facility: ________________________________

Referral Facility Location: ________________________________

Contact Person: __________________________________________

Date of Referral: ________________________________ Time of Referral: ________________________________

Method of Referral: _______________________________________

____________________________________________________________________________________________

Expected Feedback Method: ________________________________________________________________

Discharge Information

Date of Discharge: ________________________________ Time of Discharge: ________________________________

Discharge Provider (name and title): ________________________________________________________________

General Remarks: ________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________
# Gender-Based Violence Screening Tool

## A. Introduction of Screening to Client

**A1**  
*For adults:* Any information you share with me will be kept confidential and won’t be shared with anyone outside our organization. The only exception to this is that if you tell me that a child in your care is being harmed or at risk of being harmed, I will have to report this - because we are mandated by law to do so. With this understanding, may I ask you these questions?

*For minors:* Any information you share with me will be kept confidential and will not be shared with anyone outside our organization, unless you share that you are currently being harmed, or fear that you may be harmed—in which case I would be required to report this, so as to help ensure your safety. With this understanding, may I ask you these questions?

[ ] Yes  (Go to B1)  
[ ] No (End interview and give the client the list of resources.)

## B. Prior Experiences of Violence

**B1**  
In the past year, has anyone punched, slapped, kicked, bit you, or caused you any type of physical harm? (‘Anyone’ can include your partner, a family member, friend, neighbor, a client, stranger, supervisor, colleague, police officer, or other persons.)

[ ] Yes  
[ ] No  
[ ] No Response

**B2**  
In the past year, has anyone insulted you, ignored you, yelled at you, or made you feel ashamed or bad about yourself? (As with the previous question, ‘anyone’ can include your partner, a family member, friend, neighbor, a client, stranger, supervisor, colleague, police officer, or other persons.)

[ ] Yes  
[ ] No  
[ ] No Response

**B3**  
In the past year, has anyone forced you to have sex or perform any sexual act, or touched you sexually in any way that you did not want? (As with the previous question, ‘anyone’ can include your partner, a family member, friend, neighbor, a client, stranger, supervisor, colleague, police officer, or other persons.)

[ ] Yes  
[ ] No  
[ ] No Response

**B4**  
In the past year, has anyone made you feel afraid, unsafe or in danger? (As with the previous question, ‘anyone’ can include your partner, a family member, friend, neighbor, a client, stranger, supervisor, colleague, police officer, or other persons.)

[ ] Yes  
[ ] No  
[ ] No Response
### C. Assessment of Client Safety

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C1</strong></td>
<td>At this time, will you feel safe when you return home today?</td>
<td>[ ] Yes [ ] No [ ] No Response</td>
</tr>
<tr>
<td><strong>C2</strong></td>
<td>At this time, are you afraid that your partner or someone else will cause you harm? &lt;br&gt; <em>Screener:</em> If Yes—ask about and list the reason(s) for feeling unsafe:</td>
<td>[ ] Yes [ ] No [ ] No Response</td>
</tr>
<tr>
<td><strong>C3</strong></td>
<td>At this time, have you thought of harming yourself due to the violence that has happened to you?</td>
<td>[ ] Yes [ ] No [ ] No Response</td>
</tr>
</tbody>
</table>

*Instructions to Screener:* Based on the information obtained, do you think the client is in immediate danger? <br> **YES** - If the client seems to be in immediate danger, offer referrals (including internal referral if your organization offers GBV psychosocial support), make a Safety Plan with them, and escort them to support services (e.g., police station, safe shelter, hospital).<br> **NO** - If the client is not in immediate danger, offer referrals and help the client to develop a Safety Plan (see GBV Screening SOP for instructions).

### D. Further Details on Experiences of Violence

<p>| | | | |</p>
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<thead>
<tr>
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<tbody>
<tr>
<td><strong>D1</strong></td>
<td>Would you like to talk with me a bit more about these experiences? By telling me a bit more about what has happened, I will be able to help you better and refer you to appropriate support and services if you are interested.</td>
<td>[ ] Yes (Go to D2) [ ] No (Skip to Section E)</td>
<td></td>
</tr>
<tr>
<td><strong>D2</strong></td>
<td>Let’s talk about the experiences you have had in the past 12 months. What are some experiences of violence that have happened that you would like to share? <em>(If this is a repeat screen for a client who has a history of experiencing violence, then ask about experiences in the past 6 months instead.)</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Where? (Location where abuse occurred)</th>
<th>What happened? (Inquire about key injuries)</th>
<th>Where? (Location where abuse occurred)</th>
<th>What happened? (Inquire about key injuries)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</table>

*(E) Instructions to Screener:* *After screening is completed, make appropriate referrals and assist client in developing a Safety Plan.*

Developing a Safety Plan: Help the client develop a Safety Plan regarding measures they can take when needing to make urgent decisions that could save their life. Help the client assess the real risk in which they find themselves. The client is the expert in how to maximize their own safety.

### F. Client Follow-Up: To be completed by the screener.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>F1</strong></td>
<td>Was a Safety Plan developed?</td>
</tr>
<tr>
<td><strong>F2</strong></td>
<td>Was a referral provided?</td>
</tr>
</tbody>
</table>

Name of Person Completing Form:

This publication was produced by Advancing Partners & Communities (APC), a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-12-00047, beginning October 1, 2012. The authors’ views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the United States Government.
Module 2, Session 2: Uterine Evacuation Methods

Summary

Because most complications result from products of conception being retained in the uterus, removal of the contents of the uterus (uterine evacuation), is one of the primary components of emergency treatment. There are several methods of uterine evacuation; the method chosen is based on national policies, facility type, available equipment, trained staff, and local conditions. Methods of uterine evacuation are broadly divided into three categories: surgical methods; medical methods; and the expectant method. The two most common methods of surgical evacuation are vacuum aspiration (VA) and dilatation and evacuation (D&E). The WHO recommends medication abortion over surgical approaches. Misoprostol is one medical method for evacuation of the uterus and is currently recommended for emergency treatment of an incomplete abortion occurring in the first or second trimester. There are, however, other medication combinations available for emergency treatment. Another medication commonly used in the second trimester is oxytocin; however, oxytocin is losing popularity compared to misoprostol. This session introduces and describes each method; subsequent sessions will detail techniques associated with each method.

Learning Objectives

At the end of this session, participants will be able to:
1. Describe how each method of uterine evacuation works.
2. List key advantages and disadvantages of each method.
3. Identify the instruments (or parts) used for each method, as relevant.
4. Describe indications, contraindications, and precautions applicable to each method.
5. Describe counseling appropriate for any uterine evacuation procedure.

Types of Uterine Evacuation Methods

There are several treatment options for an incomplete abortion when the uterine size is up to 14 weeks gestation: medication abortion using misoprostol, VA, or D&E. Misoprostol can be used in emergency treatment for first and second trimester incomplete abortions and the WHO recommends misoprostol over surgical methods of evacuation because it is cost-effective, safe, and (for clients who are stable) does not require admission or follow-up visits. However, it cannot be used for clients with genital tract injuries, septic abortions, severe bleeding, or for those who are allergic to misoprostol. VA is advised for clients who experience severe bleeding (including after misoprostol treatment) and with cases with partial expulsion of the products of conception. D&E is only recommended in cases of first trimester incomplete abortions in which misoprostol and VA are not options; however, D&E is recommended for second trimester incomplete abortions. Sharp curettage is no longer recommended for managing incomplete abortions.64,65

Medication Abortion: Misoprostol

Misoprostol is a prostaglandin analogue initially developed to treat gastrointestinal problems. Prostaglandins are a group of chemicals made by nearly all the body’s cell membranes. Different prostaglandins have different effects on the body; for instance, prostaglandins can assist or suppress the immune system, help alleviate inflammation and pain, or lower or raise blood pressure. Prostaglandins can also stimulate contractions and labor by stimulating prostaglandin receptors on the cervical and uterine muscles. Misoprostol is highly soluble and well absorbed by the mucus membranes. It is metabolized in the liver to become an acid and an active metabolite that is excreted in urine. Misoprostol has no interactions with other medications that would make its use contraindicated in treating incomplete abortion. However, it may augment the effects of oxytocic drugs and therefore should only be used in conjunction with other oxytocic drugs in accordance with national guidelines and policies.66

Misoprostol is highly effective, as shown in the table below, and is one of the WHO’s recommended essential medicines for miscarriage and incomplete abortion. The WHO recommends that a client with an incomplete abortion of less than 14 weeks gestation be treated with 600 µg of misoprostol orally or 400 µg sublingually. The onset of action ranges from 30 minutes to four hours. A repeat dose may be considered to achieve complete evacuation of the uterus if needed.

### Effectiveness and Satisfaction With Treatment for Incomplete Abortion, Misoprostol Compared With Surgical Evacuation, 10 Countries, 2005–2012

<table>
<thead>
<tr>
<th>Article</th>
<th>Country (Sample Size)</th>
<th>Study Design: Misoprostol/Surgical Comparison Group</th>
<th>Effectiveness: % With Complete Evacuation</th>
<th>% Client Satisfaction With Procedure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blandine 2012</td>
<td>Burkina Faso (N = 99)</td>
<td>400 mcg misoprostol sublingually/referral for surgical</td>
<td>M: 98%</td>
<td>M: 99%</td>
<td>PAC with misoprostol introduced to 2 district hospitals with no previous PAC service. All eligible women chose misoprostol over optional referral for MVA.</td>
</tr>
<tr>
<td>Weeks 2005</td>
<td>Uganda (N = 317)</td>
<td>600 mcg misoprostol orally/MVA</td>
<td>M: 96%</td>
<td>M: 94%</td>
<td>Misoprostol was associated with less pain and fewer complications but increased bleeding. All received antibiotics after treatment.</td>
</tr>
<tr>
<td>Taylor 2011</td>
<td>Ghana (N = 230)</td>
<td>600 mcg misoprostol orally/MVA</td>
<td>M: 98%</td>
<td>M: 94%</td>
<td>44% were very satisfied with misoprostol vs. 8% with MVA; 95% of those treated with misoprostol would choose it again vs. 36% treated with MVA.</td>
</tr>
<tr>
<td>Shokkerela</td>
<td>Tanzania (N = 150)</td>
<td>600 mcg misoprostol orally/MVA</td>
<td>M: 99%</td>
<td>M: 99%</td>
<td>75% were very satisfied with misoprostol vs. 55% with MVA; more side effects were associated with misoprostol; greater pain with MVA.</td>
</tr>
<tr>
<td>Bique 2007</td>
<td>Mozambique (N = 270)</td>
<td>600 mcg misoprostol orally/MVA</td>
<td>M: 91%</td>
<td>M: 96%</td>
<td>87% were very satisfied with misoprostol vs. 37% with MVA; trained midwife provided MVA with only verbal anesthesia; tertiary hospital site.</td>
</tr>
<tr>
<td>Montesinos 2011</td>
<td>Ecuador (N = 242)</td>
<td>600 mcg misoprostol orally/MVA</td>
<td>M: 94%</td>
<td>M: 96%</td>
<td>47% were very satisfied with misoprostol vs. 40% with MVA; ultrasound use decreased threefold for misoprostol and MVA in 1 year.</td>
</tr>
<tr>
<td>Shoket 2012</td>
<td>Senegal (N = 199)</td>
<td>400 mcg misoprostol sublingually/standard surgical care (MVA or D&amp;C)</td>
<td>Senegal: M: 93%</td>
<td>S: 98%</td>
<td>Antibiotics given with the surgical option; success rates much higher with misoprostol after first month from introduction. Ultrasound not needed on site. Nurses and midwives had prominent roles in care in Burkina Faso, Niger, and Senegal.</td>
</tr>
<tr>
<td>Nigeria (N = 132)</td>
<td>MZT (N = 119)</td>
<td>M: 100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nigeria (N = 51)</td>
<td>Burimuna (N = 218)</td>
<td>M: 100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abbreviations: D&amp;C, dilation and curettage; M, misoprostol; MVA, manual vacuum aspiration; PAC, postabortion care; S, surgical.</td>
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</tr>
</tbody>
</table>

### Source:
such warning signs. Clients should also receive contraceptive counseling and a contraceptive method of choice before leaving the health facility.

Indications for misoprostol use for management of first and second trimester incomplete abortions and other abortion-related complications, such as missed abortion, are summarized in the table below.

### Recommendations for Use of Misoprostol for Incomplete, Inevitable, and Missed Abortions*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Gestation</th>
<th>14 Weeks, Or More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incomplete and inevitable abortion</td>
<td>Less than 14 Weeks</td>
<td>• Recommended for clients who prefer this treatment option\n• Dosage: 600 µg orally or 400 µg sublingually</td>
</tr>
<tr>
<td>(client is stable)</td>
<td></td>
<td>• Recommended for clients who prefer this treatment option\n• Dosage: 400 µg bucally, sublingually, or vaginally; repeat every three hours</td>
</tr>
<tr>
<td>Missed abortion (&lt;14 weeks) and Intrauterine fetal death (&gt;14 weeks)</td>
<td></td>
<td>• Recommended for clients who prefer this treatment option\n• Dosage: 800 µg sublingually, repeat every three hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recommended for clients who prefer this treatment option\n• Dosage: 400 µg sublingually; repeat every four to six hours</td>
</tr>
</tbody>
</table>


Misoprostol is not recommended for treating first or second trimester abortions for the following:

- Clients who are allergic to misoprostol or related drugs or who decline to accept misoprostol
- Clients with evidence of instrumentation and intra-abdominal injury
- Clients with incomplete abortions who are in shock or are experiencing severe vaginal bleeding
- Clients with septic abortions

Misoprostol is safe when administered orally and sublingually. Misoprostol may also be administered bucally or vaginally, although the WHO no longer recommends the vaginal route for managing incomplete abortions of gestation less than 14 weeks. However, the WHO does recommend vaginal administration for second trimester incomplete abortions.68,69

Misoprostol is inexpensive and stable at recommended storage conditions. Synthetic derivatives are also available and are more stable; however, they are more expensive.

Common side effects, most of which are temporary, include: abdominal pains; chills and fever; gastrointestinal disturbances such as diarrhea, nausea, and vomiting; severe vaginal bleeding; and in rare instances, allergic reactions. In rare cases, hyper stimulation of uterine muscles resulting in precipitous contractions followed by expulsion of the products of conception may occur. In extremely rare cases, the uterus may rupture.70,71 Providers must be aware of these potentially serious complications, especially when treating clients with missed abortions. Similarly, clients must receive counseling on all possible side effects and what to do if they experience any side effects, including how to alleviate common and temporary side effects and when to seek care for danger signs.

Misoprostol is also routinely prescribed to prevent bleeding in the third stage of labor and, more recently, in lower doses to induce labor in the third trimester and for augmentation of labor. Use of misoprostol during late pregnancy, labor, and in the postpartum period are beyond the scope of this manual.

70 Ibid.
Vacuum Aspiration

VA has been used for decades and can be used to treat incomplete abortions through 14 weeks uterine size. VA uses suction to remove uterine tissue and the products of conception through a cannula with minimal scraping of the uterine walls. The cannula, or tube, used may be constructed of plastic (flexible or rigid) or metal. A vacuum of at least 66 cm of mercury is required to evacuate the uterus fully and quickly. There are several VA methods: manual vacuum aspiration (MVA), foot pump suction evacuation (FSE), or electric vacuum aspiration (EVA). MVA and FSE do not require electricity and therefore can be used in remote settings, thus expanding access to emergency treatment.

MVA

MVA uses a hand-held vacuum syringe and flexible plastic cannula. MVA does not require electricity. The current MVA model is the autoclavable MVA Plus®, which has one valve and can be operated using a single hand. Once the vacuum is obtained, the valve is kept closed until the cannula is fitted into the syringe, at which point the valve is opened. Older versions of MVA syringes included no-valve, single-valve, and double-valve syringes. No-valve syringes are no longer recommended because they do not create a vacuum until the cannula is inserted into the uterus, which increases the risk of uterine perforation.

FSE

Similar to the MVA, FSE uses a flexible cannula and does not require electricity. The provider performing the procedure can easily obtain and control the vacuum by closing (with a thumb or finger) a small vent port where the cannula attaches to the suction tubing. Studies have shown that the FSE and MVA are similar in ease-of-use, effectiveness, and outcomes, requiring a similar amount of time to perform the uterine evacuation and with no cases of cervical injuries, uterine perforation, or requirements for blood transfusions.

EVA

EVA uses an electric pump and cannula to evacuate the uterus through either continuous (most common) or intermittent (available in newer devices) suctioning. A provider inserts the cannula into the uterus and then attaches it by a tube to the machine. After turning on the machine, the provider moves the cannula around gently until all the tissue of the products of conception are removed from the uterus. EVA can be used for uterine evacuation in the first and second trimesters to remove retained tissue caused by incomplete abortion or miscarriage.

Types of VA Equipment

Select MVA Equipment

EVA Equipment
Source: Apex International. n.d.


Comparison of Effectiveness of and Client Satisfaction with VA Methods

MVA, FSE, and EVA have similar effectiveness rates and similarly low rates of complications.\(^{76,77}\) Other than EVA clients citing the noisiness of the machine, client satisfaction rates for both MVA and EVA are high, and clients reported no difference in acceptability, anxiety, bleeding, or pain. Though VA and sharp curettage are equally effective for treatment of incomplete abortion, VA clients experience less blood loss and less incidence of uterine perforation than those undergoing sharp curettage.\(^{78,79}\)

### Comparisons of Vacuum Aspiration Methods

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>MVA</th>
<th>FSE</th>
<th>EVA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness</td>
<td>99% effective</td>
<td>Similar to MVA</td>
<td>98% effective</td>
</tr>
<tr>
<td>Complications</td>
<td>Low complication rates</td>
<td>Low complication rates</td>
<td>Low complication rates</td>
</tr>
<tr>
<td>Cannula</td>
<td>Plastic only; sizes range from 4 to 12 mm</td>
<td>Plastic only; sizes range from 4 to 14 mm</td>
<td>May be metal or plastic; sizes range from 4 to 16 mm</td>
</tr>
<tr>
<td>Capacity</td>
<td>60 cc</td>
<td>320 to 1,200 cc</td>
<td>320 to 1,200 cc</td>
</tr>
<tr>
<td>Portability</td>
<td>Does not require electricity</td>
<td>Does not require electricity</td>
<td>Requires reliable electricity</td>
</tr>
<tr>
<td>Suction</td>
<td>Suction decreases as syringe fills</td>
<td>Intermittent or constant, provider controlled</td>
<td>Intermittent or constant</td>
</tr>
<tr>
<td>Gestational age for use for incomplete abortion</td>
<td>Up to 14 weeks since first day of last menstrual period only</td>
<td>First trimester only</td>
<td>Second trimester</td>
</tr>
</tbody>
</table>

**Sources:**


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Contraindications and Precautions for VA Use
Do not use MVA for clients with uterine sizes over 14 weeks gestation. Do not use MVA or FSE for clients with acute cervicitis or pelvic infections, except in emergencies. Similarly, do not use MVA or FSE with clients with large fibroids, unless emergency support is available.

Use VA with caution and only in facilities with full emergency support, in the following cases:
- A client with a history of bleeding disorders (risk of excessive bleeding or hemorrhage)
- A client with a history or suspicion of a prior uterine perforation (risk of injuring the bowel)
- A client with severe anemia (risk of severe shock or death)
- A client with hemodynamic instability due to cardiac disease, hemorrhage, or septic shock (risk of severe shock or death)
- A client with uterine fibroids that make it impossible to assess gestation (risk of perforation)

For a client who presents with an infection, initiate antibiotic therapy before beginning the procedure and note that the client may require a referral to a higher level of care.

Dilatation and Evacuation\textsuperscript{80}

The WHO recommends using D&E only for second trimester incomplete abortions when medical management or VA is not indicated; however, medical evacuation is the preferred method for second trimester incomplete abortions unless there are contraindications, the client prefers surgical evacuation, or there is partial expulsion. The D&E method uses dilators to increase the cervical opening to facilitate the use of instruments (such as the forceps) to gain access into the uterine cavity and to grasp and remove the retained products of conception. Once the provider removes larger products, they may empty the remainder of the uterine cavity using a wide-bore cannula by VA. D&E is usually performed in a procedure area and does not require general anesthesia for pain management. The recommended pain management regimen for D&E clients is nonsteroidal anti-inflammatory drugs, sedation, and a local anesthetic for the paracervical block.

D&E is an effective treatment for many conditions, including:
- Incomplete abortion in the second trimester
- Missed abortion
- Septic abortion

Expectant Management

A spontaneous abortion with partial expulsion of the products of conception sometimes resolves itself over time—the remaining uterine contents expelled without any intervention. The term “expectant management” refers to allowing this process to take place while a provider monitors the client for signs of any complications and then ensures that complete uterine evacuation has occurred. Follow local guidelines for offering this option to clients and only offer expectant management as an option in the following circumstances:
- If the client declines all other available options for uterine evacuation (medical and surgical)
- If the client presents with an uncomplicated spontaneous abortion
- If skilled care and emergency services are available in case of complications
- If the facility provides ultrasound and human chorionic gonadotropin monitoring capabilities

Advantages and Disadvantages or Limitations of Different Methods

While all the methods discussed in this session are accepted and recommended by the WHO as options for treatment of abortion-related complications, each method has distinct advantages and disadvantages or limitations. The table on the following page summarizes these advantages and disadvantages or limitations.

### Advantages and Disadvantages or Limitations of Different Methods of Uterine Evacuation

<table>
<thead>
<tr>
<th>Method</th>
<th>Advantages</th>
<th>Disadvantages and Limitations</th>
</tr>
</thead>
</table>
| **Misoprostol** (medication abortion) | • Is easy, safe, and highly effective  
• Can be offered by lower-level providers  
• Does not require facility admittance for clients who are stable  
• Does not require clients with uncomplicated cases to return to the facility after treatment  
• Can be stored at room temperature  
• Side effects are temporary  
• Can be used to treat first and second trimester incomplete abortions  
• Can be used to treat missed abortions | • May take up to a week for complete expulsion of products of conception  
• May result in side effects, including abdominal cramps, bleeding, chills, and fever  
• Cannot be used by clients with severe bleeding or those in shock  
• Is not recommended for clients with septic abortions |
| **MVA** (surgical method)     | • Is easy, safe, and highly effective  
• Is inexpensive  
• Does not require electricity  
• Can be performed by nurses, midwives, clinicians, and traditional and complementary medicine professionals  
• Can easily maintain instruments | • Can only be used for first trimester incomplete abortions  
• Syringe requires emptying and recharging each time it fills  
• Equipment requires careful handling to avoid damage and breakage (handles frequently break)  
• Kits must be replaced over time as they develop mechanical problems |
| **EVA** (surgical method)     | • Is safe and highly effective  
• Can be performed to treat first and second trimester incomplete abortions  
• Requires less time to perform than MVA  
• Less likely to cause perforation than MVA  
• Can be performed for molar pregnancies with minimal chances of perforation | • Requires electricity  
• Machine is expensive  
• Machine requires regular maintenance |
| **D&E** (surgical method)     | • Is highly effective  
• Can be performed to treat first and second trimester incomplete abortions  
• Can be performed to treat septic abortions  
• Can be performed for clients with severe bleeding or in shock (after stabilization) | • Requires adequate pain management  
• Requires higher cadre of trained provider to perform procedure  
• Requires more time to complete the procedure than VA  
• May require a longer stay at facility  
• May result in post-procedure bleeding |
| **Expectant Management**      | • Is effective for selected cases of incomplete abortion with stable hemodynamics  
• Is an option for clients who decline medical or surgical interventions | • Takes longer for expulsion  
• Has a higher risk of hemorrhage  
• Requires admitting clients for observation and the presence of skilled providers to monitor client  
• Cannot be used with clients with complicated incomplete abortions, with severe bleeding, or in shock  
• Not recommended for septic abortion |
Counseling Before, During, and After Uterine Evacuation

Providers should integrate counseling and related support throughout PAC—including before, during, and after the procedure. In addition to ensuring privacy for all counseling, using language that is respectful and readily understandable by the client, and creating opportunities for the client to ask questions or express concerns, are critical components of client-centered counseling.

A core aspect of PAC counseling includes informing the client of findings and diagnoses and explaining the recommended treatment options. For each treatment option, it is important to explain what the treatment entails (including what equipment and instruments are involved), who will be responsible for the treatment, how long it will take, and when it can take place. It is also important to discuss the advantages and disadvantages of each option—including potential side effects and how to manage them as well as warning signs. Providing this information is essential to supporting the client in making an informed decision.

As each client is unique, the content, context, and timing of counseling will necessarily vary to respond to the individual client’s circumstances and needs. The following list, however, provides general guidance for structuring counseling before, during, and after the procedure.

Before the Procedure

- Summarize the procedure for the selected method of uterine evacuation, including:
  » All advantages and disadvantages, including contraindications, side effects, and risks
  » The anticipated length of the procedure and expected length of stay at the facility (as appropriate)
  » Any requirements for referral in the event of an emergency
- Reassure client of the safety and efficacy of the procedure.
- Obtain consent, as required (for instance, written consent for surgical procedures and verbal consent for misoprostol).
- For clients who opt for a surgical method, explain each step of the procedure in detail, including:
  » What the client will need to do to prepare for the procedure; for instance, whether the client needs to empty their bladder in advance and the position the client will be in for the procedure
  » Who will perform the procedure
  » Where the procedure will take place (show the client the procedure room, if possible)
  » The expected pain level and pain management plan, including the pain medication that the client will receive (for instance, light sedation and/or nonsteroidal anti-inflammatory drugs) and what the client should do if they experience any discomfort or pain
  » Any additional medications required, including their purpose and potential effects
  » The equipment used for the procedure (show the client the equipment that will be used, if possible)
- For clients who opt for misoprostol, discuss the dosage, how to administer the drug, what the client may expect to feel (including any side effects), and what to do if they experience any adverse events.
- Explore the client’s needs and feelings as appropriate; include their partner or spouse and/or any family members or friends who have accompanied the client, with the client’s permission.
- Provide contraceptive counseling:
  » If the client is stable, begin contraceptive counseling by asking about the client’s reproductive intentions; include the client’s partner or spouse, as appropriate and with the client’s consent.
  » Provide information about contraceptive options that are relevant to the client’s situation, including how and when the client may access contraceptive services and products as well as advantages and disadvantages (including side effects) of relevant methods.
  » For clients who choose misoprostol, explain which contraceptive methods can be offered with the first dosage.
For clients interested in implants, intrauterine devices (IUDs), or female sterilization, discuss how and when these methods can be provided and any other necessary considerations for care (for instance, if the client will need to provide written consent before receiving the method).

**During the Procedure**
- Explain what you are about to do, then what you are doing, for each step of the evacuation procedure—noting any discomfort the client may experience in advance.
- Use the pain management scale to determine the client’s level of pain and discomfort and continuously evaluate the effect of pain medications; adjust medications as needed.
- Provide verbal and physical distractions and reassurances (such as directing the client to take deep breaths or holding the client’s hand), as necessary and appropriate, or have another provider offer this support, throughout the procedure.
- After uterine evacuation is complete, if the client has received contraceptive counseling and chosen to adopt an IUD, advise the client that you will now insert the device.
- Inform the client when the procedure is complete and the outcome.

**After the Procedure**
- Ask the client how they are feeling (any discomfort or pain); provide support, as needed, including by using the pain management scale to determine the need for further pain management.
- Review any danger signs and what the client should do if such signs occur.
- If client requested implants or other contraceptive methods during counseling prior to the procedure, provide those methods; provide continued counseling during and after insertion of implants.

**Before Discharge**
The WHO recommends an observation time of one to two hours before discharge. Use that time to complete the following tasks:
- Advise the client on danger signs and the appropriate responses.
- Provide instructions to the client (and partner, spouse, or other family member, if appropriate) on any necessary care required after discharge, including when it will be safe to resume work and sexual activity (and the importance of not inserting anything into the vagina for a specific period of time); provide written instructions on follow-up care in the local language for the client to take home.
- Discuss the importance of follow-up care and schedule an appointment for a return visit, as necessary. *Note: Follow-up care for misoprostol clients is not mandatory.*
- If not completed before the procedure, provide contraceptive counseling and services.
- Discuss possible psychological reactions that the client may experience (such as anxiety and/or depression), the length of time the client may expect to experience those feelings, and when the client should seek additional care and support.
- Discuss safe-sex practices and the need for STI and HIV counseling, screening, treatment, and/or referral, as appropriate.
- Screen for gender-based violence and provide referrals for appropriate care, as needed.
Special Considerations for Counseling Young People

While clinical treatment of abortion and related complications does not differ with client age, standard services often fail to consider the unique characteristics and needs of young people. The table below provides general guidance for counseling adolescents (ages 10 to 19 years) and youth (ages 15 to 24). However, it is important to recognize that young people are not a homogeneous group—differences in age, developmental stage, education and literacy levels, marital status, and parity necessitate tailoring counseling to individual clients. Young clients may be unfamiliar with the health system, uncomfortable discussing personal issues with healthcare providers, and may have limited availability and limited access to financial resources. Young clients are also more at-risk of gender-based violence. Therefore, it is important to be particularly sensitive in caring for young people, including by providing timely care, allocating sufficient time for counseling, and offering respectful care without bias or judgment.

### Counseling Young People

#### Before the Procedure

- Ask the client who (if anyone) they would like to involve in the counseling (e.g., partner, parent, friend).
- Ensure privacy and confidentiality (where feasible, a separate waiting room may alleviate fears of stigma).
- Be supportive and show empathy throughout counseling and care.
- Engage the client in a timely manner; ensure the client does not have to wait for long periods before counseling or treatment and explain in advance how long the procedure will take and how long they will need to remain at the facility afterward.
- Allocate extra time for counseling to facilitate two-way communication and encourage the client to share any concerns and feelings.
- Clearly explain any service fees required.
- Use youth-friendly job aids and informational materials, in the local language.
- Inform clients of all treatment options to allow them to make informed decisions; this includes explaining:
  - Advantages and disadvantages of relevant options (including contraindications, side effects, and risks)
  - What the client will need to do to prepare for the procedure
  - Who will perform the procedure
  - Where the procedure will take place and what equipment is required (show the client the procedure room and equipment, if possible)
  - The expected pain level, pain management plans, and what the client should do if they experience any discomfort or pain
  - Any additional medications required, including their purpose and potential effects
  - Post-procedure care required and warning signs that necessitate follow-up care (and how and where to obtain follow-up care)
- Obtain consent. **Note:** If the client is underage, consent of a parent or guardian may be required.
- Reassure the client of the safety and efficacy of the procedure.
- Explore the client's needs and feelings, as appropriate; include their partner or spouse and/or any family members or friends who have accompanied the client, with the client's permission.
- Provide comprehensive contraceptive counseling; this includes:
  - Discussing the return to fertility following the procedure
  - Offering a full range of methods (but recognizing that permanent methods may not be appropriate for adolescents)
  - Effectively and systematically addressing myths and misconceptions
- Screen for sexual coercion and violence using the LIVES approach.*
- Help the client assess their risk of STIs and HIV, provide screening and testing, and emphasize dual protection to prevent unwanted pregnancies and STIs and HIV.
Counseling Young People (continued)

During the Procedure

For all methods:
• Ensure respectful care, confidentiality, and privacy.
• Provide emotional support.
• Ensure the client has provided consent prior to initiating treatment.
• Conduct procedures on an outpatient basis, if possible, to facilitate early discharge.

For misoprostol use:
• Explain dosage, route of administration, and potential side effects.
• Administer the misoprostol and pain medication.
• Monitor vital signs, bleeding, and progress.

For surgical methods:
• Explain each step of the procedure, including what you are about to do and what the client may feel.
• Be gentle and employ youth-friendly tools and equipment (such as smaller speculum), as needed.
• Monitor vital signs.
• Monitor for signs of pain or discomfort (verbal and nonverbal) and provide reassurances and support.
• Consider that MVA is preferable to D&E.
• Follow the pain management plan. Use moderate sedation for D&E.

After the Procedure

• Ask the client (again) who (if anyone) they would like to involve in the discussions.
• Continue to maintain privacy and confidentiality.
• Assess the client’s readiness to receive information.
• Explore the client’s feelings and concerns and provide appropriate support.
• Review side effects and warning signs and explain what to do if they experience either; ask the client to repeat information to ensure understanding.
• Provide youth-friendly materials for the client to take home.
• Provide comprehensive contraceptive counseling, if not completed before the procedure.
• Provide the chosen contraceptive method(s) and/or provide information and referrals for accessing contraceptive care and resupply, including emergency contraception and dual protection, as needed.
• Review safe-sex practices (including dual protection) and the need for STI and HIV counseling, screening, treatment, and/or referral, as appropriate.
• Screen for gender-based violence and provide referrals for appropriate care, as needed.
• Provide referrals to youth-friendly facilities, peer-provider networks, and/or community youth programs for emotional support, life skills training, etc., as available.
• Provide information on youth hotlines or websites, as available.
• Emphasize the purpose and importance of any referrals, using referral slips as outlined in national referral guidelines.

During Follow-Up Care

• **Note:** Not all clients will return for follow-up care.
• Review the client’s condition and assess progress toward full recovery.
• Identify and manage any problem(s) the client is experiencing.
• Assess the client’s level of satisfaction with selected contraceptive method(s).
• Provide additional counseling, as appropriate.

* LIVES is a WHO-recommended approach. LIVES stands for Listen, Inquire about needs and concerns, Validate, Enhance Safety, and provide Support.
Module 2, Session 3: Pain Management

Summary
While most health facilities have a general protocol for pain management, the service provider must recognize and respond to the individual needs of each client. Pain management for PAC includes not only appropriate medication, but also supportive interactions and gentle performance of procedures. In addition to pain management, other medications or related interventions may be necessary during emergency treatment including, for example, provision of antibiotics, intravenous fluids, and oxytocics. This session focuses on various types of pain management for PAC and information needed to appropriately select and administer each type.

Learning Objectives
At the end of this session, participants will be able to:
1. Describe the goal of pain management in emergency treatment for PAC clients.
2. Describe key information to share when counseling clients on pain management.
3. Describe the types of pain clients may experience from incomplete abortions and from different uterine evacuation procedures, including post-procedure pain.
4. List the types of pain management and available methods for each type.
6. Demonstrate counseling related to pain management and integrated with care, as appropriate.

Pain Management for Uterine Evacuation
Pain management is an essential component of care for all clients who require uterine evacuation, including for emergency treatment procedures, such as medication abortion, VA, and D&E. The goal of pain management is to reduce the physical pain and anxiety that the client experiences without risking their health. This often includes a combination of medication, emotional (verbal and physical) support, and clinical technique.

Pain management options vary based on several factors, including the treatment method.81 For example, analgesics (with or without mild sedatives) may be used for VA, rather than riskier general or regional anesthetics; whereas, for misoprostol, nonprescription, nonsteroidal anti-inflammatory drugs may be adequate.

Pain management involves working with the client to develop an individualized plan that will allow for the successful completion and uneventful recovery after the uterine evacuation procedure or process. Therefore, a key component of counseling is discussing pain management, including reviewing the procedure and the level of pain that the client may experience, and allowing the client to ask questions and share concerns. The list below highlights key points to discuss with the client during this counseling.

- Any preexisting pain
- Length of procedure (for example, VA takes approximately 10 to 15 minutes; for misoprostol, the expulsion of most products of conception typically occurs within 24 hours)
- Steps and processes of the procedure, including the degree of cervical dilatation required (if dilatation is required) and the equipment and/or instruments used for the procedure
- Available pain medications, how they are administered, and any side effects
- Any client conditions (allergies, contraindications, or prior adverse reactions) that may affect the procedure and/or the pain management plan selected
- Any emotional or psychological concerns of the client

In addition to the physical pain, the client may be experiencing emotional or psychological distress, including depression and/or stress about the circumstances surrounding the abortion or miscarriage as well as anxiety about the pending procedure. Physical discomfort and pain can be exacerbated by anxiety and fear. Successful

https://doi.org/10.1016/s0029-7844(01)01529-0.
pain management for uterine evacuation therefore involves, in addition to appropriate medication, a supportive interaction and a relaxed environment. Providers can support clients dealing with difficult emotions by:

- Ensuring that the exam and treatment or procedure rooms are quiet, comfortable, and provide privacy
- Providing clear explanations of the steps of the procedure in advance and again during treatment including what, if any, discomfort or pain the client may expect to feel at each stage
- Clearly explaining pain management options (including benefits and possible side effects) for before, during, and after the procedure and ensuring the client is able to make informed decisions
- Encouraging clients to ask questions and express concerns and responding with empathy
- Inviting the client to engage a partner or spouse, family member, or friend to participate in the discussion
- Providing emotional support, including affirming that feelings such as anxiety, confusion, and fear, are common and providing verbal reassurances and physical comfort, before, during, and after the procedure
- Being calm, friendly, gentle, and unhurried throughout all stages of care
- Demonstrating that the team of providers is competent, efficient, and well-trained

These elements are not a substitute for pain medication but are critical to providing high-quality care. It is also important to follow all local and institutional protocols related to informed consent for both the procedure and pain management decisions.

Counseling and Pain Management Tasks

- Arrange the setting to facilitate a confidential discussion.
- Ask the client if there is anyone else that they would like to join the discussion, such as a partner or spouse, family member, or friend.
- Be sure the client understands what level of pain and discomfort to expect during the procedure.
- Acknowledge that feeling confused, scared, or worried are common for most clients.
- Explain pain management options using simple terms and explanations. Include information about pre- and post-procedure pain management, benefits, and possible side effects.
- Be sure that the client understands everything by asking them to repeat or summarize the information in their own words.
- Follow local or facility protocols for documenting informed consent for the procedure and pain management, as appropriate.

Requirements for Informed Consent

Some pain medications (particularly non-opioid analgesics) do not require formal client consent. However, pain medications that may affect consciousness or alertness (such as narcotics or some sedatives) typically necessitate consent and it is critical to obtain the client’s consent before administering such drugs.

In cases of emergency and for clients who are either unconscious or otherwise incapable of providing informed consent, consent may be considered implied, depending on local laws. This allows providers to take necessary actions to provide appropriate and urgent care, including pain management.

Requirements for verbal and/or written consent for contraception and pain medication may vary. Always follow local policies or protocols regarding informed consent. **Note:** A client who wishes to adopt a contraceptive implant or IUD following emergency treatment should provide consent for the contraceptive method before receiving any pain medication, to ensure informed consent.

Assessing Pain

Asking clients to rate the intensity of their pain is an important part of determining treatment and pain

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management plans. It is important to assess the client’s degree of pain before, during, and after the procedure to ensure adequate pain management.

There are two common approaches for discussing pain intensity. The first approach involves a numerical scale. A numerical pain scale allows clients to describe the intensity of discomfort or pain using numbers across a set range, for instance, from 0 to 10. Numerical pain scales may also include descriptive labels accompanying the high and low values, for example, “no pain” to “excruciating pain.” This type of combination scale may be more sensitive to gender and ethnic differences for describing pain than other scales.

**Example of a Numerical Pain Scale**

<table>
<thead>
<tr>
<th>No Pain</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Excruciating Pain</th>
</tr>
</thead>
</table>

Another pain assessment tool is the Wong-Baker Faces Pain Rating Scale, which was originally designed for children and which offers visual illustrations. This scale is best used with clients who lack the ability to explain their level of pain using words or the numerical scale. To use this scale, explain that each face depicts how a person is feeling by pointing to the faces and words beneath and noting that they may feel happy because they are not experiencing any pain, or sad because they are experiencing a great degree of pain. Then, ask the client to choose the face that best reflects their pain level. **Note: A client does not have to be crying to be at level 10.**

**Wong-Baker Faces Pain Rating Scale**

<table>
<thead>
<tr>
<th>0</th>
<th>2</th>
<th>4</th>
<th>6</th>
<th>8</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO HURT</td>
<td>LITTLE BIT</td>
<td>LITTLE MORE</td>
<td>EVEN MORE</td>
<td>WHOLE LOT</td>
<td>WORST</td>
</tr>
</tbody>
</table>

**Types and Origins of Pain**

There are two primary types of pain associated with uterine evacuation.

- Lower-abdominal cramping, which may occur as the result of movement of the uterus, muscle spasms, or scraping of the uterine wall during the evacuation procedure
- Deep and tense pain, which may occur as a result of dilatating and/or stimulating the cervix

There are two paths that transmit pain from the cervix and uterus:

- Hypogastric plexus: body and fundus of the uterus
- Utero-vaginal plexus: cervix and upper vagina

**Types of Pain Management Medication**

Effective pain management for uterine evacuation often includes medication or a combination of medications. There are three main types of pain management medication, summarized below and subsequently detailed, each of which acts differently to manage pain.

- Analgesics (including acetaminophen or paracetamol, nonsteroidal anti-inflammatory drugs, and rarely narcotics) ease the sensation of pain.
- Anxiolytics depress central nervous system functions, reduce anxiety, induce amnesia, and relax muscles.
- Anesthetics, local or regional, block the transmission of pain stimuli thus eliminating all physical sensations.

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84 Ibid.
Analgesics

In cases of incomplete abortion where the cervix is already open, administering analgesics 30 minutes before the evacuation is often sufficient. Similarly, abdominal cramps associated with misoprostol use can be managed by nonsteroidal anti-inflammatory drugs. Special considerations for using analgesics include the following:

- Acetaminophen and paracetamol may not provide sufficient pain relief for VA clients.
- Nonsteroidal anti-inflammatory drugs (e.g., diclofenac, ibuprofen, and mefenamic acid) reduce cramping and uterine pain during and after the procedure. These are administered orally, are relatively inexpensive, and provide adequate pain relief for many clients.\(^8^5\)
- Analgesics with narcotics (e.g., fentanyl and meperidine or pethidine), may be administered intramuscularly, intravenously, or orally, depending on the specific medication, on an individualized basis, as needed.\(^8^6\) Because one adverse event of this group of medications is respiratory depression, healthcare providers must know the safe dosage limits, the duration of action, and how to reverse the effects in the case of respiratory depression. Additionally, using narcotics in combination with anxiolytics is not recommended due to both associated costs and risks of side effects.

The table below outlines the route of administration, duration of effect, and common side effects associated with analgesics commonly used for uterine evacuation.

### Analgesics Used for Uterine Evacuation

<table>
<thead>
<tr>
<th>Name</th>
<th>Administration</th>
<th>Duration</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen or Paracetamol</td>
<td>Orally</td>
<td>Up to 4 hours</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Acetaminophen or Paracetamol with Codeine (Tylenol with Codeine)</td>
<td>Orally</td>
<td>4 to 6 hours</td>
<td>Drowsiness, dry mouth, euphoria, light-headedness, weakness</td>
</tr>
<tr>
<td>Diclofenac, Ibuprofen, or Mefenamic Acid</td>
<td>Intramuscularly or orally</td>
<td>3 to 6 hours</td>
<td>Gastrointestinal upset</td>
</tr>
<tr>
<td>Motrin</td>
<td>Orally</td>
<td>Up to 5 hours</td>
<td>Gastrointestinal upset</td>
</tr>
<tr>
<td>Pethidine</td>
<td>Intramuscularly, intravenously, or orally</td>
<td>2 hours</td>
<td>Drowsiness, dry mouth, euphoria, light-headedness, weakness</td>
</tr>
</tbody>
</table>

Anxiolytics

Anxiolytics, such as diazepam (valium) or midazolam, decrease anxiety and facilitate amnesia; however, they do not reduce physical pain. Anxiolytics can be administered intravenously or orally. For clients with anxiety, the provider should assess the anxiety level and individualize the dosage accordingly. Providers must also be aware of the duration of effect, safe upper limits, and potential interactions with narcotics when using anxiolytics. Further, when administering anxiolytics (or narcotics), the following medical support resources are required in case of any adverse reactions, including respiratory depression.

- Clinicians trained in resuscitation
- Appropriate antagonistic drugs
- Resuscitation equipment and supplies (see text box)

### Addressing Respiratory Depression

- Assist respiration with bag valve mask and oxygen
- Reverse pethidine or fentanyl with naloxone 0.4 mg intravenously
- Reverse benzodiazepines with flumazenil (or physostigmine) 0.2 mg intravenously

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Anesthesia

There are three main types of anesthesia—local, regional, and general—as summarized in the table below.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Local</th>
<th>Regional</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Management Approach</td>
<td>Interrupts transmission of sensations in local tissue; client remains conscious</td>
<td>Blocks sensation from a specific point on the spine; client remains conscious</td>
<td>Affects pain receptors in the brain; client is completely unconscious</td>
</tr>
<tr>
<td>Risk of Complication</td>
<td>Low</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Recovery Time</td>
<td>Short</td>
<td>Long</td>
<td>Long</td>
</tr>
<tr>
<td>Potential Complications</td>
<td>Cardiac arrhythmia, drug allergy, lidocaine toxicity, seizure, twitching</td>
<td>Cardiac arrest, central nervous system infection, drug allergy, hypotension, seizure, spinal cord injury</td>
<td>Aspiration of drug, cardiac arrest, drug allergy, hypoxia</td>
</tr>
</tbody>
</table>

The WHO no longer recommends using general anesthesia for VA or D&E procedures, and instead recommends local anesthesia or a combination of analgesics and anxiolytic medications.  


This treatment may be effective for as long as 60 to 90 minutes, depending on the specific anesthetic used. The table below summarizes the duration of effectiveness, advantages, and disadvantage of two common medications used for the paracervical block.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Duration</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chloroprocaine</td>
<td>30 to 45 minutes</td>
<td>Less toxic due to rapid breakdown</td>
<td>More allergic reactions, more expensive</td>
</tr>
<tr>
<td>(Nesacaine)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lidocaine</td>
<td>60 to 90 minutes</td>
<td>Rare allergic reactions</td>
<td>More toxic due to slow breakdown</td>
</tr>
<tr>
<td>(Xylocaain)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In addition to common side effects (buzzing in the ears, metallic taste, and numbness of the mouth and tongue), complications are rare but include hematoma. Ensuring the correct infiltration technique and adherence to maximum dosage limits are necessary for safe use.92,93

Performing a Paracervical Block with Lidocaine

To perform a paracervical block, the provider injects the medication directly into the tissues surrounding the cervix. It is important to anaesthetize early to provide sufficient time for the medication to take effect. However, before administering a paracervical block, the provider should ensure that the client is not allergic to lidocaine or related medications.

Prepare to inject the lidocaine by grasping the cervix, either with a tenaculum, ring, or sponge forceps. Ring or sponge forceps, which are less likely than the tenaculum to tear the cervix and which do not require the use of lidocaine for placement, are preferable. When using a tenaculum to grasp the cervix, first inject 1 ml of a 0.5% lidocaine solution into the anterior or posterior lip of the cervix that has been exposed by the speculum (use a 10 or 12 o’clock position). After placing the tenaculum or ring forceps on the cervix vertically (one tooth in the external os, the other on the face of the cervix), use slight traction and movement to help identify the area between the smooth cervical epithelium and the vaginal tissue, which will be the injection site.

Use a 3.5 cm, 22-gauge, or 25-gauge spinal needle or needle extender with 10 cc syringe to inject the lidocaine. Insert the needle just under the epithelium, at the 3 o’clock position, no deeper than 3 mm. **Note:** Some practitioners have suggested placing the tip of the needle just over the site selected for insertion and asking the client to cough; this will force the needle to pierce just under the surface of the tissue, while also diverting the client’s attention from the procedure. Be careful not to inject the medication into a vessel. To check, aspirate (pull back on the plunger of the syringe) before administering the medication. If blood is visible in the syringe with aspiration, remove the needle, recheck the position of the needle, and try again. Never inject lidocaine if blood is aspirated, as this can result in convulsions and death.

After confirming the needle placement, inject 2 ml of the lidocaine solution. Repeat this at the 5, 7, and 9 o’clock positions; note, additional optional injection sites are 2 and 10 o’clock (see diagram). The maximum dose for lidocaine is 16 ml. When the injection is correctly placed, the tissue will blanch and swell. After completing the series of injections, wait two minutes and then pinch the cervix using forceps. Ask if the client feels the pinch, and, if so, wait two more minutes and then test again.


Module 2, Session 4: Uterine Evacuation via Dilatation and Evacuation

Summary

This session presents an overview and description of the dilatation and evacuation (D&E) procedure for uterine evacuation. Each step of the procedure is outlined in detail. Always follow local guidelines or protocols for the procedure, including anesthesia or related care.

Learning Objectives

At the end of this session, participants will be able to:

1. Identify the instruments used for D&E.
2. Explain and demonstrate the procedure for D&E using a model.
3. Describe post-procedure care.

Recommendations for Dilatation and Evacuation

The WHO no longer recommends sharp curettage to treat incomplete abortions, instead recommending VA for first trimester or D&E for first and second trimester cases. Whereas sharp curettage under general anesthesia is associated with cervical trauma, increased blood loss, and other problems, D&E can be performed safely using analgesics rather than general anesthesia.

This manual provides a summary of the D&E procedure. Refer to appropriate medical texts or training materials for additional information needed to safely perform the procedure—such as local guidelines, protocols, and practice standards related to D&E, including anesthesia and related care.

Ensuring Client-Centered Care

As with other uterine evacuation methods, it is important to provide high-quality, client-centered care. For D&E, this includes:

- Ensuring client confidentiality, dignity, privacy, and respect before, during, and after the procedure
- Explaining each step of the procedure, including what the client should expect to feel and any action(s) required by the client, before and during the procedure (as applicable)
- Offering contraceptive counseling and services (see text box)
- Discussing the procedure with the client and obtaining informed consent in writing before the procedure
- Discussing and ensuring adequate pain management plans are in place before and during the procedure (as applicable) (Note: A paracervical block is typically used in cases where cervical dilatation is necessary.)
- Gently handling tissues throughout the procedure
- Observing infection prevention practices at all times

Reminder: Contraceptive care is a vital component of PAC. Providing contraceptive counseling and services to clients increases the number of clients adopting a contraceptive method before discharge, thereby potentially decreasing the incidence of unplanned pregnancies that may result in future abortions.

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Essential Equipment and Supplies
The D&E should be performed in a procedure room or similarly designated room with all the necessary furniture, equipment, and supplies, as listed below:

- Analgesics (ibuprofen or diclofenac tablets or injectables)
- Antiseptic solution
- Anxiolytics (such as diazepam)
- Contraceptive kits (such as implant or IUD kits), as required
- Leak-proof sharps disposal container
- Local anesthesia (if cervical dilatation is required)
- Strainer and receptacle
- Sterile equipment and supplies:
  - Cannula, graduated sizes
  - Dilators, graduated sizes
  - Drapes
  - Gloves
  - Graves Speculum or Jacksonian Retractor
  - Ring forceps
  - Single tooth tenaculum or vulsellum
  - Sponge forceps
  - Syringes and needle (for paracervical block), as required
  - Uterine sound

The Procedure: Step-by-Step
The following is a summary of key steps for completing a D&E procedure. Adapt the steps listed below to comply with local or institutional protocols.

1. Confirm the following:
   - The client presents with an incomplete abortion less than 14 weeks' gestation, with or without complications.
   - Misoprostol or VA are not available.
   - The client has chosen D&E for uterine evacuation.

2. Assess and make a treatment plan:
   - Greet and assess the client.
   - Confirm the diagnosis and identify potential complications, if any.
   - Stabilize the client and begin treatment of complications, if needed.
   - Assess pain management needs based on the client's current discomfort, the client's level of anxiety, the client's history of pain tolerance, and the expected level of discomfort of the anticipated procedure.
   - Discuss pain management options (analgesia, anesthesia, anxiolytics) with the client and, if the client wishes, the client's partner or spouse, family, or friend.

3. Provide counseling, emotional support, and encouragement before, during, and after the procedure. (See Counseling Before, During, and after Uterine Evacuation in Module 2, Session 2 for more details.)

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4. Provide contraceptive counseling. For clients who meet the medical eligibility criteria, this includes offering IUD insertion immediately after the uterine evacuation (if there is no evidence of sepsis) and offering implant insertion prior to discharge.

5. Obtain consent for the procedure, the pain management plan (medication), and for any contraceptive methods, in accordance with national policies and protocols (e.g., written consent for undergoing the D&E procedure and verbal consent for contraception). Obtain consent before administering any anesthesia or medication.

6. Organize the procedure area for D&E:
   » Perform hand hygiene.
   » Don personal protective attire (gloves and surgical apron).
   » Establish a sterile field on the instruments trolley(s).
   » Organize equipment and supplies (see previous list).

7. Prepare the client for the procedure:
   » Ask the client to empty their bladder and clean their perineum, if able to do so.
   » Administer any prophylactic antibiotics (according to local protocol).
   » Help the client onto the examination table and into the lithotomy position; drape the client.

8. Perform a pelvic examination to assess the size and position of the uterus and the condition of the fornices.

9. Administer analgesia, anxiolytic, and/or local anesthesia, as indicated in the pain management plan:
   » Administer diclofenac orally 45 to 60 minutes before procedure, or intramuscularly 5 to 10 minutes before the procedure for pain management.
   » Administer diazepam orally 45 to 60 minutes before the procedure to alleviate anxiety.
   » Administer 10 units of oxytocin intramuscularly or 0.2 mg of ergometrine before the procedure to make the myometrium firmer and reduce the risk of perforation.
   » As applicable, apply a paracervical block.

10. Prepare the surgical team:
    » Each surgical team member performs hand hygiene and dons personal protective attire (gloves and surgical apron).
    » Identify and review roles (see text box).

11. Cleanse the perineum with the antiseptic solution.

12. Gently insert a sterile speculum or retractor into the vagina.

13. Apply the antiseptic solution to the vagina and cervix (especially the os).

14. Check the cervix for tears or protruding products of conception. If any products of conception are present in the cervix or vagina, remove them using ring or sponge forceps.

15. Carefully and gently initiate uterine D&E:
    » Gently grasp the anterior lip of the cervix with a tenaculum or forceps to straighten the uterine cavity. Note: If using a tenaculum, first inject 1 ml of a 0.5% lidocaine solution into the anterior or posterior lip of the cervix that has been exposed by the speculum in the 10 or 12 o'clock position.
    » Gently pass a uterine sound through the cervix to assess the length and direction of the uterus; compare with the previous size estimate.

D&E Surgical Team

Ensure that a team of at least three qualified providers (as defined by local policies) are available to perform the procedure; this cannot be performed by a single provider. While one provider performs the D&E procedure, the second and third providers will need to monitor the client’s vitals and serve as a circulating nurse who can support the client, ensure the availability of needed supplies, and assist with resuscitation in the event of an emergency.
» Dilatate the cervix (as needed) to introduce ring forceps. **Note:** Dilatation is needed when the larger retained products of conception cannot be removed using a cannula. Use graduated dilators only if the cannula or curette will not pass. Begin with the smallest dilator that can pass through the cervix and end with the largest dilator that ensures adequate dilatation (usually 10 to 12 mm). Exercise extreme care so as not to tear the cervix or create a false passage.

» Gently insert the ring forceps and begin to evacuate the products of conception. Continue removing the products of conception until no more remain in the uterine cavity. Then remove the ring forceps. **Note:** Bleeding may increase at this stage.

» Gently insert the cannula, attach the vacuum, and evacuate all quadrants of the uterine cavity until you observe signs of completion including: contraction of the uterus (increased cramping), a gritty sensation throughout the cavity, and cessation of the removal of retained tissue (frothy, pink aspirate).

16. **Insert the Retractor and Hold the Anterior Lip of the Cervix**

17. **Dilatate the Cervix**

18. **Evacuate the Uterus**

19. Quickly assess tissue for completeness and consistency with diagnosis. Assuming the procedure was completed successfully:

   » Assess bleeding, remove any remaining instruments from the client, make them comfortable, and let them know that the uterine evacuation is complete.

   » If the client voluntarily opted for an IUD during counseling before the procedure, inform them that you will now insert the IUD and then insert the IUD.

   » Clean the perineum and apply a sanitary pad.

   » If the client voluntarily opted for implants during counseling before the procedure, inform them that you will now insert the implant and then insert the implant.

18. Inform the client that they will now be transferred to a comfortable area to rest and recover while being monitored.

19. When the client is fully awake and alert, share any findings and implications for continued treatment.

20. Continue treatment and monitoring, as necessary.

20. Initiate post-procedure care, including conducting post-procedure counseling, offering contraceptive care (if not previously completed), and providing discharge instructions.
Post-Procedure Care

Clients with uncomplicated cases may be discharged within one or two hours after the completion of the D&E procedure. The client may be discharged when they are stable, can walk without assistance, and have received post-procedure counseling and services. The time prior to discharge should be used to complete the following tasks.99

- Administer 500 mg paracetamol orally, as needed. Discuss the client’s level of discomfort or pain and administer any other medications necessary according to the pain management plan.
- Administer antibiotics, as required by national guidelines. Note: The national guidelines may require provision of prophylactic antibiotics to all PAC clients following a D&E procedure.
- Check the client’s vital signs and check for vaginal bleeding every 15 minutes for at least one hour before discharging the client from the facility.
- Encourage client to eat, drink, and walk around, as they are comfortable doing so.
- Explore the client’s feelings and concerns and provide the following additional care and support, as needed:
  - Counseling, emotional support, and referrals for postabortion psychological sequelae
  - Counseling on safe-sex practices and services or referrals for STI and HIV testing and treatment
  - Screening for gender-based violence and referrals to available services for survivors
  - Delivery of other health services or referrals, as necessary, including breast and cervical cancer screenings, malaria and tetanus prophylaxis, and Rh immune globulin if the client is Rh-negative
  - Contraceptive counseling and services or referrals, if not previously completed, emphasizing the return to fertility (as soon as within two weeks) and the benefits of birth spacing for maternal and child health, as well as how to obtain resupply, if necessary
  - Additional counseling as appropriate (See Counseling Before, During, and After Uterine Evacuation in Module 2, Session 2 for additional guidance.)
- Instruct the client not to have intercourse and not to put anything into their vagina (douches, tampons, etc.) until after the bleeding stops (usually within five to seven days).
- Instruct the client on when they may return to normal chores and/or work.
- Instruct the client to watch for the following signs and symptoms requiring immediate attention:
  - Abdominal cramping that is prolonged
  - Bleeding that is heavy and/or prolonged (more than normal menstrual bleeding)
  - Fainting
  - Fever, chills, or malaise
  - Foul-smelling vaginal discharge
  - Increased and/or severe pain
- Complete or update client charts and other forms, as required.

Reminder: PAC counseling is critical throughout all phases of care and PAC is incomplete without the inclusion of voluntary contraceptive care. Clients may wish to include their partners, spouses, or other family members in counseling to be informed about their condition, treatment, and/or follow-up care; similarly those accompanying the client may be interested in learning more so they can provide additional support after leaving the facility. Refer to the Counseling Before, During, and After Uterine Evacuation section in Module 2, Session 2 for additional guidance.

Module 2, Session 5: Uterine Evacuation via Vacuum Aspiration

Summary
This session focuses on various vacuum aspiration (VA) equipment and procedures (electric, foot pump, and manual). Participants will learn how to perform the procedure through a step-by-step process and then discuss how to recognize and solve problems that may arise during the procedure.

Learning Objectives
At the end of this session, participants will be able to:
1. Identify the parts of manual vacuum aspiration (MVA) equipment and select the correct size syringe and cannula.
2. If locally applicable, for electric vacuum aspirator (EVA) and/or foot pump suction evacuation (FSE):
   » Identify the parts of the EVA and/or FSE equipment
   » Select the correct size cannula
3. Demonstrate the ability to assemble, test, and prepare MVA, EVA, or FSE equipment.
4. Perform the VA procedure using MVA, EVA, or FSE, according to the steps outlined.
5. Demonstrate appropriate counseling before, during, and after the procedure.
6. Recognize and solve technical and/or procedural problems.
7. Record complete, accurate case information in client charts, logbooks, and other forms, as needed.

Types of Vacuum Aspiration Methods
There are three types of VA, as summarized below.
- MVA uses a hand-held vacuum syringe and flexible plastic cannula to apply suction and perform the evacuation procedure. This method does not require electricity.
- FSE uses a foot pump suction evacuator with a flexible plastic cannula to obtain vacuum and perform the evacuation procedure, using either intermittent or continuous suction. This method does not require electricity.
- EVA uses an electric pump and cannula (metal or plastic) to evacuate the uterus using either intermittent or continuous suctioning. This method requires reliable electricity.
Manual Vacuum Aspiration Basics

How It Works

- The provider generates the vacuum in the syringe.
- The provider inserts a sterile cannula into the uterine cavity through the cervix.
- The provider connects the syringe to the cannula.
- The provider releases the valve, and through the established suction, empties the contents of the uterus into the syringe.
- Every time the syringe becomes full, the provider detaches and empties it, and generates vacuum again before reconnecting it to the cannula and repeating the process.

Equipment Benefits\(^{100}\)

- It does not require electricity.
- It is portable.
- The syringe holds 60 cc of aspirate fluid and tissue.
- Single-valve (not available in all settings), double-valve, and the MVA Plus’ syringes are compatible with other cannulae. \(\text{Note: }\) The amount of force to create a vacuum suction varies depending on the syringe type.

Cleaning and Decontamination for Reuse\(^{101}\)

- Soft brushes are more appropriate for cleaning syringes and cannulae than metal brushes or hard substances.
- Steam-sterilization is recommended for MVA Plus’ kits.


\(^{101}\) Ibid.
An Evaluation of Manual Vacuum Aspiration Instruments

In 2001, EngenderHealth and PATH (formerly known as Program for Appropriate Technology in Health) conducted the first-ever comparative evaluation of MVA instruments. This evaluation involved testing the durability, quality, safety, and usability of all instruments available at the time. According to this study, “no single brand of MVA instruments is perfectly suited to every setting, and no single element of the instruments unequivocally identifies one brand as superior to another...However, it is evident that certain instruments do not meet minimum safety, functionality, and durability standards.”\textsuperscript{102} Further, “while the lowest-cost MVA instruments may appear most appealing...these products may not necessarily be the safest or most cost-effective, due to their decreasing safety, functionality, or effectiveness over time. Accordingly, some products that cost more at the outset may in fact prove less expensive over the long term.”\textsuperscript{103}

Other key findings included:

- Sterilization techniques involving boiling and steaming caused moderate to significant changes in quality and durability. \textit{Note: The WHO no longer recommends boiling as a method of disinfection or sterilization of instruments for reuse.}\textsuperscript{104}
- Most users had difficulty assembling and disassembling single-valve instruments and disassembling double-valve instruments.
- Using a chlorine (or bleach) solution and glutaraldehyde did not cause significant change to cannulae (e.g., loss or alteration of depth or size markings). \textit{Note: The WHO no longer recommends using a chlorine solution to disinfect cannulae and any instruments that may be used in human body cavities or sterile tissues.}\textsuperscript{105}

Since the completion of the study, the MVA EasyGrip\textsuperscript{®} cannula and the MVA Plus\textsuperscript{®} syringe and cannula have become available. These instruments have fewer parts, are autoclavable, are easier to disassemble, and are compatible with other syringes and cannulae.\textsuperscript{106}

Pre-Procedure Care

Before beginning the MVA procedure, complete the tasks listed below.

- Greet the client and perform a rapid assessment, ruling out or treating complications and ensuring the client is stable.
- Assess the client.
  - Obtain the client’s history.
  - Perform physical and pelvic examinations, assessing the uterine size.
  - Request any necessary laboratory or other testing.
  - Rule out any contraindications to MVA.
  - Review precautions, as appropriate.
- Explain findings from the assessment and emergency treatment options to the client—including what to expect before, during, and after the procedure—and allow them to make an informed decision.
- Provide counseling, emotional support, and encouragement.
  - Discuss pain management options with the client.
  - Provide contraceptive counseling. \textit{Note: If the client meets the medical eligibility criteria, explain that an...}

\textsuperscript{103} Ibid.
\textsuperscript{104} WHO. 2016. \textit{Decontamination and Reprocessing of Medical Devices for Health-Care Facilities}. Geneva: WHO. \url{https://www.who.int/publications/i/item/9789241549851}.
IUD can be inserted immediately after the uterine evacuation procedure, if there is no evidence of infection, and that an implant can be inserted immediately after the procedure or anytime thereafter.

» Provide additional counseling as appropriate. (See Counseling Before, During, and After Uterine Evacuation in Module 2, Session 2 for additional guidance.)

• Obtain consent—verbal and/or written, as required—for the evacuation procedure selected, the pain management plan chosen, and the contraceptive method selected.

• Organize the procedure area and team for MVA.
  » Ensure all necessary equipment are available and sterilized, including emergency resources. (See the Instrument Preparations section of this session for additional guidance.)
  » Ensure required medications and contraceptive kits (if applicable) are available.
  » Ensure each surgical team member (including staff to monitor the client, provide emotional support, and provide emergency assistance, if needed) is in place.
  » Perform hand hygiene and don personal protective attire (provider and team).

• Prepare the client for the procedure.
  » Ask the client to empty their bladder and clean their perineum, if able to do so.
  » Help the client onto the examination table and into the lithotomy position; drape the client.
  » Administer medication, as indicated in the pain management plan.

• Implement infection prevention measures.

Instrument Preparations

Prepare instruments, according to the guidance below, and, if possible, allow the client to see the instruments in advance (for instance, while you are explaining the procedure during pre-procedure counseling).

MVA Instruments

• Select and inspect cannulae.
  » Identify several cannulae of different sizes.
  » Select cannulae according to the assessment of uterine size (see table below) and considering the cannula needs to be large enough to allow passage of the tissue expected (according to gestation) and to fit snugly through the cervix.
  » Inspect selected cannulae for cracks or other defects; discard if there are any signs of weakness or wear and identify another cannula for inspection and use.
  » Select the appropriate adapter, if needed (see table on the following page).

<table>
<thead>
<tr>
<th>Approximate Uterine Size*</th>
<th>Approximate Cannula Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 to 7 weeks</td>
<td>5 mm</td>
</tr>
<tr>
<td>7 to 9 weeks</td>
<td>6 mm</td>
</tr>
<tr>
<td>9 to 12 weeks</td>
<td>7 to 12 mm</td>
</tr>
</tbody>
</table>

* Weeks since last menstrual period
• Select and inspect syringes and adapters, if required (see table below).
  » Prepare two syringes, recognizing that the amount of blood and tissue in the uterus can be unpredictable.
  » Ensure that the colored dots on the cannula match the color of the adapter, if applicable.
  » Ensure the syringe can hold a vacuum. Apply lubricant to or replace the O-ring (if worn) of syringes unable to hold a vacuum. Discard any syringes with cracks or defects and any that do not hold a vacuum, and identify alternate syringes for inspection and use.

<table>
<thead>
<tr>
<th>Cannula Size</th>
<th>Adapter Color</th>
<th>Syringe Type</th>
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</table>

* The single-valve syringe is no longer available in most settings.

• Attach the adapter, if required, to the end of the syringe or cannula. **Note: The MVA Plus® syringe does not require an adapter.**

• Check the plunger and valve on the syringe. The plunger should be positioned all the way into the barrel, with the pinch valve open and the valve button out.

• Close the pinch valve by pushing the button down and forward until it locks into place.

• Prepare the syringe.
  » Grasp the barrel and pull the plunger back until the arms of the plunger snap outward.
  » Ensure the plunger arms are fully secured over the edge of the barrel, so the plunger cannot move forward involuntarily. Incorrect positioning could allow the arms to slip back inside the barrel. Improperly securing only one arm of the plunger can lead to breakage.
  » Never grasp the syringe by the plunger arms.

• Confirm and prepare the syringe vacuum.
  » Establish vacuum and leave the syringe for several minutes with the vacuum established. Then, open the pinch valve—you should hear a rush of air into the syringe indicating that there was a vacuum in the syringe. If the syringe failed to maintain vacuum, identify a new syringe and repeat the test.
  » Reestablish the vacuum in the syringe for use during the procedure.
EVA and FSE Instruments

Select and inspect cannulae:

- Identify several cannulae of different sizes.
  - Select cannulae according to the uterine size and considering the cannula needs to be large enough to allow passage of the tissue expected (according to gestation) and to fit snugly through the cervix.
  - Inspect selected cannulae for cracks or other defects; discard if there are any signs of weakness or wear and identify another cannula for inspection and use.
- Check that the EVA or FSE equipment creates a vacuum.

All VA Methods

- Ensure all required sterile equipment and supplies are assembled on the sterile, draped trolley. These include: antiseptic solution, receptacle, gauze, gloves, safety boxes, speculum, sponge holding forceps, strainer and receptacle for products of conception, and tenaculum.
- For clients who have opted to receive an implant or IUD, ensure the relevant contraceptive and insertion kit is also in place.

The Procedure: Step-by-Step

Note: The following is a summary of key steps for completing a VA procedure, as adapted from Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors. Adapt the steps listed below to comply with local or institutional protocols.

Step 1: Prepare for the Procedure

The following tasks must be completed before beginning the procedure.

- Counsel the client about the treatment options, pain management plan, and contraceptive options and verify that the client has provided consent (verbal and/or written, as required).
- Prepare the client for the procedure, including by completing the following:
  - Ask the client to empty their bladder and clean their perineum, if able to do so.
  - Help the client onto the examination table and into the lithotomy position; drape the client.
  - Administer pre-procedure medication, as indicated in the pain management plan.
- Ensure that:
  - Emergency equipment and supplies (including medications) are available.
  - Emergency back-up is available.
  - Instruments are sterilized and assembled on the sterile field (e.g., a trolley).
  - Contraceptive methods are available in the treatment room, as required.
- Perform hand hygiene and don personal protective attire (e.g., apron and gloves).
- Perform a bimanual exam to determine the uterine size and position and degree of cervical dilation. Confirm that the uterine size is less than 14 weeks.
- Insert a vaginal speculum and visualize the cervix.
- Using the no-touch technique, apply an antiseptic solution two times to the cervix (especially the os) and vagina using sterile ring forceps and a cotton or gauze swab.
- Check the cervix for tears or protruding products of conception. If there are products of conception present in the vagina or cervix, remove them using ring or sponge holding forceps.
- Gently apply a vulsellum or single toothed tenaculum to the anterior lip of the cervix.

Step 2: Dilate the Cervix, If Indicated

The cervix is often dilated in cases of induced abortion; however, cervical dilatation is usually necessary in cases of missed abortion and in other cases in which the cervical canal will not allow passage of a cannula appropriate to the uterine size. When needed, gently dilate the cervix using dilators; cannulae of increasing size may also be used, taking care not to traumatize the cervix. In cases of missed abortion, cervical preparation may also be necessary prior to the evacuation using medication or osmotic dilators. If cervical dilatation is needed:

- Assess the need for pain management and provide appropriate pain management care—including, as necessary, paracervical block—before proceeding.
- Begin dilatation by using the smallest dilator and progress to the largest dilator that ensures adequate dilatation (usually 10 to 12 mm). Be extremely careful not to tear the cervix or create a false opening during this process.

Step 3: Insert the Cannula

Gently introduce the cannula according to the uterine size (use the largest cannula available for the uterine size). While applying gentle traction to the cervix with the vulsellum (or tenaculum), use the no-touch technique to insert the cannula through the cervix into the uterine cavity, just past the internal os. Note: Rotating the cannula with gentle pressure can help ease insertion.

Step 4: Measure the Uterus

- Slowly push the cannula into the uterine cavity until it touches the fundus (but not more than 10 cm) and note the uterine depth by the dots visible on the cannula.
- Withdraw the cannula slightly.

Step 5: Evacuate the Uterus

MVA Process

- Prepare the syringe (establish vacuum).
- Hold the vulsellum (or tenaculum) and the end of the cannula in one hand and the prepared syringe in the other. Attach the syringe to the cannula. Be careful not to push the cannula further into the uterus as you attach the syringe.
- Release the pinch valve(s) on the syringe to transfer the vacuum through the cannula to the uterine cavity. Evacuate the uterine contents by gently moving the syringe from side-to-side and slowly rotating the cannula within the uterine cavity. Bloody tissue and bubbles should flow through the cannula into the syringe. Note: The client may complain of pain during this part of the procedure; provide reassurances, as necessary.
- To avoid losing vacuum, be careful not to withdraw the cannula opening beyond the cervical os. If the vacuum is lost or if the syringe becomes more than half full, close the valve(s), detach the syringe from the cannula, empty the contents into the strainer, and reestablish the vacuum. Then, reattach the syringe to the cannula and release the valve(s). Also, avoid grasping the syringe by the plunger arms while the vacuum is established, and the cannula is still in place.
- Check for signs of completion; these include: red or pink foam, a gritty sensation as the cannula passes over the surface of the evacuated uterus, and the uterus contracting (or gripping) around the cannula.
- Once the evacuation is complete, detach the syringe and remove the tenaculum and speculum. Place the instruments into a container filled with clean water. Withdraw the cannula and place it into the same container with clean water. Note: Decontamination with chlorine is no longer recommended.
- Perform a bimanual examination to check the firmness and size of the uterus. Repair any cervical tears, if needed.
• Inform the client that you have completed the emergency evacuation procedure.
• If client has provided prior voluntary consent for an implant or IUD, complete the insertion.

**EVA and FSE Processes**

*Note: Refer to the manufacturer’s instructions for more information.*

• Attach the cannula to the suction source.
• Evacuate the uterine contents by gently moving the syringe from side-to-side and slowly rotating the cannula within the uterine cavity. Bloody tissue and bubbles should flow through the cannula into the receptacle on the suction machine. *Note: The client may complain of pain during this part of the procedure; provide reassurances, as necessary.*
• To avoid losing vacuum, be careful not to withdraw cannula opening beyond the cervical os. If the vacuum is lost, reestablish the vacuum before continuing.
• Check for signs of completion; these include: red or pink foam, a gritty sensation as the cannula passes over the surface of the evacuated uterus, and the uterus contracting (or gripping) around the cannula.
• Once the evacuation is complete, detach the vacuum source. Then, remove the tenaculum and speculum and place them into a container filled with clean water. Withdraw the cannula and place cannula in the same container with clean water. *Note: Decontamination with chlorine is no longer recommended.*
• Perform a bimanual examination to check the firmness and size of the uterus. Repair any cervical tears, if needed.
• Inform the client that you have completed the emergency evacuation procedure.
• If client has provided prior voluntary consent for an implant or IUD, complete the insertion.

**Step 6: Inspect the Tissue**

• Inspect the tissue removed from the uterus to determine the total volume (quantity) of blood, clots, and products of conception. If necessary, strain and rinse the tissue to remove excess blood clots and then place the tissue in a container filled with clean water, saline, or weak acetic acid (vinegar). If sending tissue specimens for pathology, prepare tissue according to local laboratory requirements.
• Examine the products of conception to ensure complete evacuation and to check for a molar pregnancy. *Note: Molar pregnancies are rare and MVA is not recommended for evacuating these pregnancies because the amount of tissue is often copious; refer clients with suspected molar pregnancies to higher levels of care. If no products of conception are visible:*
  » The client may have already voided the products of conception before the VA procedure (complete abortion).
  » The client’s uterine cavity may appear to be empty but still contain products of conception. Repeat the evacuation procedure.
  » The client’s vaginal bleeding may not have been due to an incomplete abortion but rather be the sign of another health problem, such as fibroids.
  » The client may have an ectopic pregnancy.
  » The uterus may be abnormal, such as in a double uterus (rare).
• Gently insert a speculum into the vagina and check for bleeding. If the uterus is still soft and not smaller, or if rapid bleeding persists, repeat the evacuation.

Refer to the Managing Common Problems section of this session for additional guidance on how to address issues that may arise during the VA procedure.
Post–Procedure Care

Clients with uncomplicated cases may be discharged within one or two hours after the completion of the VA procedure. The client may be discharged when they are stable, can walk without assistance, and have received post-procedure counseling and services. The time prior to discharge should be used to complete the following tasks.

- Check the client’s vital signs before removing the client from the procedure area.
- Discuss the client’s pain level and administer 500 mg paracetamol orally, as needed, or any other medications necessary according to the pain management plan.
- Administer 10 units of oxytocin or ergometrine 0.2 mg intramuscularly (if oxytocin is unavailable and the client does not have hypertension or other contraindications to ergometrine). Misoprostol (200 ug) can also be used.
- Check for vaginal bleeding at least once before discharge.
- Confirm with the client that any cramping has declined; prolonged cramping is not normal.
- Encourage client to eat, drink, and walk around, as they are comfortable doing so.
- Explore the client’s feelings and concerns and provide the following additional care and support, as needed:
  » Counseling, emotional support, and referrals for postabortion psychological sequelae
  » Counseling on safe-sex practices and services or referrals for STIs and HIV testing and treatment
  » Screening for gender-based violence and referrals to available services for survivors
  » Delivery of other health services or referrals, as necessary, including breast and cervical cancer screenings, malaria and tetanus prophylaxis, and Rh immune globulin if the client is Rh-negative
  » Contraceptive counseling and care or referrals, if not previously completed, emphasizing the return to fertility (as soon as within two weeks) and the benefits of birth spacing for maternal and child health, as well as how to obtain contraceptive resupply, if necessary
  » Additional counseling as appropriate (See Counseling Before, During, and After Uterine Evacuation in Module 2, Session 2 for additional guidance.)
- Instruct the client not to have intercourse or to put anything into their vagina (douches, tampons, etc.) until after the bleeding stops.
- Instruct the client on when they may resume normal chores and/or work.
- Instruct the client to watch for the following signs and symptoms requiring immediate attention:
  » Abdominal cramping that is prolonged
  » Bleeding that is heavy and/or prolonged (more than normal menstrual bleeding)
  » Dizziness, light headedness, or fainting
  » Fever, chills, or malaise
  » Foul-smelling vaginal discharge
  » Increased and/or severe pain
- Complete or update client charts and other forms, as required.

Reminder: PAC counseling is critical throughout all phases of care and PAC is incomplete without the inclusion of voluntary contraceptive care. Clients may wish to include their partners, spouses, or other family members in counseling to be informed about their condition, treatment, and/or follow-up care; similarly those accompanying the client may be interested in learning more so they can provide additional support after leaving the facility. Refer to the Counseling Before, During, and After Uterine Evacuation section in Module 2, Session 2 for additional guidance.
Infection Prevention
Several steps performed before, during, and after the procedure relate to infection prevention.

Before the Procedure
- Perform hand hygiene
- Don personal protective equipment
- Drape the client
- Cleanse the cervix and vagina with an antiseptic solution

During the Procedure
- Use sterile instruments and equipment throughout the procedure
- Use gentle surgical techniques

After the Procedure
- Undertake proper waste management, including:
  - Place contaminated, disposable objects into a properly marked and leak-proof container.
  - Place sharp instruments in a separate puncture-proof container.
  - Immediately clean all instruments (adapters, cannulae, speculum, syringes, tenaculum, etc.) by immersing in clean water with detergent and water. Use a soft brush to clean the serrated surfaces, including the joints of hinged instruments, and allow them to dry before inspection, functionality testing, packaging, and labeling in readiness for sterilization.
  - Dispose of products of conception in accordance with local or institutional guidelines.
  - Manage other waste generated according to local or institutional guidelines.
- Remove surgical gloves by turning them inside out and discard; then wash hands thoroughly with soap and water.
- Provide post-procedure instructions to the client, including self-care actions that will minimize risk of infection (such as not inserting any objects into the vagina before bleeding has ceased).
- Administer antibiotics, as applicable.

Managing Common Problems
Providers may face various problems when performing VA procedures and after completing these procedures—including technical problems with the equipment as well as medical problems with the procedure. Most of these problems are not serious, and, if recognized and corrected or treated immediately, will not affect the results for the client or their recovery. The key to managing problems is understanding that they can occur in the best of circumstances, taking care to recognize them early, and addressing them swiftly. This section examines several common problems associated with VA procedures and provides guidance for resolving them.

Technical Problems with Equipment
Full Syringe
In most MVA procedures, the syringe vacuum remains constant until the syringe is approximately 90% full. However, the syringe vacuum may decrease before the procedure is complete if the cannula is blocked or withdrawn prematurely. If the syringe becomes full:
- Close the pinch valve of the syringe.

Reminder: Problems can occur even under ideal circumstances—identifying issues early and acting immediately are key to success.
• Disconnect the syringe from the cannula, leaving the tip of the cannula in place inside the uterus. Be careful not to push the plunger when disconnecting the syringe.

• Empty the syringe into a container for later inspection by opening the pinch valve and pushing the plunger into the barrel. Be careful not to splash or spill the contents of the syringe.

• If you only have one syringe available, reestablish the vacuum in the syringe, reconnect it to the cannula, and resume the aspiration. Another option is to have a second prepared syringe available and to switch syringes if one becomes full.

Cannula Withdrawn Prematurely

If the opening of the cannula is pulled into the vaginal canal while the valve is open, the vacuum will be lost. This problem can occur during MVA, FSE, and EVA procedures.

If this occurs during an MVA procedure:

• Remove the syringe and cannula, being careful not to contaminate the cannula through contact with the vaginal walls or other non-sterile surfaces.

• Close the pinch valve of the syringe.

• Disconnect the syringe from the cannula and empty the syringe contents into a container for later inspection by opening the pinch valve and pushing the plunger into the barrel.

• Either reestablish the vacuum in the syringe or use another previously prepared syringe.

• Reinsert the cannula using the no-touch technique, if it has not been contaminated, or, if contamination occurs, insert a new sterile cannula.

• Reconnect the syringe to the cannula, release the valve, and continue aspiration.

If this occurs during an FSE or EVA procedure:

• Switch off the vacuum pump or machine and disconnect the tubing from the cannula.

• Reinsert the cannula using the no-touch technique, if it has not been contaminated, or, if contamination occurs, insert a new sterile cannula.

• Reconnect the tubing to the FSE or EVA vacuum and then switch on or release the vacuum.

Cannula Clogged

If there are no visible products of conception or bubbles in the syringe or tubing, the cannula may be clogged. This problem can occur during MVA, FSE, and EVA procedures.

If this occurs during an MVA procedure:

• Close the pinch valve of the syringe.

• Remove the syringe and cannula, being careful not to contaminate the cannula through contact with the vaginal walls or other non-sterile surfaces.

• Remove the material from the opening in the cannula using a sterile forceps or sponge, without contaminating the cannula.

• Reinsert the cannula using the no-touch technique, if it has not been contaminated, or, if contamination occurs, insert a new sterile cannula.

• Either reestablish the vacuum in the syringe or use another previously prepared syringe.

• Reconnect the syringe to the cannula, release the valve, and continue aspiration.

If this occurs during an FSE or EVA procedure:

• For EVA, switch off the vacuum; or, for FSE, release the vacuum by removing a finger from the vent.

• Remove the cannula, being careful not to contaminate the cannula through contact with the vaginal walls or other non-sterile surfaces.
• Remove the material from the opening in the cannula using a sterile forceps or sponge, without contaminating the cannula.
• Reinsert the cannula using the no-touch technique, if it has not been contaminated, or, if contamination occurs, insert a new sterile cannula.
• For EVA, switch on the vacuum and continue with the evacuation procedure; or, for FSE, create a vacuum by covering the vent with a finger.

**Note:** Never try to unclog a cannula by pushing the plunger back into the barrel while the cannula tip is still in the uterus.

**Syringe Does Not Maintain Vacuum**
If the MVA syringe does not maintain a vacuum, try lubricating the plunger and barrel with a drop of silicone. If this does not work, replace the O-ring. If the syringe still does not maintain a vacuum, discard it and use another syringe.

**Plunger Arm Breaks**
It is important to be gentle with the equipment, especially when creating the vacuum, and ensure both arms of the plunger are free and out of the barrel before releasing the plunger. A plunger arm may break if the provider does not handle the syringe gently enough, particularly when creating the vacuum. If a plunger arm breaks, replace the syringe and plunger immediately and continue with the procedure.

**Medical Problems with the Procedure**
Medical problems may occur during a VA procedure; however, these problems occur infrequently (typically among inexperienced providers), are not usually serious, and can often be corrected easily.

**Less Tissue than Expected**
The most common procedural problem is obtaining less tissue than expected. Tissue that is inadequate in quantity, or that contains no definite products of conception, may indicate that either: (1) the client has already voided the products of conception before the VA procedure, (2) the client's vaginal bleeding is not due to pregnancy or an incomplete abortion, or (3) the client has an ectopic pregnancy. Guidance for addressing these issues is included later in this section.

**Incomplete Evacuation**
The best way to ensure a complete evacuation is to use the correct size of cannula and to diligently watch for the signs of completion. Using a cannula that is too small or stopping the aspiration too soon can result in an incomplete evacuation—which results in retained tissue, subsequent hemorrhage, infection, and continued cramping and pain. Repeating the evacuation is the solution for an incomplete evacuation.

**Uterine Perforation**
Uterine perforation occurs rarely with VA and can happen before the client presents at the facility for care. Signs that may indicate uterine perforation include the cannula going through the uterine cavity beyond the expected uterine size, continuous and persistent vaginal bleeding, abdominal distension and/or rigidity, cervical motion tenderness, and shoulder pain. However, when a client who has received PAC treatment complains of severe pain, consider intra-abdominal injury (i.e., injury to the abdominal organs such as the cervix, uterus, vagina, or even bowel). Module 2, Session 7 provides guidance on managing intra-abdominal injuries.

**All Products of Conception Passed before the VA Procedure**
In some cases, the client may have voided all products of conception before the VA procedure takes place. In such cases, further evacuation is unnecessary unless the clinical findings suggest that the evacuation is still incomplete—for instance, if the client is experiencing a fever, persistent vaginal bleeding, or similar symptoms.

**Vaginal Bleeding Not Due to Pregnancy**
Clients of reproductive age may have irregular periods (missed or skipped periods) followed by vaginal bleeding due to reasons other than pregnancy.
Possible reasons include:
- Estrogen-breakthrough bleeding (anovulation)
- Progesterone-breakthrough bleeding with use of progestin-only contraceptive methods (implants, injectables, or oral contraceptives)
- Uterine fibroids (benign, smooth muscle tumors that grow in the wall of the uterus)

**Ectopic Pregnancy**

Ectopic pregnancies can become dangerous if not treated quickly. If an ectopic pregnancy ruptures—a real and life-threatening possibility—death can be prevented only by immediately performing surgery to remove the ectopic pregnancy, stopping the hemorrhage of blood, and replacing blood lost, if required. If an ectopic pregnancy is suspected, check for common signs—including adnexal mass, fullness or bogginess in the pouch of Douglas, and hemoperitoneum—and quickly prepare the client for referral if surgery (laparotomy or laparoscopy) is not available at the facility. A client with a history of any of the following is at higher risk of ectopic pregnancy: previous ectopic pregnancy or pregnancies, pelvic infections, IUD or progestin-only contraceptive use.
Module 2, Session 6: Medical Treatment for Postabortion Care

Summary
This session covers use of misoprostol for medical treatment of abortion-related complications, particularly incomplete and inevitable abortions in the first and second trimester. This session aims to equip participants with the skills required to provide medical treatment for PAC using misoprostol. The session will begin with key information about misoprostol then explain the recommended steps for providing medical treatment and related components of PAC.

Learning Objectives
At the end of this session, participants will be able to:
1. List the key steps of medical treatment for abortion-related complications according to standards.
2. Describe indications and contraindications for using misoprostol to manage abortion-related complications.
3. Demonstrate competencies in counseling and providing medical treatment for abortion-related complications using misoprostol.
4. Demonstrate competencies in providing other postabortion services to clients who choose misoprostol to treat abortion-related complications.

Misoprostol for Abortion and Abortion-Related Complications
Misoprostol is the most commonly used drug for managing first- and second-trimester abortions and abortion-related complications. Oxytocin is not effective in cases of first-trimester incomplete or inevitable abortions but is effective for late second-trimester abortions. However, the WHO no longer recommends oxytocin for treatment of first- and second-trimester incomplete abortions. Misoprostol is a cost-effective treatment for first- and second-trimester incomplete, inevitable, and missed abortions and can also be used for labor augmentation. Misoprostol should not be used with clients who are in shock or experiencing severe bleeding, clients who are allergic to the medication, clients with septic abortions, clients with intra-abdominal injuries following unsafe abortions, clients with ectopic or molar pregnancies, or clients with hemodynamic instabilities. Additionally, caution is required for clients with uterine scars.

Misoprostol is readily available in most settings, stable at room temperature, and should be stored in a cool, dry location, away from direct sunlight. Misoprostol is packaged in different strengths, mostly in 200 µg, but there are also tablets with 25 µg for use in augmentation of labor. The WHO-recommended dosage for incomplete or inevitable abortions less than 14 weeks gestation is 400 µg administered sublingually or 600 µg administered orally as a single dose; the WHO does not recommend vaginal administration of misoprostol for treatment of incomplete abortions less than 14 weeks. The WHO-recommended dosage for 14 weeks or more gestation is 400 µg buccally, sublingually, or vaginally, and may be repeated every three hours until complete expulsion of the products of conception (although the maximum number of repeat doses should be determined with clinical judgment).

Trained healthcare provider cadres who can dispense misoprostol to manage an incomplete abortion include traditional and complementary medicine professionals, pharmacists and pharmacy workers, midwives, nurses, associate clinicians, medical doctors, and specialists.

Key Characteristics of Misoprostol
- Safe for managing first- and second-trimester incomplete, inevitable, and missed abortions
- Readily available in most settings
- Stable if stored at room temperature, away from direct sunlight
- Can be administered by the client and on an outpatient basis in most cases
- Side effects are minimal, temporary, and easily managed
- Complications may occur, and in rare cases, may require access to emergency care

109 Ibid.
110 Ibid.
Depending on national policies and guidelines, clients should ideally receive the medicine at the point of care; however, the medicine is dispensed at pharmacy outlets within the facility in some settings. Clients with incomplete abortions who are stable can be treated as outpatients (do not require admission), as long as they can reach the facility within one hour if they experience complications, such as heavy bleeding. For most incomplete abortion cases, complete expulsion of the products of conception occurs within 24 hours. Some clients (2% to 8%) will require surgical evacuation following misoprostol use. Facilities offering misoprostol should be prepared to manage clients with heavy bleeding. The recommended approach for addressing heavy bleeding is to assess the client for shock and related complications, stabilize the client, and then evacuate the client’s uterus either via VA or D&E procedure. In rare cases, misoprostol may cause hyperstimulation of the uterus and uterine rupture.

There are few side effects associated with misoprostol—most of which are temporary; these include abdominal pain and cramping, diarrhea, fever and chills, low to moderate vaginal bleeding, and nausea and vomiting. It is important to explain what side effects clients may experience and provide guidance on how to manage these side effects, for instance, by using nonsteroidal analgesics to manage pain and/or fever.

There are several generic versions of misoprostol available; however, some are not as stable and do not have the same recommended properties. National programs should ensure that any generic medications available are quality-assured and meet minimum standards, including proper packaging.

A summary of common indications and contraindications associated with misoprostol or misoprostol plus mifepristone use for abortion and abortion-related complications are highlighted in the table below.

### Indications and Contraindications

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<td>• Inevitable abortions</td>
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<td>• Clients with intra-abdominal injuries from unsafe abortions</td>
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<td>• Clients with hemodynamic instabilities</td>
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### The Procedure: Step-by-Step

The following is a summary of key steps for using misoprostol to treat clients with incomplete, inevitable, and missed abortions up to 14 weeks of gestation. Before the procedure, the provider should undertake necessary preparations. This includes ensuring privacy and confidentiality and ensuring the necessary equipment and supplies are available—including the correct dosage of misoprostol, equipment for VA in case of emergency, and contraceptive supplies, if applicable.

1. Greet the client and perform a rapid assessment, ruling out or treating complications and ensuring the client is stable.
2. Assess the client.
   - Obtain the client’s history.
   - Perform physical and pelvic examinations, assessing the uterine size.
1. Request any necessary laboratory or other testing.
2. Review precautions, including allergies to medication (specifically known allergy to misoprostol).

3. Establish the diagnosis; confirm the client has a first- or second-trimester incomplete, inevitable, or missed abortion and is not experiencing complications (e.g., heavy bleeding, infection, or intra-abdominal injury).

4. Explain findings from the assessment and emergency treatment options to the client—including what to expect before, during, and after the procedure—and allow them to make an informed decision.

5. If the client chooses medical treatment with misoprostol, review the following ensuring the client understands the information:
   - Name and dosage of the medication
   - Route of administration (buccally, orally, sublingually, or vaginally, depending on gestation)
   - When and where to take the medication (the first dose may be taken at the facility or at home, if the client resides within one hour of the facility in case complications arise necessitating a return visit)
   - When the medication should take effect (most clients report complete expulsion of the products of conception within the first 24 hours)

6. Explain potential side effects that the client may experience—including abdominal cramping and pain, diarrhea, fever and chills, nausea and vomiting, and vaginal bleeding (light to moderate)—noting they are most often temporary and manageable.

7. Explain warning signs that indicate the need to return to the facility, including:
   - Abdominal cramping that is prolonged
   - Bleeding that is heavy and/or prolonged (more than normal menstrual bleeding)
   - Dizziness, light headedness, or fainting
   - Fever, chills, or malaise that are severe or persistent
   - Foul-smelling vaginal discharge

8. Explain that if the medication does not effectively lead to the expulsion of the products of conception, the client may need to return to the facility for a second dose or surgical treatment.

9. Provide contact information for the facility staff who can advise the client if they experience any problems, have additional questions, or need further assistance.

10. Provide misoprostol and analgesics to the client to take at the clinic or at home, as appropriate.

11. Provide contraceptive counseling, emphasizing the return of fertility and benefits of birth spacing, and instructing the client on how to obtain resupply, if necessary. Provide the contraceptive method of choice the same day as the first dose of misoprostol for all methods except IUD or sterilization (see Module 3).

12. Provide additional care and support as needed, including:
   - Counseling, emotional support, and referrals for postabortion psychological sequelae
   - Counseling on safe-sex practices and services or referrals for STIs and HIV testing and treatment
   - Screening for gender-based violence and referrals to available services for survivors
   - Delivery of other health services or referrals, as necessary, including breast and cervical cancer screenings, malaria and tetanus prophylaxis, and Rh immune globulin if the client is Rh-negative
   - Additional counseling as appropriate (See Counseling Before, During, and After Uterine Evacuation in Module 2, Session 2 for additional guidance.)

13. Remind the client that there is no need to return to the facility unless they experience problems (warning signs or failure to fully void the products of conception). For clients who have opted for surgical contraceptives or other methods that are unavailable, schedule follow-up care or provide a referral.

14. Complete or update client charts and other forms, as required.
Module 2, Session 7: Postabortion Complications and Management

Summary
A client with an incomplete abortion may experience life-threatening complications. Healthcare providers must recognize these complications and initiate immediate treatment to save lives. This session provides an overview of the major postabortion complications—shock, severe vaginal bleeding, intra-abdominal injury, infection, sepsis, and uterine perforation—and then provides details for managing each.

Learning Objectives
At the end of this session, participants will be able to:
1. Identify potential postabortion complications and their signs and symptoms.
2. Describe rapid assessment, treatment, and other measures for:
   » Shock
   » Severe vaginal bleeding
   » Infection and sepsis
   » Intra-abdominal injury
   » Uterine perforation
3. Explain elements of emergency resuscitation and preparation for referral and transport to a tertiary care facility.

Common Postabortion Complications
Regardless of the type of abortion, complications can develop at any time, including before the client seeks care. Complications can become life-threatening within minutes if a provider does not act quickly. Thus, providers must be able to immediately recognize and manage complications when clients present for care. Complications that PAC clients most commonly experience include:

- Shock
- Severe vaginal bleeding
- Infection and sepsis
- Intra-abdominal injury
- Uterine perforation

Shock
Shock is a life-threatening condition that requires immediate and intensive treatment and monitoring. Shock is characterized by a failure of the circulatory system to maintain adequate blood flow to vital organs, depriving those organs of oxygen. In cases of incomplete abortion, shock is usually caused by blood loss (hemorrhage) and/or dilation of the blood vessels (vasodilation) from infection, sepsis, or trauma.

The primary goal in treating shock is to stabilize the client—to restore the efficiency and volume of the circulatory system as measured by an increase in blood pressure and decrease in the pulse and respiratory rates. It is also critically important to identify and treat the underlying cause of the condition to prevent the client from worsening.

Reminder: Clients suffering from shock require immediate treatment and close monitoring, as the condition can worsen quickly.
Signs and Symptoms of Shock\textsuperscript{112}

The signs and symptoms of shock include:

- Anxiousness, confusion, or unconsciousness
- Fast and weak pulse (rate ≥110 per minute)
- Low blood pressure (systolic <90)
- Pallor (especially around the mouth, on the inner eyelid, and/or on the palms)
- Rapid breathing (respiration ≥30 per minute)
- Scanty urine output (<30 ml per hour)
- Sweaty or cold, clammy skin

Initial Treatment for Shock\textsuperscript{113}

Guidelines for the initial treatment of shock include:

- Call for assistance (from other staff trained to manage shock) to help urgently manage the client. Resuscitation requires teamwork.
- Monitor the client’s vital signs (blood pressure, pulse, respiration, temperature) every 15 minutes.
- Turn the client onto their side to minimize the risk of aspiration if vomiting occurs.
- Make sure the client’s airway is open. If the client is unstable, administer oxygen (6 to 8 liters per minute) via mask or cannula.
- Keep the client warm (but do not overheat).
- Elevate the client’s legs to increase return of blood to the heart, either by raising the foot of the bed or by placing blankets or pillows under the feet.
- Administer intravenous fluids—either normal saline or Ringer’s lactate—using a large-bore needle (16 to 18 gauge). Do not give fluids by mouth—if intravenous fluids are unavailable, arrange to transfer the client immediately to a location where they are available. Start with one liter over the course of 15 to 20 minutes and give at least two liters in the first hour; however, note that a client may need three liters if they have experienced significant blood loss. \textit{Note: In cases of shock resulting from excessive bleeding, rapid replacement is critical and two to three times the estimated fluid loss should be replaced.} Monitor intravenous fluids and urine output. \textit{Note: An hourly output of less than 30 ml is suggestive of decreased circulatory fluid volume and may indicate acute renal failure.} If the client’s condition improves (improving mental status, increasing blood pressure, increasing urine output, stabilizing pulse), adjust the rate of the intravenous infusion to one liter in six hours and continue managing the underlying cause of shock.
- Collect blood for hemoglobin or hematocrit testing. \textit{Note: A hemoglobin of 5 g/100 ml or less or hematocrit of 15\% or less is life-threatening and will require a blood transfusion.}
- Immediately cross-match blood and perform a clotting test (if laboratory facilities are available).
- Obtain blood cultures if there are any signs of infection or sepsis (for instance, a fever or foul-smelling vaginal discharge) and administer broad-spectrum intravenous or intramuscular antibiotics. Do not give antibiotics by mouth—if intravenous antibiotics are unavailable, arrange to transfer the client immediately to a location where they are available.
- Remove any visible products of conception to help the uterus to contract and control bleeding. Be careful to maintain aseptic technique and do not conduct a complete pelvic exam until the client is fully stable.


\textsuperscript{113} Ibid.
Definitive Management of Shock
After the initial treatment and once the client is stable, promptly determine and treat the underlying cause of the shock while continuing to monitor fluids, urine output, and vital signs.

- If heavy bleeding is the suspected cause:
  » Empty the uterine cavity of any retained products of conception.
  » Conduct a transfusion as soon as possible.
  » Reassess the client’s condition for improvement.
- If infection is the suspected cause:
  » Collect blood and other relevant samples before beginning antibiotic treatment.
  » Administer a combination of antibiotics to address aerobic and anaerobic infections and continue until the client remains fever-free for 48 hours.
  » Reassess the client’s condition for improvement.
- If there is evidence of peritonitis or if pelvic abscess is suspected, prepare the client for a laparotomy. If the facility does not have the capacity for this surgical intervention, prepare the client for referral and transfer while resuscitation is ongoing.
- If trauma is the suspected cause, prepare for surgical intervention, or referral and transfer to another health facility if there is no surgical capacity at your facility.

Severe Vaginal Bleeding
When a client has prolonged or excessive vaginal bleeding and symptoms of incomplete abortion, the bleeding usually is caused by either retained products of conception or by injury to the cervix, uterus (including uterine perforation), or vagina. Such injuries usually indicate an attempt to terminate a pregnancy and the client may therefore have an infection (from contaminated instruments or unsafe methods) and may need antibiotics.

Acting promptly to stop the bleeding and to replace fluid or blood volume can be lifesaving. Blood pressure, pulse, hematocrit or hemoglobin, and urine output are the primary indicators of the amount of blood loss. Treatment for severe bleeding includes: controlling the bleeding, administering intravenous fluids (as available) to replace fluid volume, administering antibiotics to fight infection, and stabilizing the client before conducting uterine evacuation procedures. Surgery may also be required to identify and repair the source of bleeding. If such surgery is required, refer the client to a higher level of care as soon as they are stable. It is also important to monitor the client’s blood pressure, heart rate, respiration, temperature, and urine output, as shock may develop at any time.

Signs and Symptoms of Severe Vaginal Bleeding
The signs of severe vaginal bleeding include:
- Blood-soaked clothing, pads, or towels and/or dried blood streaks on extremities
- Dizziness and/or fainting
- Heavy, bright red vaginal bleeding, with or without clots
- Pallor (especially around the mouth, on the inner eyelid, and/or on the palms)

Initial Treatment of Severe Vaginal Bleeding
Guidelines for the initial treatment of severe vaginal bleeding include:
- Monitor the client’s vital signs (blood pressure, pulse, respiration, temperature) and monitor blood loss (number of pads soaked or amount of blood on clothing, sheets, etc. and hematocrit testing, if available).
- Elevate the client’s legs to increase return of blood to the heart, either by raising the foot of the bed or by

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116 Ibid.
117 Ibid.
placing blankets or pillows under the feet.

- Make sure the client’s airway is open. If the client is unstable, administer oxygen (6 to 8 liters per minute) via mask or cannula.
- Administer intravenous fluids—either normal saline or Ringer’s lactate—using a large-bore needle (16 or higher gauge). Start with one liter over the course of 15 to 20 minutes and give at least two liters in the first hour; however, note that a client may need three liters if they have experienced significant blood loss. Monitor intravenous fluids and urine output. **Note:** An hourly urine output of less than 30 ml is suggestive of decreased circulatory fluid volume and may indicate acute renal failure.
- Collect blood for hemoglobin or hematocrit testing. **Note:** A hemoglobin of 5 g/100 ml or less or hematocrit of 15% or less is life-threatening and will require a blood transfusion.
- Immediately cross-match blood and perform a clotting test (if laboratory facilities are available).
- Obtain blood cultures if there are any signs of infection or sepsis (for instance a fever or foul-smelling vaginal discharge) and administer broad-spectrum intravenous or intramuscular antibiotics. Do not give antibiotics by mouth—if intravenous antibiotics are unavailable, arrange to transfer the client immediately to a location where they are available.
- Give tetanus toxoid if the client may have been exposed to tetanus (e.g., in the case of an unsafe abortion) and their vaccination history is uncertain.
- Administer intramuscular or intravenous analgesics for pain management.

**Definitive Management of Severe Vaginal Bleeding**

After the initial treatment and once the client is stable, promptly determine and treat the underlying cause of bleeding. Complete a client assessment to identify the cause of the vaginal bleeding and determine the appropriate treatment approach. Consider there may be more than one cause of bleeding requiring treatment.

- If there are visible cervical or genital tract lacerations, suture promptly.
- If there are signs of an incomplete abortion, treat with the relevant uterine evacuation method.
- If there are signs of uterine atony, manage with ergometrine or oxytocin and massage the uterus to ensure that the uterus is well contracted after the evacuation.
- If there are signs of intra-abdominal injury or ectopic pregnancy, immediate surgical treatment is required. If the facility does not have the capacity for surgical intervention, prepare the client for referral and transfer while resuscitation is ongoing. (See the section entitled Intra-Abdominal Injury for additional details.)
- If there are signs of uterine perforation, follow the steps for treating this condition. (See the section entitled Uterine Perforation for additional details.)
- If the client is bleeding from multiple places and the bleeding does not stop after initial treatment, they may have a serious condition called coagulopathy. Immediately refer the client to a higher level of care. (See text box entitled Coagulopathy in the Infection or Sepsis section for additional details.)

**Infection or Sepsis**

Infection is a common complication of incomplete abortion. The presence of products of conception makes it easy for infections to develop and spread, especially when they result from an unsafe abortion where contaminated instruments or unsafe methods were used. Localized infections from induced or spontaneous abortions can rapidly lead to more generalized sepsis and septic shock, which can be fatal.

**Signs and Symptoms of an Infection or Sepsis**

The signs and symptoms of infection or sepsis include:

- Abdominal distension
- Abdominal pain and/or tenderness, with or without rebound tenderness

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- Adnexal tenderness on bimanual examination
- Bleeding that is prolonged (more than eight days)
- Chills, fever, sweating, general malaise (flu-like symptoms) \( \text{(Note: In very severe infections, the client may present with a subnormal temperature.)} \)
- Dilated cervix and/or cervical motion tenderness or pain
- Enlarged uterus
- Foul-smelling vaginal discharge
- Mucopurulent discharge from the cervix
- Signs of severe illness
- Previous (particularly recent) miscarriage or a history of induced abortion

If an infection is suspected, it is important to assess the client's risk for developing septic shock.

**Initial Treatment of an Infection or Sepsis**

If the infection is localized or if the risk of septic shock is low, the client can usually be treated with broad-spectrum antibiotics (intramuscular or intravenous) that are effective against Gram-negative and Gram-positive anaerobic organisms and chlamydia. If the infection is generalized or if the risk of septic shock is high, immediate additional treatment—including referral and transport to a higher level of care, as necessary—is needed to save the client’s life. This additional treatment may include:

- Monitor the client’s vital signs (blood pressure, pulse, respiration, temperature) continuously.
- Make sure the client’s airway is open. If the client is unstable, administer oxygen (6 to 8 liters per minute) via mask or cannula.
- Administer broad-spectrum intravenous antibiotics immediately. Do not give antibiotics by mouth (as surgery may be necessary) unless there is no alternative. If blood cultures are available, obtain specimen for cultures before beginning antibiotics.
- Give tetanus toxoid if the client may have been exposed to tetanus (e.g., in the case of an unsafe abortion) and their vaccination history is uncertain.
- Administer intravenous fluids—either normal saline or Ringer’s lactate—if the client becomes unstable. Do not give fluids by mouth (as surgery may be necessary) unless there is no alternative. Start with one liter over the course of 15 to 20 minutes; however, note that a client may require rapid administration of several liters to restore fluid balance. Monitor intravenous fluids and urine output. \( \text{Note: An hourly urine output of less than 30 ml is suggestive of decreased circulatory fluid volume and may indicate acute renal failure.} \)
- Collect blood for hemoglobin or hematocrit testing if the client has lost a lot of blood or appears to be anemic. \( \text{Note: A hemoglobin of 5 g /100 ml or less or hematocrit of 15% or less is life-threatening and will require a blood transfusion.} \)
- Immediately cross-match blood and perform a clotting test (if laboratory facilities are available).
- Take abdominal X-rays if the facility has the necessary equipment. Flat abdominal X-rays (horizontal) can help identify air or fluid levels in the bowel and, in the case of clostridia infection, gas in the tissues. Upright abdominal X-rays can help identify air under the diaphragm indicating a bowel or uterine perforation.

**Definitive Management of an Infection or Sepsis**

After the initial treatment and once the client is stable, promptly determine and treat the underlying cause of infection or sepsis. Because retained products of conception are most often the source of infection, prompt uterine evacuation is usually the first step in treatment. However, the possibility of an intra-abdominal injury, pelvic abscess, or peritonitis—all of which may require surgery—must also be considered as sources of infection. If the client shows signs of a septic abortion with an IUD in place, start antibiotics before removing the IUD. If the client is not pregnant but has PID, and if they meet the WHO Medical Eligibility Criteria category 2
(the advantages of using the method generally outweigh the risks), then they should receive counseling and antibiotics and be advised that they can keep the IUD in place while taking antibiotics. Gas gangrene and tetanus are also possibilities; these conditions require referral and transport for specialized care at a higher-level facility. All sources of infection must be identified and treated.

**Intra-Abdominal Injury**

**Coagulopathy**

If the client is bleeding from several places and the bleeding is not easily stopped, an immediate assessment for coagulopathy (a bleeding disorder that can present with severe cases of sepsis, excessive bleeding, and in later second and third trimester pregnancies with amniotic fluid embolism) is key. Signs of coagulopathy include:

- Bleeding from the mouth, bladder, or injection or venipuncture site
- Blood in the urine
- Blood that fails to clot *(Note: If laboratory services are unavailable, examine places where blood has pooled, such as on the bed or floor, to assess clotting.)*
- Decreased platelet count
- High fever or subnormal temperature
- Notably elevated D-dimer marker
- Signs of severe illness
- Signs of organ failure

Treating the underlying sepsis is the basis of coagulopathy management. Giving blood products, such as fresh whole blood or fresh frozen plasma, can help control bleeding while treating the infection. Referral and transport to a higher-level facility for specialized care is usually required.

An injury to any internal organ can cause serious, long-term, poor health and become a life-threatening situation; thus, rapid diagnosis and treatment are essential. Because a client with an intra-abdominal injury may initially present without symptoms and then progress rapidly to a serious and potentially life-threatening situation, every client seeking treatment for postabortion complications should be checked for signs of intra-abdominal injury.

Potential injuries include uterine perforation as well as damage to surrounding organs, including the bowel, cervix, or vagina. A uterine perforation may be discovered during the initial physical exam or later during uterine evacuation; and, in rare cases, a uterine perforation can occur during a VA procedure.

If there is any indication of intra-abdominal injury, it is important to closely monitor blood pressure and heart rate as shock can also develop at any time. Additionally, there is a high risk of infection, peritonitis, sepsis, and tetanus associated with intra-abdominal injuries.

A ruptured ectopic pregnancy or ovarian cyst can present with symptoms of intra-abdominal hemorrhage that are similar to intra-abdominal injury. A client with a history of ectopic pregnancy, pelvic infection, or use of certain contraceptive methods is at greater risk of experiencing an ectopic pregnancy. Any delay in treatment is extremely dangerous and may lead to death without surgical intervention—making a quick diagnosis critical.

**Signs and Symptoms of Intra-Abdominal Injury**

The signs and symptoms of intra-abdominal injury include:

- A hard, tense abdomen and/or rebound tenderness in the abdomen
- Abdominal distension
- Abdominal pain and/or cramping that is severe

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• Chills and/or fever
• Decreased bowel sounds
• Evidence of bowel, viscera, or fecal matter from the uterine cavity
• Nausea and/or vomiting
• Shoulder pain

Any of the above symptoms, combined with any of the signs of shock previously detailed, may indicate a major intra-abdominal hemorrhage.

Initial Treatment of Intra-Abdominal Injury

Guidelines for the initial treatment of intra-abdominal injury include:

• Monitor the client’s vital signs (blood pressure, pulse, respiration, temperature).
• Make sure the client’s airway is open. If the client is unstable, administer oxygen (6 to 8 liters per minute) via mask or cannula.
• Administer intravenous fluids—either normal saline or Ringer’s lactate. Do not give fluids by mouth, as surgery may be necessary. Start with one liter over the course of 15 to 20 minutes; however, note that a client may need three liters if they have experienced significant blood loss or are in shock. Monitor intravenous fluids and urine output. **Note:** An hourly urine output of less than 30 ml is suggestive of decreased circulatory fluid volume and may indicate acute renal failure.
• Administer broad-spectrum intramuscular or intravenous antibiotics if there is any indication of infection (for instance, chills or fever). Do not give antibiotics by mouth, as surgery may be necessary. If blood cultures are available, obtain specimen for cultures before beginning antibiotics.
• Collect blood for hemoglobin or hematocrit testing. **Note:** A hemoglobin of 5 g/100 ml or less or hematocrit of 15% or less is life-threatening and will require a blood transfusion.
• Immediately cross-match blood and perform a clotting test (if laboratory facilities are available).
• Give tetanus toxoid if the client may have been exposed to tetanus (e.g., in the case of an unsafe abortion) and their vaccination history is uncertain.
• Administer intramuscular or intravenous analgesics for pain management.
• Take abdominal X-rays if the facility has the necessary equipment. Upright abdominal X-rays can help determine if there is gas in the abdominal cavity, for instance in the case of a perforated or ruptured bladder, bowel, or uterus.

Definitive Treatment of Intra-Abdominal Injury

The client may be experiencing a bowel injury, peritonitis, ruptured ectopic pregnancy, or uterine perforation. It may be necessary to drain the abdomen to remove or repair the injured tissue. A multi-disciplinary team is necessary to manage this treatment, especially if there is significant bowel injury and/or evidence of organ failure. In extreme cases, a hysterectomy may also be required. Any of the following conditions indicates a surgical emergency requiring immediate laparotomy under general anesthesia to find and repair the injury:

• Abdomen rigidity
• Acute abdominal pain accompanied by persistent low blood pressure or shock that fails to stabilize after an infusion of up to three liters of normal saline or Ringer’s lactate
• An abdominal X-ray showing air or gas in the peritoneal cavity

If the facility does not have the capacity for laparotomy under general anesthesia, prepare the client for immediate referral and transfer.

After treating the intra-abdominal injury—or if an intra-abdominal injury is suspected but the client is stable, does not show air or gas on X-ray, does not have a rigid abdomen, and is not showing signs of an ectopic pregnancy—
the next step is to evacuate the uterus. If an intra-abdominal injury is discovered during a uterine evacuation procedure, a laparotomy may be needed to repair the injury.

**Uterine Perforation**

Uterine perforation most often occurs during an unsafe abortion when an unqualified person inserts an object into the cervix. These perforations can be life-threatening and prompt management is critical because of the high probability of infection and damage to other abdominal and pelvic organs. Further, large perforations will not close spontaneously, can bleed profusely, and the blood can collect intra-abdominally with little or no vaginal bleeding. Clients with such perforations may also present with signs of shock.

Uterine perforation during VA is rare. If uterine perforation occurs during the VA procedure, it usually causes only a small tear that does not require laparotomy to repair. Contraction of the uterus after evacuation often closes the opening and stops the bleeding.

**Signs of a Uterine Perforation**

The signs of uterine perforation **before** VA include:

- Excessive bleeding
- Falling blood pressure (diastolic <60)
- Fast pulse (≥110 per minute)
- Signs and symptoms of intra-abdominal injury

The signs of uterine perforation **during** VA include:

- Cannula, dilator, or other instrument penetrates beyond the expected size of the uterus during the uterine evacuation process
- Amount of vacuum decreases while the cannula is well inside the uterus
- Excessive bleeding begins during the evacuation process and continues after the uterus is empty (**Note**: If the bleeding becomes severe, vital signs may change—specifically, blood pressure may fall and pulse and respiration may increase.)
- Evidence of fat, bowel, or fecal matter in aspirated tissue found during or after the procedure

**Initial Treatment of a Uterine Perforation**

Guidelines for the initial treatment of uterine perforation include:

- For a lower-level facility: stabilize, refer, and transfer the client to a higher-level facility with capacity to manage the perforation. Do not attempt to perform an evacuation in a lower-level facility as the client will require further assessment to determine the extent of the injury.
- For higher-level facilities that are able to manage a uterine perforation, before performing the uterine evacuation, check for signs of intra-abdominal injury:
  - If there are signs present, treat accordingly before performing evacuation.
  - If there are no signs present, proceed cautiously with evacuation.
  - If there is evidence of shock, manage accordingly.
- If a uterine perforation is discovered or occurs during uterine evacuation (before the evacuation is complete):
  - Introduce fluids and antibiotics intravenously.
  - Collect blood for hemoglobin or hematocrit testing and arrange for a blood transfusion if indicated. **Note**: A hemoglobin of 5 g/100 ml or less or hematocrit of 15% or less is life-threatening and will require a blood transfusion.
  - Repair damage as necessary, either by coagulating the bleeding or suturing the defect via minilaparotomy.

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Make sure that the bowel is intact and that there is no injury to other abdominal organs.

» Complete the evacuation under direct visual control (laparotomy or laparoscopy) to assess damage to pelvic organs and to prevent further damage. If laparotomy or laparoscopy are not available, refer to a higher level of care.

» After surgery, administer oxytocics (if the uterus has not been removed) and observe vital signs every 15 minutes for at least two hours.

» If the client becomes stable and bleeding slows, administer 0.2 to 0.5 mg ergometrine intramuscularly (contraindicated in clients with hypertension) and observe overnight.

» If the client’s condition worsens, transfer to a higher level of care.

- For treating a perforation after the evacuation is complete:
  » Administer broad-spectrum intravenous antibiotics.
  » Observe vital signs every 15 minutes for at least two hours.
  » Administer 0.2 to 0.5 mg ergometrine intramuscularly (or oxytocin or misoprostol), repeating as needed up to three doses.
  » If the client becomes stable and bleeding slows, administer additional ergometrine (same dosage) and continue observation overnight.
  » If bleeding continues, a laparoscopy or minilaparotomy may be needed; refer and transfer the client as soon as possible to a higher level of care.

**Referral Guidelines**

Established arrangements for referral and transportation are important for all health facilities. Such arrangements may require coordination with local resources—including other health programs, community leaders, churches, military units, police departments, taxi operators, and private owners of vehicles. This is key to ensuring that when a client needs to be referred and transferred, arrangements can be timely and efficient. If it is immediately apparent that the client will need referral and transport, one team member should make the necessary arrangements while the rest of the team resuscitates and stabilizes the client. The referral facility must also have everything required to stabilize and treat the client. Follow national guidelines and protocols for emergency referrals and transfers.

**Preparing for Referral and Transport**

- Stabilize the client:
  » Monitor the client’s vital signs (blood pressure, pulse, respiration, temperature).
  » Make sure the client’s airway is open; administer oxygen via mask, as necessary.
  » Manage the bleeding and administer intravenous fluids, as necessary.
  » Administer intramuscular or intravenous analgesics for pain management.

- Inform the client and their partner, spouse, or relevant family member (with the client’s consent) of the examination findings, explaining that the condition requires care that is unavailable at this level of facility, necessitating a referral to a higher-level facility for care.

- Prepare referral documentation (client information, history, assessment, and initial treatment) using local or national referral forms (see sample referral slip on the following page) and arrange for transport; alert the referral center when the client is on the way.

**During Transport**

A trained provider should accompany the client during transport, if possible, to continue treatment, including administering intravenous and oxygen therapy (as necessary). The client should be kept warm and, if experiencing hemorrhaging or shock, their feet should be kept elevated.
Sample Referral Slip

REFERRAL SLIP

Name of Clinic: 
Patient Name: 
Patient Address: 
Sex: Age: 
Treatment Date: 
Diagnosis: 
Temporary Treatment: 
Refer To: 
For: 

Vital Signs

<table>
<thead>
<tr>
<th>Initial Contact</th>
<th>Before Discharge</th>
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<tr>
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<td>BP:</td>
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</tr>
<tr>
<td>Pulse:</td>
<td>Pulse:</td>
</tr>
<tr>
<td>Resp:</td>
<td>Resp:</td>
</tr>
</tbody>
</table>

Day: Month: Year: 
Signature: 
Clinic Physician: 

Adapted from Reproductive Health Association of Cambodia (RHAC)

Source: This form can be downloaded for free, unrestricted use at: https://postabortioncare.org/sites/pac/files/Referral_Slip.pdf.
Module 3: Family Planning Counseling and Service Provision, Sexually Transmitted Infection Evaluation and Treatment, and HIV Counseling and Testing
Module 3, Session 1: Family Planning Counseling and Service Provision

Summary

Fertility can resume almost immediately following an abortion or miscarriage—the average time to ovulation postabortion is three to four weeks, but it can occur in as few as eight days. Postabortion clients therefore should carefully consider whether they want to become pregnant again and, if so, when. Some clients may wish to conceive again soon; others may not wish to conceive again soon or at all. In either case, every PAC client (and their partner, if the client desires), should receive counseling and information about the return of fertility and available contraceptive options. It is important to emphasize healthy timing and spacing of pregnancy during counseling, as delaying pregnancy for at least six months after an abortion or miscarriage can reduce adverse outcomes, including the chances of low birth weight, maternal anemia, and preterm birth.\(^{123}\) **Note:** A systematic review and meta-analysis primarily comprising studies from high-income countries suggests that an interval of less than six months following miscarriage is not associated with adverse outcomes.\(^{124}\)

As emphasized throughout this training: PAC is incomplete without family planning (FP) counseling and services. Comprehensive contraceptive methods and counseling information is not included in this session. This session focuses on aspects of FP most relevant to PAC. However, resources with current, evidence-based information are readily available. Recommended materials are listed in the table below.

### Recommended Resources

#### Comprehensive Contraceptive Guidance

- Contraceptive Technology (2023): Available to [order](#)
- Selected Practice Recommendations for Contraceptive Use (2016): Available from the [WHO](#)

#### Counseling Frameworks

- Counseling the Postabortion Client: A Training Curriculum (2003): Available from [EngenderHealth](#)

#### Job Aids

- Family Planning Wall Chart: Also known as "the wall chart" or "the Tiahrt Chart," available to [order](#)
- Medical Eligibility Criteria for Contraceptive Use (2015): Available in [print](#) or as an [app](#) from the WHO

#### Other Relevant Articles and Similar

- Post Abortion Family Planning: A Key Component of Post Abortion Care (2013): Available from [USAID](#)
- Saving Women’s Lives through Emergency Obstetric Care and Voluntary Family Planning (2019): Available from [Global Health Sciences and Practice](#)

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Learning Objectives
At the end of this session, participants will be able to:
1. State the essential FP information that all PAC clients should receive before discharge.
2. Explain the importance of informed choice for effective FP services.
3. Describe the personal and clinical factors that should be discussed during FP counseling.
4. Demonstrate appropriate FP counseling during different phases of care.
5. State one point of consensus from the International Federation of Gynecology and Obstetrics (FIGO); International Confederation of Midwives (ICM); International Council of Nurses (ICN); United States Agency for International Development (USAID); White Ribbon Alliance (WRA); United Kingdom Foreign, Commonwealth & Development Office (FCDO) (formerly Department for International Development, DFID); and Bill & Melinda Gates Foundation joint statement on postabortion FP.125

Unmet Need for Family Planning
Approximately 214 million women of reproductive age had an unmet need for FP in 2022.126 The term “unmet need for FP” refers to clients who want to avoid or delay pregnancy but are not currently using any contraceptive method. Many factors contribute to this unmet need, such as lack of knowledge about contraceptives (including misinformation and myths), lack of access to contraceptive services, concerns about side effects, and social disapproval.127

Reducing unmet need for FP has multiple health benefits, particularly in improving maternal and child health outcomes. By reducing the overall number of pregnancies, modern contraception likewise reduces the number of times women of reproductive age are exposed to pregnancy-related complications. For instance, modern contraceptive use in low- and middle-income countries in 2019 prevented an estimated 376 million unintended pregnancies, 79 million unplanned births, 256 million abortions (100 million of which would have been unsafe), 39 million miscarriages, and 70,000 maternal deaths.128

For the healthiest pregnancies, the global health community recommends that the pregnant person is between the ages of 18 and 34, that the pregnancy occurs at least 24 months after the pregnant person’s last birth (for all births after the first), and that a person has no more than four births.129 High-risk pregnancies—those that occur outside of these recommendations—are associated with greater rates of mortality and morbidity. Reducing unmet need for FP improves maternal and child health outcomes (including low birth weight, premature birth, and maternal anemia) by reducing the proportion of pregnancies that are high-risk. To reduce unmet need for FP and to increase opportunities for healthy timing and spacing of pregnancies, FP programs should implement strategies that will support individuals and communities in promoting healthy behaviors, advancing high-quality health services, and strengthening health systems. One evidence-based strategy for reducing unmet need for FP is promoting voluntary postabortion contraception, including offering information, counseling, and services covering a full range of FP methods (including permanent, long-acting reversible, and short-acting methods) at all PAC service delivery points.

Postabortion Family Planning
As a key point of contact with the healthcare system, PAC represents an important opportunity to provide critical contraceptive information and services. Currently, the role of the PAC provider related to FP service

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128 Ibid.
delivery varies by country and, in some cases, by site within a country. For instance, some PAC providers may offer contraceptive counseling and referrals for services available at separate sites, whereas other PAC providers may offer contraceptive counseling for services located within the same facility, and yet other PAC providers may offer integrated PAC and contraceptive care—with the same staff providing both services at the same facility.

Evidence demonstrates an increase in voluntary postabortion FP uptake when contraceptive services are available at the same time and in the same location as emergency treatment and when couples are counseled together about contraceptive options, which in turn can reduce future unintended pregnancies and abortions.\(^\text{130}\) The PAC provider can and should serve an important function in helping postabortion clients in understanding return to fertility, considering reproductive intentions, overcoming misconceptions and fears related to contraceptive methods, and building confidence and trust in the healthcare system—all of which will increase their likelihood of voluntarily adopting a contraceptive method. The important role of the PAC provider in delivering contraceptive care is illuminated in the joint consensus statement between the FIGO, ICM, ICN, USAID, WRA, FCDO, and Bill & Melinda Gates Foundation.\(^\text{131}\) This statement notes that FIGO, ICM, and ICN health professionals play a special advocacy role with policymakers and governments for ensuring quality postabortion FP services, sharing responsibilities, strengthening professional education, and improving health outcomes.

**Postabortion Family Planning Information**

To help prevent additional unplanned pregnancies and unsafe abortions, and to help clients achieve healthy spacing between pregnancies, all PAC clients should receive contraceptive information, counseling, and services. Before discharge, each client should understand:

- That they can become pregnant again before their next menses, as fertility typically returns within two weeks
- That the risk of an adverse outcome to a future pregnancy, including a repeat miscarriage, may be less when there is an interval of at least six months between a miscarriage and the next pregnancy;\(^\text{132,133}\) although, recent evidence suggests that an interval of less than six months following a miscarriage is not always associated with adverse outcomes\(^\text{134}\)
- That there are safe contraceptive methods that the client can begin using immediately
- Key characteristics of all contraceptive methods, including how to use the method as well as method effectiveness, reversibility, limitations (including protection against HIV and other STIs), and side effects
- Where and how they can obtain contraceptive care (including for method switching and resupply), at the time of treatment, before discharge, or after discharge, depending on the availability of services at the PAC facility

Postabortion FP care should include the same essential elements of general high-quality FP care, including:

- Information and counseling about a full range of methods, including their characteristics (short-acting, long-acting, or permanent; hormonal or nonhormonal), effectiveness, limitations, and side effects
- Counseling about contraceptive options in the context of personal reproductive health intentions
- Assurance of contraceptive resupply and access to follow-up care

**Postabortion Family Planning Counseling**

The goals of postabortion FP counseling are to help the client (and their partner or spouse, if the client wishes to


include them) with:

- Exploring and understanding their reproductive intentions and goals
- Understanding the factors that led to the unintended pregnancy and/or miscarriage and what the client can do to avoid repeating the situation
- Understanding that fertility can return almost immediately following an abortion
- Understanding the benefits of healthy timing and spacing of pregnancy
- Determining whether the client wants to use a contraceptive method, and, if so, helping the client make a free and informed choice about a method and use the method effectively
- Understanding healthy behaviors (including timing and spacing) the client can adopt to support a healthy pregnancy in the future

To be effective, postabortion FP counseling should also be responsive to the client’s unique situation, including:

- The client’s individual characteristics, needs, and reproductive intentions
- The client’s current clinical condition
- The client’s choice of emergency treatment option (e.g., medical, surgical or expectant management)
- The service delivery capabilities at the treatment facility and in the client’s community

A clear and comprehensive discussion with the client is crucial to allowing the provider to understand the client’s circumstances (including the circumstances that have brought the client to the facility for PAC), which is essential to enabling the provider to assist the client in voluntarily choosing the most appropriate contraceptive method for their situation. This discussion is also important for increasing the likelihood that the client will voluntarily adopt a contraceptive method before leaving the facility.\(^{135}\)

**Including a PAC Client’s Spouse or Partner in Counseling**

When a PAC client is accompanied by a partner or spouse, the partner or spouse may want to be informed about their partner’s condition and options for emergency treatment as well as FP methods. With the client’s consent, counseling a partner or spouse, either separately\(^{136,137}\) or jointly\(^{138,139}\), can increase support for the client’s recovery and for FP use. However, it is important to respect the client’s wishes and reproductive autonomy, including their preferences for sharing information with and counseling their partner or spouse.

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Counseling for Free and Informed Choice

Free and informed choice means that the client selects an FP method voluntarily, without any pressure or coercion. This requires the client to have a clear understanding of the benefits and limitations of the various FP methods that are available. For postabortion clients, this includes understanding that most methods can be used safely and effectively immediately after emergency treatment and that, except in the case of permanent methods, they can change to another method later, or discontinue method use, as desired.

Free and informed choice is crucial for several reasons.

- Free and informed choice is key to FP uptake and continuation as it involves clients: (1) understanding how to use the method properly for maximum effectiveness; (2) knowing about and how to manage possible side effects; and (3) being satisfied with and continuing to use a particular method or understanding options for switching to another method (for short-acting and reversible methods), if desired. If a client lacks adequate information about a method (such as how to properly use the method or how to manage side effects), effectiveness may be reduced, which can lead to method discontinuation.140 Assisting clients with accessing other FP options if their initial method(s) becomes unsatisfactory will also reduce the possibility of discontinuation.141

- Coercing a client to adopt contraception is a violation of the client’s right to bodily autonomy, to their right to access the information and services needed to make an informed decision, and to their right to be treated with dignity and respect and without discrimination. Further, a client who is resentful for being coerced into adopting a method is less likely to return for future care and a healthcare provider or facility with a reputation of coercion can discourage community members from seeking needed PAC, contraceptive care, and/or other essential medical services.

- In the long term, clients who are unable to make free and informed choices are more likely to discontinue use, which in turn can lead to additional unintended pregnancies and unsafe abortions, a reluctance to seek care or to seek care in a timely manner, and greater rates of maternal morbidity or mortality related to clients having too many or too closely spaced pregnancies and delaying seeking essential treatment in the future.

Some PAC clients, including those who do not wish to conceive immediately after an abortion, may not wish to or may not be prepared to make an FP decision during their visit. Therefore, it important for PAC facilities to have a mechanism in place to ensure that PAC clients can return for FP counseling and services later or receive a referral to another facility in their community. Providers should offer these clients condoms and encourage them to return or to visit another facility at a later date. A client may also choose not to adopt any method.

Personal Situations to Consider

Each client’s unique personal situation affects their contraceptive needs and choices. It is important that the provider, while maintaining confidentiality and privacy, explore each client’s unique circumstances to help them select the most appropriate method for their situation.

The questions below can help a provider understand a client’s situation.

- Is the client currently experiencing pain, stress, or any other condition that may prevent them from making an informed, voluntary decision?
- Does the client wish to become pregnant again? If so, when?
- Is the client a survivor of sexual abuse or rape?
- Is the client a survivor of physical abuse or violence?
- Has the client ever used an FP method? If not:
  - Did the client lack access to FP information or services?
  - Did the client have access to FP information and services but choose not to use FP, and if so, what are the reasons?

Reminder: Adoption of postabortion contraception, or a particular method, should never be a prerequisite for obtaining emergency treatment.

Reminder: A client’s personal situation and preferences are as important as their clinical condition in choosing an FP method.

some of the factors that led to that decision?
» Does the client desire FP counseling now?
• Was the client using a contraceptive method when they became pregnant? If so:
  » Was the client using the method correctly and consistently?
  » Does the client know why the method failed?
  » Would the client be able to use the method effectively in the future?
  » Would the client prefer a different method?
• Is there a partner, spouse, or other person or issue that the client needs to consider? For example:
  » A partner who may not be monogamous
  » A partner who is unwilling to use condoms
  » A partner or family members who disapprove of contraception
  » A partner who desires more children or children of a specific sex
  » Sociocultural or religious expectations or limitations (for instance, an expectation of fertility or a restriction on modern FP methods)
  » Limited access to health services, including access to care and resources to cover the costs of care

The table below and continuing on the following page presents a few examples of potential client situations and suggested responses that can help clients to make free and informed FP decisions.

### Responding to Clients’ Personal Situations during Counseling*

<table>
<thead>
<tr>
<th>Situation</th>
<th>Suggested Responses</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| Client is experiencing stress or pain  | • Schedule a follow-up visit or provide a referral for a later date or time if the client does not wish to make a decision at this time  
• Explore all contraceptive methods; provide short- or long-acting reversible contraceptives at the time of treatment with the client’s consent; schedule a follow-up visit if the client (or their partner or spouse) is interested in sterilization | Stress and pain can interfere with a client’s ability to make a free and informed decision; planning to revisit counseling later can help ensure they make the best decision for the situation. While some PAC clients may not wish to have any (or any additional) children, the decision to undergo sterilization is best made when the client is not experiencing stress or pain; providing a short- or long-acting method, scheduling a follow-up visit, or providing a referral for sterilization at a later date can ensure the client achieves their reproductive intentions but does not make a decision they will regret later. |
| Client wishes to become pregnant again soon | • Provide information about the benefits of healthy spacing and short-acting methods for consideration, if desired  
• Provide information and referrals for other reproductive health services, as needed  
• Respect the client’s wishes—do not pressure them to adopt a method | If the client has experienced multiple miscarriages, they may need to explore infertility treatment or undergo STI screening to understand the cause |
<table>
<thead>
<tr>
<th>Situation</th>
<th>Suggested Responses</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client does not wish to become pregnant soon</td>
<td>• Explore all reversible methods (short- and long-acting)</td>
<td>Healthy timing and spacing of pregnancies helps prevent future unintended pregnancies and abortions</td>
</tr>
</tbody>
</table>
| Client was using an FP method when they became pregnant | • Assess reason for method failure, including any problems the client might have had using the method effectively  
• Help the client choose a method that they will be able to use effectively  
• Explore strategies for effective use of the chosen method  
• Ensure that the client understands how to use the method, obtain follow-up care and resupply (if needed), discontinue use, or change methods | Method failure, unacceptability, ineffective use, or lack of access to supplies are all potential reasons for an unintended pregnancy; these factors may continue after the abortion, leading to another unintended pregnancy |
| Client had discontinued use of contraception       | • Assess reason for discontinuing use of contraception (e.g., side effects, lack of access to resupply, desire for pregnancy)  
• Help the client choose a method they will be able to use effectively (if desired)  
• Ensure the client understands how to use the method, obtain follow-up care and resupply (if needed), discontinue use, or change methods | Dissatisfaction due to side effects and lack of access to resupply are two potential reasons for discontinuing use of contraception; these factors may continue after the abortion, leading to another pregnancy  
Clients who have experienced a miscarriage of a desired pregnancy may wish to delay their next pregnancy, based on recommendations for healthy spacing |
| Client’s partner or spouse is unwilling to use condoms or will prevent use of another method | • Protect the client’s confidentiality  
• Include the partner in counseling only with the client’s consent  
• Discuss methods that the client can use without the partner or spouse knowing (e.g., injectables)  
• Do not recommend methods that the client will not be able to use effectively | Involving the partner or spouse in counseling can sometimes result in gaining their support for contraception; if the client consents, the client and their partner or spouse may be counseled separately or together  
If the client does not wish to involve their partner or spouse, respect their wishes |
| Client is a survivor of gender-based violence (including rape or sexual assault) | • Explore all contraceptive methods, including particularly emergency contraception  
• Refer the client to available services for survivors (e.g., legal and psychosocial support) | The client may be at risk for repeat assaults or rapes and may have a continuing need for contraception, including emergency contraception, as well as other types of support |

Considerations for Serving Adolescents and Youth

Adolescents and youth face many barriers to accessing essential health services, including contraceptive care and PAC. They may lack the support of their partners, families, or friends and they may not have the decision-making power or resources to implement their decisions. Further, many young people, especially those who are single, experience specific barriers to accessing sexual and reproductive healthcare. As a result, they often present at health facilities for the first time only after becoming pregnant or experiencing complications from unsafe abortions. Providers should do their best to use this opportunity to address young people’s comprehensive sexual and reproductive health needs. Additionally, where available, providers should refer these clients to programs that focus on adolescent and youth health and well-being to support comprehensive and continuous care.

Young people seeking PAC and contraceptive care are not a homogeneous group. For instance, they may be at different stages of physical and psychosocial development, married or unmarried, in- or out-of-school, employed or unemployed. Additionally, they may have experienced gender-based violence—for example, they may have become pregnant as a result of child marriage, forced sexual debut, rape, sexual abuse, or sex work. Therefore, providers should screen young clients for gender-based violence and provide referrals, as needed.

Providers must offer compassionate, empathetic, nonjudgmental, supportive, and unbiased care—including by respecting client confidentiality and ensuring privacy. In addition to ensuring services are affordable and available at times and locations convenient for young people, it is also important to allow adequate time for the provider-client interaction, to ensure that the provider is able to clearly explain available options and that the client is comfortable asking questions and expressing concerns. Providers have a responsibility to provide accurate information to help clients make voluntary, informed decisions for themselves. Providers must also be careful to not let any of their personal beliefs about adolescent sexual activity affect their interactions with young clients. For instance, providers should support free and informed choice and never deny a client access to contraception because of their age, marital status, or requirements for parental or partner approval.

Clinical Conditions

Most modern contraceptive methods can be started immediately after emergency treatment, provided that:

- The client is not experiencing any severe complications requiring further treatment.
- The client receives adequate counseling and voluntarily consents.
- The provider has screened the client for any precautions for using a particular method.

A client interested in acquiring an IUD or undergoing female sterilization should wait until after emergency treatment or following the complete expulsion of the products of conception (in cases of medication abortion or expectant management). Natural FP is not recommended until a regular menstrual pattern returns. Additionally, PAC clients should avoid sexual intercourse until bleeding stops (usually within five to seven days) and any complications are resolved.

The table on the following pages provides guidance to assist providers in recommending contraceptive methods based on various clinical conditions associated with PAC, including clients who are not experiencing any complications, those who may have an infection or sepsis, those with severe vaginal bleeding, those who have a genital tract injury (such as uterine perforation or cervical or vaginal injury), and those who have sought treatment for an incomplete second trimester abortion. Please also refer to the Recommended Resources table at the beginning of this session, the section entitled Postabortion Family Planning Method Options that follows the table on the next few pages, and to the Medical Eligibility Criteria tools included later in this session for additional guidance about contraceptive service provision.

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## Guidelines for Contraceptive Use by Clinical Condition*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recommendations</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No complications at onset of medical treatment or after emergency treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical cap and diaphragm: Can begin use when client resumes sexual activity</td>
<td></td>
<td>Cervical cap and diaphragm: Should be refit after a second-trimester incomplete abortion</td>
</tr>
<tr>
<td>Condoms (external and internal): Can begin use when client resumes sexual activity; use for dual protection (with another method)</td>
<td></td>
<td>IUD (copper and hormonal): Should only be inserted after complete expulsion of products of conception following medical management or expectant management</td>
</tr>
<tr>
<td>Female sterilization: Can begin use after emergency treatment by surgical management or after complete expulsion of products of conception after medical treatment or expectant management</td>
<td></td>
<td>Natural FP: Not recommended until a regular menstrual pattern returns</td>
</tr>
<tr>
<td>Implants*: Can begin use immediately</td>
<td></td>
<td>Sterilization: It is best to delay female sterilization, as the stress that frequently accompanies abortion can affect decision-making; male sterilization may be performed at any time</td>
</tr>
<tr>
<td>Injectable contraceptives*: Can begin use immediately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUD (copper and hormonal): Can begin use after emergency treatment by surgical management or after complete expulsion of products of conception after medical treatment or expectant management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral contraceptives (combined and progestin-only): Can begin use immediately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patch (combined hormonal): Can begin use immediately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spermicidal films, foams, jellies, tablets, and sponges: Can begin use when client resumes sexual activity, but should be avoided if the client is at risk for HIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal ring (combined and progesterone): Can begin use after infection has stopped</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vasectomy: Can be provided at any time irrespective of the clinical condition of the PAC client</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Confirmed or presumptive diagnosis of infection</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signs and symptoms of infection or sepsis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signs of unclean or unsafe induced abortion</td>
<td></td>
<td></td>
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<tr>
<td>Unable to rule out infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical cap and diaphragm: Can begin use when client resumes sexual activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condoms (external and internal): Can begin use when client resumes sexual activity; use for dual protection (with another method)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implants*: Can begin use immediately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injectable contraceptives*: Can begin use immediately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUD (copper and hormonal): Can begin use after emergency treatment by surgical management or after complete expulsion of products of conception after medical treatment or expectant management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral contraceptives (combined and progestin-only): Can begin use immediately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patch (combined hormonal): Can begin use immediately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spermicidal films, foams, jellies, tablets, and sponges: Can begin use when client resumes sexual activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal ring (combined and progesterone): Can begin use after infection has treated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vasectomy: Can be provided at any time irrespective of the clinical condition of the PAC client</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female sterilization: Should not be performed until infection is fully resolved (approximately 3 months) or until risk of infection is ruled out</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUD (copper and hormonal): Should not be inserted until infection is fully resolved (approximately 3 months) or until risk of infection is ruled out</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Guidelines for Contraceptive Use by Clinical Condition (continued)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recommendations</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Genital tract injury</strong></td>
<td>![Image description]</td>
<td>![Image description]</td>
</tr>
<tr>
<td>Uterine perforation, with or without bowel injury</td>
<td>![Image description]</td>
<td>![Image description]</td>
</tr>
<tr>
<td>Serious cervical or vaginal injury, including chemical burns</td>
<td>![Image description]</td>
<td>![Image description]</td>
</tr>
<tr>
<td><strong>Severe vaginal bleeding (hemorrhage) and related severe anemia</strong></td>
<td>![Image description]</td>
<td>![Image description]</td>
</tr>
<tr>
<td>HB&lt;7 gm/dl or Hct &lt;20</td>
<td>![Image description]</td>
<td>![Image description]</td>
</tr>
</tbody>
</table>
## Guidelines for Contraceptive Use by Clinical Condition (continued)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recommendations</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second trimester</td>
<td>Condoms (external and internal): Can begin use when client</td>
<td>Cervical cap and diaphragm: Should be refit after uterus returns to</td>
</tr>
<tr>
<td>incomplete abortion</td>
<td>resumes sexual activity; use for dual protection (with another method)</td>
<td>pre-pregnancy size (4 to 6 weeks)</td>
</tr>
<tr>
<td>Implants†:</td>
<td>Can begin use immediately</td>
<td>Female sterilization: Perform postpartum minilaparotomy, or, if this</td>
</tr>
<tr>
<td>Injectable contraceptives‡:</td>
<td>Can begin use immediately</td>
<td>is not possible, delay procedure until uterus returns to pre-pregnancy</td>
</tr>
<tr>
<td>Oral contraceptives (combined</td>
<td>Can begin use immediately</td>
<td>size (6 weeks)</td>
</tr>
<tr>
<td>and progestin-only): Can begin</td>
<td>Injectable contraceptives‡: Can begin use immediately</td>
<td>IUD (copper and hormonal): Use postpartum insertion technique with high</td>
</tr>
<tr>
<td>use immediately</td>
<td>Patch (combined hormonal): Can begin use immediately</td>
<td>fundal placement; if an experienced provider is not available, delay</td>
</tr>
<tr>
<td>Spermicidal films, foams, jellies,</td>
<td>Vaginal ring (combined and progesterone): Can begin use as soon as</td>
<td>insertion for 6 weeks</td>
</tr>
<tr>
<td>tablets, and sponges:</td>
<td>bleeding has stopped</td>
<td></td>
</tr>
<tr>
<td>Vasectomy:</td>
<td>Can be provided at any time irrespective of the clinical condition</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of the PAC client</td>
<td></td>
</tr>
</tbody>
</table>


† This includes progestin-only implants, such as Jadelle, Levoxplnt, and Nexplanon.

‡ This includes DMPA (intramuscular and subcutaneous), NET-EN, and combined injectable contraceptives.

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### Postabortion Family Planning Method Options

As detailed in the previous section, most PAC clients can safely adopt modern contraception immediately after emergency treatment. The client’s clinical condition and personal situation (as detailed in the previous sections), and ability to access resources (see Community Resources for Referral and Follow-Up Care later in this session for additional information) are important factors to explore during contraceptive counseling. Providers should also be familiar with national and institutional guidelines and protocols related to contraceptive service provision. However, these protocols are often outdated and can pose unnecessary barriers to client access; for example, such guidelines often limit provision of methods containing estrogen to postabortion clients or restrict delivery of methods until six weeks after an incomplete abortion. Providers should be aware of these barriers and, when appropriate, contribute to efforts to update protocols in line with international standards. The table on the following pages summarizes key characteristics of various FP methods—including the timing for postabortion use as well as notable advantages and challenges—that providers and clients should consider when exploring method options.

Reminder: While clients are not recommended to resume sexual relations until bleeding stops (typically within five to seven days), fertility can return in less than two weeks. Therefore, any client wishing to delay a future pregnancy should begin or resume contraception immediately.
### Guidelines for Selecting a Postabortion Family Planning Method

<table>
<thead>
<tr>
<th>Method</th>
<th>Timing Postabortion</th>
<th>Advantages</th>
<th>Challenges</th>
</tr>
</thead>
</table>
| **Cervical cap and diaphragm, with spermicidal foam or jelly**         | Cervical cap should be fitted or refitted after uterus returns to pre-pregnancy size 4 to 6 weeks  
Diaphragm may be fitted or refitted immediately after first-trimester abortion but should be delayed after second-trimester abortion until uterus returns to pre-pregnancy size (4 to 6 weeks) | • Inexpensive  
• Immediately effective  
• Easily discontinued  
• Medical supervision not required  
• Partner engagement not required  
• Provides some protection against STIs, including HIV | • Less effective than IUD or hormonal methods  
• Requires trained provider to fit  
• Requires use with each episode of intercourse  
• Requires continued motivation  
• Requires resupply availability  
• Associated with urinary tract infections in some users  
• Should not be used by clients living with or at high-risk of HIV†  |
| **Condoms (external and internal, latex and vinyl) and Spermicidal films, foams, jellies, tablets, and sponges** | Can begin use when client resumes sexual activity                                      | • Accessible (via community health workers, drug shops, etc.)  
• Inexpensive  
• Immediately effective  
• Easily discontinued  
• Medical supervision not required  
• Good interim method if preferred method must be delayed  
• Condoms provide protection against STIs, including HIV | • Less effective than IUD or hormonal methods  
• Requires use with each episode of intercourse  
• Requires continued motivation  
• Requires resupply availability  
• May interfere with or interrupt intercourse  
• External condoms require partner engagement |
| **Emergency contraception (progesterone, ulipristal, etc.)**           | Can use any time client engages in sexual activity                                    | • Accessible (via community health workers, drug shops, etc.)  
• Highly effective, when used as directed (not routinely)  
• No affect on fertility  
• No interference or interruption to intercourse  
• Partner engagement not required | • Ineffective as a routine contraceptive method for regular sexual intercourse  
• Possible side effects  
• No protection against STIs and HIV |
### Guidelines for Selecting a Postabortion Family Planning Method (continued)

<table>
<thead>
<tr>
<th>Method</th>
<th>Timing Postabortion</th>
<th>Advantages</th>
<th>Challenges</th>
</tr>
</thead>
</table>
| **Female sterilization**      | *First trimester:* Can be performed as soon as the abortion treatment is complete and the client is free of complications (such as genital injury, infection, severe blood loss) and is able to provide free and informed consent  
*Second trimester:* Should be delayed and performed as interval procedure | • Most effective female method  
• Immediately effective  
• Permanent protection against pregnancy  
• Requires no further action once completed  
• No change in sexual functioning  
• No interference or interruption to intercourse  
• No long-term side effects  
• Protects against cancer and provides other health benefits  
• Partner engagement not required | • Not recommended at time of emergency treatment due to need for counseling, careful consideration, and written informed consent of a free and informed decision for permanent method before surgery  
• Requires trained provider and appropriate equipment  
• Possibility (slight) of surgical complications  
• No protection against STIs and HIV |
| **Implants** (progestin-only implants, such as Jadelle, Levoplant, and Nexplanon) | Can be inserted immediately after surgical treatment or same day of medication abortion (assuming counseling and free and informed consent) | • Highly effective  
• Long-acting protection (effective 3 to 5 years) against pregnancy  
• Immediate return to fertility upon removal  
• No interference or interruption to intercourse  
• Resupply not required  
• Partner engagement not required | • Requires trained provider to insert and remove  
• May cause irregular bleeding (especially spotting) or amenorrhea  
• Only cost-effective if used long-term  
• No protection against STIs and HIV |
| **Injectable contraceptives** (intramuscular and subcutaneous DMPA, NET-EN, and combined injectable contraceptives)† | Can be injected immediately after surgical treatment or same day of medication abortion (assuming counseling and free and informed consent) | • Highly effective  
• Can begin use immediately, even if infection is present  
• Nonphysicians may perform injections  
• No interference or interruption to intercourse  
• User responsibility limited to attending follow-up visits  
• Partner engagement not required | • Requires follow-up injections every 2 or 3 months  
• May delay return to fertility  
• May cause irregular bleeding, especially amenorrhea; excessive bleeding occurs rarely  
• No protection against STIs and HIV |
<table>
<thead>
<tr>
<th>Method</th>
<th>Timing Postabortion</th>
<th>Advantages</th>
<th>Challenges</th>
</tr>
</thead>
</table>
| **IUD (copper and hormonal)**               | First trimester: Can be inserted immediately after surgical treatment or after complete uterine evacuation for those choosing medication abortion, if the client is free of complications (assuming counseling and free and informed consent)  
Second trimester: Can be inserted as above, if appropriate expertise or equipment are available (similar to postpartum insertion procedure); otherwise, should be delayed for 6 weeks | • Highly effective  
• Long-term protection against pregnancy  
• Immediate return to fertility upon removal  
• No interference or interruption to intercourse  
• User responsibility limited to one follow-up visit (or more, for problems) and monthly checking for strings (by client)  
• Partner engagement not required | • Requires trained provider to insert and remove  
• May increase menstrual bleeding and cramping in the first few months  
• May increase risk of PID and subsequent infertility for those who have chlamydia or gonorrhea at the time of insertion  
• Possibility of uterine perforation during insertion  
• No protection against STIs and HIV |
| **Natural FP and fertility awareness**       | Not recommended for immediate use due to unpredictable ovulation postabortion; can begin use only after regular menstrual cycle resumes | • No cost  
• No change in sexual functioning  
• No interference or interruption to intercourse  
• No long-term side effects  
• Partner engagement not required | • Unreliable until after return of regular menstrual cycle; alternative methods required in interim  
• Requires extensive provider-client instruction and counseling and thorough understanding of method by client and partner  
• Requires continued motivation  
• No protection against STIs and HIV |
| **Oral contraceptives** (combined and progestin-only) | Can begin use immediately, preferably starting same day of treatment | • Highly effective  
• Can begin use immediately, even if infection is present  
• Nonphysicians may provide method  
• No interference or interruption to intercourse  
• Partner engagement not required | • Reduced effectiveness among clients with long-term use of certain medications (e.g., phenytoin and rifampin)  
• Requires continued motivation for daily use  
• Requires resupply availability  
• No protection against STIs and HIV |
<table>
<thead>
<tr>
<th>Method</th>
<th>Timing Postabortion</th>
<th>Advantages</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patch (combined hormonal)</td>
<td>Can begin use immediately</td>
<td>• Highly effective</td>
<td>• Side effects (minimal) possible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Immediate return to fertility after discontinuation</td>
<td>• No protection against STIs and HIV</td>
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<tr>
<td></td>
<td></td>
<td>• No interference or interruption to intercourse</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Partner engagement not required</td>
<td></td>
</tr>
<tr>
<td>Vaginal ring (combined and progesterone)</td>
<td>Can begin use as soon as bleeding stops</td>
<td>• Highly effective</td>
<td>• May be expensive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Immediate return to fertility upon removal</td>
<td>• Side effects (minimal) possible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Partner engagement not required</td>
<td>• No protection against STIs and HIV</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>Can be performed at any time</td>
<td>• Most effective male method</td>
<td>• Partner engagement required</td>
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<tr>
<td></td>
<td></td>
<td>• Permanent protection against pregnancy</td>
<td>• Ineffective until 12 weeks after procedure; alternative methods required in interim</td>
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<td></td>
<td></td>
<td>• Requires no further action once completed</td>
<td>• Requires counseling, careful consideration, and written informed consent of a free and informed decision for permanent method before surgery</td>
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<td></td>
<td></td>
<td>• No change in sexual functioning</td>
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<td>• No long-term side effects</td>
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<tr>
<td></td>
<td></td>
<td>• Client engagement not required</td>
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*Sources:*


Dual Protection

Few FP methods provide effective protection against STIs, including HIV. Dual protection prevents pregnancy and transmission of STIs including HIV. Dual protection may be achieved through either:

- Using condoms alone to prevent pregnancy and the transmission of STIs and HIV (*Note: Condoms alone are not the most effective contraceptive method.*)
- Using condoms and a second contraceptive method (e.g., implants, injectable contraceptives, or oral contraceptives) to prevent pregnancy and the transmission of STIs and HIV

The primary goal of dual protection—whether to prevent pregnancy, infection, or both—should inform which approach a client should adopt. If pregnancy prevention is the primary goal, using condoms and a second contraceptive method may be appropriate, especially if the client is unable to use condoms correctly and consistently. If infection prevention is the primary goal, using condoms alone may be appropriate. Providers should assist PAC clients in determining their goals as well as risks to ensure selection of the most appropriate approach to dual protection for their situation.

Community Resources for Referral and Follow-Up Care

A client’s ability to use certain contraceptive methods effectively depends partly upon their ability to access resupply and/or follow-up care. This in turn depends on a facility’s ability to maintain an adequate supply of the methods and/or to ensure trained providers are available to offer care. In addition to accessing maintenance medications (such as refills of oral contraceptives or removals and reinsetions of implants), clients may also need follow-up care to assist them with managing side effects and changing methods. Clients who have traveled long distances for PAC will likely be unable to return to the PAC facility for contraceptive follow-up care and instead need to be able to access care from providers in their communities. Providers need to help clients consider challenges they may encounter in accessing resupply and/or follow-up care; this includes considering convenience (location and hours of resources) and consistency of supply. Additionally, PAC providers need to know what resources clients will be able to access after returning home to help clients choose a method they can sustain.

To assess the local community’s capability to provide contraceptive care, including resupply of self-directed methods (such as condoms or emergency contraceptives) as well as provider-offered services (such as contraceptive injections), the provider should consider:

- Availability of public sector FP resources (including community-based and mobile clinics):
  - What resources are available (including self-care)?
  - Where are resources located?
  - How much do the resources cost?
- Availability of private sector FP resources (including local drug shops or pharmacies):
  - What resources are available (including self-care)?
  - Where are resources located?
  - How much do the resources cost?
- Availability of other community resources, including:
  - What services are available for survivors of gender-based violence?
  - Are there any community resources dedicated to young people (such as youth centers) that provide FP and/or do the public and private FP resources identified offer youth-friendly services?

Reminder: Free and informed contraceptive care is an integral part of PAC. However, having an FP clinic on-site and giving a client a referral is not sufficient as such clinics often only operate in the daytime and during the week—and therefore may be closed when the PAC client is ready to seek care. Instead, all PAC providers should be trained to offer comprehensive contraceptive counseling and service provision and should integrate this support throughout PAC.
• Does the PAC facility have established referral arrangements with community resources that clients can easily access if they prefer to delay or are unable to adopt a method of choice at the time of PAC treatment? If such arrangements do not yet exist, can they be established?

PAC providers can also help clients to choose a method that they will be able to continue by offering a wide range of methods—without bias or judgment—at the time of emergency treatment. For PAC facilities that are unable to offer all methods of contraception, providing a referral to another facility is important to ensure the client is able to adopt their preferred method. Similarly, for a PAC client who may need to wait to begin using their preferred method due to their clinical condition, who may choose to delay selecting a method, who has chosen to adopt a short-acting method requiring resupply, or who experiences problems with or becomes dissatisfied with a chosen method and needs to change, a referral is important. Therefore, functional referral mechanisms between PAC facilities and FP service delivery points are essential to postabortion FP programs.

Further, it is important that providers and clients both understand the referral system and how to use it. While providers may be guided by standard protocols, the client will need the following information to effectively access the referral system:

• Where the referral facility is located and how to access the facility, including the street address of the facility, directions to the facility, and transportation options
• When the facility is open, including days and hours of operation
• Contact information, including phone number and name of the provider to visit (if the client needs to see a specific provider)
• Whether a referral card is required to access methods or services
• Whether the client’s medical information will be transferred to the referral facility and/or if the client needs to bring any medical records to discuss with the provider
• What FP resources (supplies and services) may be available
• What additional services may be available (e.g., STI and HIV counseling and testing, cancer screening, maternal and newborn care, legal and social services for gender-based violence survivors)
• How much (approximately) the supplies and/or services will cost
• Answers to any other questions the client may have

Simple Answers to Clients’ Questions about Postabortion Family Planning

When can I resume sexual activity?
After your bleeding has stopped, which should be in approximately five to seven days.

How soon can I become pregnant again?
Almost immediately—even before your next period. It is possible to become pregnant again less than two weeks after this treatment.

How can I avoid becoming pregnant again?
Start using a modern contraceptive method immediately.

Which method can I use?
You can discuss all available methods with your provider (and include your partner or spouse, if you wish) to decide what may be right for you. If you are otherwise healthy and free of infection, there are many contraceptive methods that are safe to start immediately after incomplete abortion, including:143

• Condoms (Note: Abstinence and condoms are the only methods that provide protection against STIs and HIV. Therefore, it is advisable to use condoms with all other methods—dual method use—to protect against both pregnancy and STIs.)

• Oral contraceptives, also known as “the pill” and “birth control pills”
• Injectable contraceptives, or “injectables”
• Contraceptive patch, also known as “the patch” and “birth control patch”
• Contraceptive implants
• Vaginal ring
• Cervical cap
• Contraceptive diaphragm
• Intrauterine device, or IUD *
• Emergency contraception
• Voluntary surgical contraception or sterilization, including tubal ligation * and vasectomy

* Clients without other health problems who choose misoprostol to treat an incomplete abortion, can receive any contraceptive method with the first dose of misoprostol except IUD or female sterilization, which may only be administered, with the client’s consent, after the complete expulsion of the products of conception from the uterus.

I had a miscarriage and want to become pregnant again soon—which methods are right for me?

To give your body the rest it needs and to make sure the next pregnancy is healthy, it is strongly recommended that you wait until your body has healed. Waiting six months before becoming pregnant again can help reduce the risk of low birth weight, premature birth, and maternal anemia. Note: A systematic review and meta-analysis primarily comprising studies from high-income countries suggests that an interval of less than six months following miscarriage is not associated with adverse outcomes. You can use any short- or long-acting method to space your pregnancies, which can help reduce the risk of another miscarriage. However, you may wish to consider that there may be a delay in the return of fertility with some methods after you stop using them—your provider can explain which methods have this delay. Short-acting methods that you can use include barrier methods (such as condoms), oral contraceptives, and injectables. Long-acting reversible methods that you can use include implants and IUDs.

Family Planning Counseling Approaches

There are several approaches to providing FP counseling. The GATHER and REDI approaches, which are summarized in this manual, are two examples. These (and other) approaches take the client through four stages of counseling, as summarized in the figure below and detailed in the following pages.

---

Stage 1: Create a Rapport and Assess the Client’s Needs and Concerns

The primary purposes at this stage are to:

- Establish a connection with the client.
- Determine the reason for the client’s visit.
- Gather information about the client’s situation.

To achieve the above, the provider should complete the following tasks:

- Greet the client appropriately to establish a good connection.
- Ensure the client is comfortable and that there is adequate visual and auditory privacy; assure the client that everything discussed will be kept confidential.
- Ask the client about the reason(s) for the visit. This is an important question for PAC clients who have been referred to the FP clinic as well as returning clients.
- Using simple and nonjudgmental language, ask the client about their personal situation.
  - Begin by asking about their relationship status, sexual activity, and general health.
  - Ask about the client’s reproductive intentions and ideal family size, including their current desire (or not) for contraception to delay or prevent pregnancy.
  - Explore the client’s STI and HIV risk by asking what actions the client is currently taking to protect themselves. Carefully form questions and responses in ways that help the client to explore their own risk level. Refrain from telling the client they are at risk (even if you think they are).
  - Discuss other health and well-being issues, including screening the client for gender-based violence (particularly intimate partner violence and reproductive coercion) and either provide relevant counseling (if trained to do so) or offer referrals, as appropriate.
- Use information from this stage of discussion to tailor the rest of the counseling session to the client’s individual needs.

Stage 2: Provide Information and Address All of the Client’s Needs and Concerns

The second stage focuses on providing the client with information and addressing any expressed concerns. The provider should tailor the information based on the discussion from the first stage about the client’s needs and circumstances—including discussing options for preventing pregnancy and protecting against STIs and HIV.

Ask about the client’s experience with FP and, if they are considering FP for the first time, describe the benefits. If the client is planning to become pregnant soon, provide guidance for healthy pregnancy—including the importance of healthy timing and spacing, particularly after an abortion or miscarriage. If the client is seeking to limit or delay childbearing, ask if they already have a method in mind. If so, provide information about the method; if not, explain that there are many options. Consider showing the client samples or using available counseling tools to show images of the different methods.

To begin exploring the best options for the client, ask specific questions, such as those included below, to eliminate methods that would not fit the client’s needs:

- Do you wish to have children in the future? If the answer is yes, inform the client that certain methods—particularly permanent contraceptive methods (sterilization) are not a good option. Otherwise, keep permanent methods on the list for further discussion.
- Is your partner willing to cooperate with and contribute to FP? If the answer is no, inform the client that this eliminates methods that require the partner’s involvement (such as condoms and vasectomy). Otherwise, keep these methods on the list for further discussion.
- Are there any methods that you do not want to use—including any you have been dissatisfied with in the past? If the answer is yes, ask which method or methods and remove them from the list of potential options.
These questions will help narrow the list of methods that are suitable for the client. The next step at this stage is to provide information about the main features of the remaining methods—five to seven key facts for each method—taking care not to overwhelm the client with too much information. As appropriate, consider supplying the client with reading materials on the method(s) to help them further consider the options.

Encourage the client to share any concerns or ask any questions that they may have and respond to all the concerns or questions. If you are unable to address the client’s concerns or questions, provide guidance on where the client can seek additional counseling. This may require referring the client to another provider in the same facility or to a different facility.

**Stage 3: Help the Client to Make an Informed Decision or Address a Problem**

This stage focuses on helping the client make an informed decision about the FP method(s) discussed or helping to address any problems they are experiencing. There are four tasks to complete at this stage:

- Ask if the client has any questions about the method(s) discussed.
- Ask the client to choose their preferred method. **Note:** The client may ask for the provider’s opinion. The provider should offer unbiased, factual information—taking care not to impose any personal beliefs or opinions. If the client is having difficulty choosing a method, review key information about methods they are considering, including explaining how the methods differ.
- Use a pregnancy checklist or method screening checklist to confirm the client can use their preferred method. There are existing tools for this purpose that will help determine if there are any reasons that a particular method may be unsafe for the client. After discussing the questions in the tool, let the client know if they will be able to safely use their preferred method.
- Agree on the decision or plan with the client. Summarize the client’s decision—confirming the client’s preferred method—and introduce next steps. If the client chooses a method that the provider cannot offer, inform the client that they will receive a referral to another facility where they can receive the preferred method.

**Stage 4: Help the Client to Carry Out the Decision**

The purpose of the last stage of counseling is to help the client to successfully carry out their decision. This stage has six tasks:

- Provide the client with the requested contraceptive method, or with a referral to a different facility to obtain the preferred method. If the client is unable to access their preferred method at this time, offer condoms for use in the interim.
- Explain and/or demonstrate how to use the method correctly.
- Ask the client to explain and/or demonstrate how to use the method to reinforce and confirm understanding.
- Remind the client about any side effects that they may experience and signs of problems or complications that would require them to return for additional care.
- If the client needs help preparing to talk with their partner or spouse, role play or rehearse negotiation skills. This may include discussing when and where the client can talk with their spouse or partner as well as what the client will say, helping the client to brainstorm responses and role playing the conversation as they rehearse.
- Invite the client to return at any time (for instance, if they have additional questions or experience problems) and schedule a follow-up appointment, if necessary. Additionally, provide the phone number and contact information for facility staff who can address questions or concerns, including to advise the client if a return to the facility is necessary. If the client has chosen a method that requires resupply, explain where to obtain resupply of the method. If the client will be required to return to the facility for resupply (for instance, for contraceptive implants), explain what will happen during future visits and schedule the next visit. Finally, offer the client additional informational materials about the method to take home and see if the client has any remaining questions.
The GATHER Method of Counseling

Note: The content contained within this section is adapted from the GATHER Guide to Counseling.145

Providing counseling about FP and other reproductive health matters often includes six elements or steps and it may be helpful to remember these elements using the English word GATHER (or another word in the participants’ language), as each letter in the word GATHER represents one of these elements. However, effective counseling is more than the GATHER elements. Providers must not only ensure confidentiality and privacy, they must understand and address any pain or discomfort clients may be experiencing. Skilled counselors also understand their clients’ feelings and needs and use this understanding to adapt counseling to best support each client. PAC counseling should be tailored to each client’s unique needs. For instance, not all clients need to be counseled according to all six GATHER elements or in the order presented here, and some clients may need an element repeated.

G: Greet (Greet the client)
- Greet the client, introduce yourself, and offer the client a seat (as applicable).
- Be polite, friendly, and respectful, including by giving the client your full attention.
- Conduct counseling in a private space and reassure the client that your conversation will be kept confidential.
- Determine if the client is ready for counseling.
- If there is a partner, spouse, or other companion present, ask the client if they would like this person to participate in the conversation.
- Explain what will happen during the client’s visit.

A: Ask (Ask the client about themselves)
- Ask the client about their reason(s) for coming and how you can help.
- Ask the client about their concerns, doubts, feelings, needs, and wants and allow them to ask questions.
- Ask the client about their experience with the reproductive health matter that concerns them.
- Ask the client for any information needed to complete client records.
- Ask the client what they want to do and help them understand their choices and options.
- Actively listen to the client and allow them to lead the discussion.
- Keep questions brief, open, and simple.
- Demonstrate your interest in and understanding of the client by expressing empathy; avoid showing any bias or judgment.

T: Tell (Tell the client about their options)
- Present information respectfully, including by looking at the client as you speak.
- Help the client understand their options.
- Tailor and personalize information, focusing on what is important and relevant to the client’s situation.
- If the client is choosing an FP method:
  » Ask the client which methods interest them and explain that you will help them obtain their preferred method, assuming it is available and there is no medical reason that they should not use that method.
  » Ask the client what they know about the method already. If the client has important information wrong, gently correct them.
  » Briefly describe the client’s preferred method, being sure to address: (1) effectiveness of the method; (2) how to use the method; (3) other characteristics, including possible side effects and complications; and (4) danger or warning signs. Use samples and other audiovisual materials, if possible.
  » Mention any other available method(s) that the client might wish to consider using, now or later.
  » Explain that condoms are the only method that offers reliable protection against STIs.

**H: Help (Help the client choose)**

- Tell the client that the decision is theirs.
- Offer advice but avoid deciding for the client.
- To help the client make the decision, ask them to think about:
  - Their plans and family situation
  - The implications of each possible choice
  - What their partner might want
- Ask if the client understands the options and if they have any questions. Repeat and reword information, as needed.
- Explain that some FP methods may not be safe for clients with certain medical conditions. Once a client makes a choice, ask about these conditions or perform a clinical exam, if necessary, and discuss results with the client. If a method would not be safe, clearly explain why, and then help them choose another method.
- Check whether the client has made a decision by asking, “What have you decided to do?” and then wait for the client to answer.

**E: Explain (Explain what to do)**

After the client has made a choice:

- Provide the client with their chosen method, as appropriate. If the method or services cannot be given at this time, tell the client how, when, and where they can access the service or method.
- For voluntary sterilization, ask the client to voluntarily sign a consent form that confirms that the client has chosen the method, has received information about the method, and understands that information. Help the client understand the consent form before they sign.
- Provide instructions on how to use the method and, if possible, demonstrate how to use the method and have the client return the demonstration to confirm understanding.
- Describe possible side effects and explain what the client should do if they occur.
- Tell the client when to return for routine follow-up care or for resupply, as needed.
- Tell the client to come back whenever they wish, and particularly if they develop any side effects, experience any danger signs, or if there are medical reasons to return (explain potential medical reasons).
- Ask the client to repeat instructions to make sure they remember and understand the instructions.
- Give the client printed instructions to take home, if possible.

**R: Return (Return for follow-up care)**

During a follow-up visit:

- Check if the client is using the method correctly.
- Ask if the client has any questions or concerns. Answer any questions and treat all concerns seriously.
- Ask the client if they have experienced any problems. Help address any problems.
- Ask if the client is satisfied with the current method. If the client is not satisfied, ask if they want to try a different method. If so, help the client choose another method and explain how to use it. Remember and explain to the client: changing methods is normal; no one can determine if a method works well for them without trying it. Also, a person’s situation can change, making a different method a better choice.
- Ask if the client has experienced any health problems since the last visit. Discuss if another method may be better, based on such problems, and provide referrals for additional care, as needed.
- If a client wants an IUD or implant removed, arrange for the removal. If the client plans to become pregnant, provide information for prenatal care as well as voluntary counseling and testing to prevent possible mother-to-child transmission of HIV, as appropriate.
- Check whether the client might need STI protection and/or voluntary counseling and testing for HIV.
The REDI Model of Counseling

*Note: The content contained within this section is adapted from REDI: A Client-Centered Counseling Framework.*

The REDI framework, designed with a client-centered approach, aims to ensure provision of comprehensive FP counseling as part of integrated health services. REDI is an acronym for the four components of the framework:

- **Rapport-building with the client**
- **Exploring the client’s needs and situation**
- **Decision-making with the client**
- **Implementing the decision and helping the client develop an action plan**

The REDI framework is appropriate for PAC counseling because: it emphasizes the client’s responsibility for making and implementing a decision; it provides guidelines for considering the client’s sexual relationship(s) and social context; it takes into consideration gender issues; it addresses the challenges that a client may face in implementing a decision; and it offers skills development to help clients meet these challenges. REDI provides a useful framework for counseling, but it does not necessarily need to be followed exactly or in sequential order. REDI is rather a suggested guide of steps and topics to cover while engaging the client in an interactive, two-way discussion of the client’s needs, desires, and method eligibility. The table below provides a summary of each phase of the REDI framework.

<table>
<thead>
<tr>
<th>Phase 1: Rapport-Building</th>
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<tbody>
<tr>
<td>• Welcome the client.</td>
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<tr>
<td>• Make introductions.</td>
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<tr>
<td>• Introduce the subject of sexuality.</td>
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<tr>
<td>• Assure confidentiality and privacy.</td>
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<tr>
<th>Phase 2: Exploring</th>
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</thead>
<tbody>
<tr>
<td>• Explore the client’s circumstances, needs, risks, sexual life, social context, and reproductive intentions.</td>
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<tr>
<td>• Assess the client’s knowledge and give information as needed.</td>
</tr>
<tr>
<td>• Assist the client to perceive or determine their own HIV and other STI risk.</td>
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<tr>
<td>• Explore reasons for satisfaction or dissatisfaction with FP method(s) for current users.</td>
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<tr>
<th>Phase 3: Decision-Making</th>
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<tbody>
<tr>
<td>• Identify what decisions the client needs to make in this session.</td>
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<tr>
<td>• Identify the client’s options for each decision (e.g., pregnancy prevention, STI and HIV risk reduction).</td>
</tr>
<tr>
<td>• Confirm medical eligibility for any method(s) the client is considering.</td>
</tr>
<tr>
<td>• Help the client consider the advantages, disadvantages, and consequences for each action.</td>
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<tr>
<td>• Confirm that any decision the client makes is informed, well-considered, and voluntary.</td>
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<tr>
<th>Phase 4: Implementing the Decision</th>
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<tr>
<td>• Assist the client to make a concrete and specific plan for carrying out their decision.</td>
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<tr>
<td>• Identify barriers that the client may face in implementing the plan.</td>
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<tr>
<td>• Develop strategies to overcome the barriers identified.</td>
</tr>
<tr>
<td>• Make a plan for follow-up care and/or provide a referral, as needed.</td>
</tr>
</tbody>
</table>

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World Health Organization Medical Eligibility Criteria for Contraceptive Use

The WHO’s Medical Eligibility Criteria for Contraceptive Use, which has been published in several languages, offers evidence-based recommendations for initiating use of nine common contraceptive methods for clients with specific medical conditions or relevant characteristics. It serves as an important reference tool for FP providers and can be used to inform reviews of national FP service delivery guidelines and other related documents. In general, the purpose of the tool is:

- To guide FP practices based on the best available evidence
- To address misconceptions about who can and cannot safely use contraceptive methods
- To reduce medical, policy, and practice barriers, particularly those that are not supported by evidence
- To improve access to and quality and use of FP services

The tool classifies conditions affecting method eligibility into four categories, as shown in the table below.

### Guidelines for Selection of Contraception, by Method

<table>
<thead>
<tr>
<th>Category</th>
<th>With Clinical Judgment</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Use the method in any circumstance</td>
<td>Yes Use the method</td>
</tr>
<tr>
<td>2</td>
<td>Generally use the method</td>
<td>Use the method</td>
</tr>
<tr>
<td>3</td>
<td>Use of method not usually recommended unless other more appropriate methods are not available or not acceptable</td>
<td>No Do not use the method</td>
</tr>
<tr>
<td>4</td>
<td>Method not to be used</td>
<td>Method not to be used</td>
</tr>
</tbody>
</table>

Categories 1 and 4 are self-explanatory. Category 2 indicates that the method generally can be used but may require careful follow-up. A method in Category 3 is usually not recommended unless other more appropriate methods are unavailable or unacceptable to the client. Use of a Category 3 method requires careful clinical judgment and access to follow-up services; the provider should consider the severity of the client’s condition and the acceptability, availability, and practicality of alternative methods for these cases. When resources for clinical judgment are limited—for example, in community-based services—the framework can be simplified into two categories. With this simplification, Category 3 indicates that a client is not medically eligible for this method.

The Medical Eligibility Criteria Wheel for Contraceptive Use is a job aid developed to help providers quickly identify the eligibility criteria relevant to their clients. This easy-to-use tool is included on the following three pages; it may be printed, cut, and assembled for use. Additionally, the WHO also offers this resource as a user-friendly app for Android and Apple devices, which providers can download directly to mobile phones or tablets.

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WHO Medical Eligibility Criteria Wheel for Contraceptive Use

1. Use the method in any circumstance
2. Generally use the method
3. Use of the method not usually recommended unless other, more appropriate methods are not available or acceptable
4. Method NOT to be used

WHO Medical Eligibility Criteria Wheel for contraceptive use, 2015

These methods do not protect against STI/HIV. If there is a risk of STI/HIV, the correct and consistent use of condoms, male or female, is recommended.
WHO Medical Eligibility Criteria Wheel for Contraceptive Use (continued)
WHO Medical Eligibility Criteria Wheel for Contraceptive Use (continued)

- **A**: If condition develops while using method, can continue using it during treatment.
- **B**: If very high likelihood of exposure to gonorrhea or chlamydia = 3.
- **C**: If past pelvic inflammatory disease (PID) all methods = 1, including IUDs.
- **D**: If <3 wks, not breastfeeding & no other VTE risk factors = 3.
- **E**: If not breastfeeding = 1.
- **F**: If >3 to ≤6 wks, not breastfeeding & no other VTE risk factors = 2, with other VTE risk factors = 3.

- **G**: If >6 wks & not breastfeeding = 1.
- **H**: If uterine cavity distorted preventing insertion = 4.
- **I**: Refer to hematocellular adenoma (benign) or carcinoma/hematoma (malignant).
- **J**: If adenoma CIC = 3, if carcinoma/hematoma CIC = 3/4.
- **K**: CIC = 3.
- **L**: If established on anticoagulation therapy = 2.
- **M**: If condition developed while on this method, consider switching to non-hormonal method.
- **N**: Risk factors: older age, smoking, diabetes, hypertension, obesity & known dyslipidemia.
- **O**: If cannot measure blood pressure & no known history of hypertension, can use all methods. Either systolic or diastolic blood pressure may be elevated.
- **P**: If age <15 yrs & obese DMMA/NET-EN = 2.
- **Q**: For insulin-dependent & non-insulin-dependent, if complicated or >20 yrs duration, COCP/OCR, CIC = 3/4; DMMA, NET-EN = 3.
- **R**: If <15 cigarettes/day CIC = 2. If ≥15 cigarettes/day COCP/OCR = 4.
- **S**: Aura is focal neurological symptoms, such as flickering lights. If no aura & age ≤35 COCP/OCR, CIC = 2, POP = 1.
- **T**: If aura & age ≥35 COCP/OCR, CIC = 3, POP = 1.
- **U**: Barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate & lamotrigine.
- **V**: If lamotrigine = 1.
- **W**: DMMA = 1, NET-EN = 2.
- **X**: OCs = 2.
- **Y**: If antiretroviral therapy with NNRTIs, ATV, LPV/r, DRV/r, RTV; COCP/OCR, CIC, POP, NET-EN, implants = 2; DMMA = 1. For all NNRTIs, ETR, RPV, RAL each method = 1. See jacket for full names of medications.
- **Z**: If WHO Stage 3 or 4 (severe or advanced HIV clinical disease) IUD = 3.

**Conditions that are category 1 and 2 for all methods (method can be used)**

**Reproductive Conditions:**
- Benign breast disease or undiagnosed mass
- Benign ovarian tumors, including cysts
- Dysmenorrhea
- Endometriosis
- History of gestational diabetes
- History of high blood pressure during pregnancy
- History of pelvic surgery, including cesarean delivery
- Irregular, heavy or prolonged menstrual bleeding (explained)
- Past ectopic pregnancy
- Past pelvic inflammatory disease
- Postabortion (no sepsis)
- Postpartum > 6 months

**Medical Conditions:**
- Depression
- Epilepsy
- HIV asymptomatic or mild clinical disease (WHO Stage 1 or 2)
- Iron-deficiency anemia
- Sickle-cell disease
- Asthma
- Malaria
- Mild cirrhosis
- Schizophrenia (unstable)
- Superficial venous disorders, including varicose veins
- Thyroid disorders
- Tuberculosis (non-pelvic)
- Uncomplicated venereal disease
- Myeloid leukemia (carry or chronic)
- Other: Adolescents
- Breast cancer family history
- Venous thromboembolism (VTE) family history
- High risk for HIV
- Surgery without prolonged immobilization
- Taking antibiotics (excluding rifampicin/rifabutin)

With few exceptions, all women can safely use emergency contraception, barrier and behavioural methods of contraception, including lactational amenorrhea method; for the complete list of recommendations, please see the full document.

"Combined" is a combination of ethinyl estradiol & norethisterone.
POST ABORTION FAMILY PLANNING:  
A KEY COMPONENT OF POST ABORTION CARE

We commit ourselves and call upon all programs serving post abortion women of all ages to:
• Ensure that voluntary family planning counseling and services are included as an essential component of post abortion care in all settings
• Empower and serve post abortion women of all ages to prevent unintended pregnancies and further abortions
• Provide information on optimal pregnancy spacing for those women who want a pregnancy in order to realize critical health benefits, such as reduced maternal, neonatal, and childhood deaths, and prevention of HIV transmission from mother to child

We recognize that post abortion family planning is a cost-effective strategy for helping countries meet their commitments under Millennium Development Goal 5; FP2020; A Promise Renewed and the United Nations General Assembly Special Session on HIV/AIDS (UNGASS).

The International Federation of Gynecology and Obstetrics (FIGO), the International Confederation of Midwives (ICM), and the International Council of Nurses (ICN) have committed to fully collaborate across their professions to optimize the provision of post abortion family planning, and through this statement, they are joined by collaborating partners to achieve universal access to voluntary post abortion family planning.

What is post abortion family planning and why is it important?
Every year, an estimated 44 million women of all ages have an induced abortion. They all need family planning information and voluntary contraceptive services. Since 1994, all models for post abortion care have included two essential services in their definition of such care: treatment, and voluntary family planning counseling and service delivery.

Globally, about 210 million women become pregnant each year. Of these,
• 135 million have live births
• 80 million have unintended pregnancies
• 44 million have an induced abortion, and of these about 22 million are unsafe
• 31 million have spontaneous abortions (miscarriages) or stillbirths
• 47,000 women die due to unsafe abortion, accounting for about 13% of all maternal deaths.1,2

Post Abortion Family Planning: A Key Component of Post Abortion Care (continued)

Post abortion family planning services need to be provided immediately after an induced or spontaneous abortion or treatment of complications, because fertility returns very quickly. Voluntary post abortion contraception is recommended to reduce unintended pregnancies and repeat abortions and to reduce the risks of adverse maternal and perinatal outcomes for pregnancies following induced or spontaneous abortion (miscarriage).4

Who needs post abortion family planning?
Millions of women have no control over the circumstances under which they become pregnant, and when faced with an unwanted pregnancy, many seek safe or unsafe abortion. Women who have an induced abortion often have had a previous abortion,5,6,7 yet many of these women do not have access to effective contraceptives and are not offered immediate post abortion family planning services, even though post abortion women are at risk of pregnancy almost immediately after the procedure.8 In 12 countries of Central Asia and Eastern Europe, total abortion rates dropped dramatically as the use of effective contraceptives increased.9

Women who have spontaneous abortions also need access to post abortion contraception. Some women wish to become pregnant again, and current evidence indicates that pregnancy spacing of six months after a spontaneous abortion is associated with optimal pregnancy outcomes.4,9

What are the results of providing post abortion family planning services?
When family planning counseling and services are offered immediately after all types of treatment, and provided before the woman leaves the facility, post abortion contraception acceptance rates can increase rapidly, from 0–10% prior to a program intervention to 50–80% within one to two years after implementation.3,10 Voluntary contraceptive counseling and methods should be available at the same time and place as where the woman is treated.

Reducing costs and optimizing staff time
Providing post abortion contraception makes financial sense for both the individual and the institution, including saving staff time.11 For example, in Nigeria, where access to safe abortion is very limited, the cost of treatment for complications of abortion is four times higher than the cost of providing family planning services to prevent these abortions.12

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**Key Consensus Points**

- Globally, one in three pregnancies (75 million) end by either induced abortion (44 million), or spontaneous abortion or stillbirth (31 million).1,2
- Unmet need for family planning one of the primary causes of induced abortion.5,6,9
- Post abortion women are at risk of pregnancy almost immediately.8
- All post abortion women should receive voluntary post abortion family planning counseling and should be offered FP services at the site of care, including a wide range of methods.3,12,13,14
- Post abortion family planning uptake is high (50–80%) when quality services are offered before discharge.3,10,15,16
- Provision of universal access to voluntary post abortion contraception should be a standard of practice for doctors, nurses, and midwives.13
- Organizing services to ensure access to voluntary family planning counseling and choice of contraceptives can save costs, staff time, and lives, and empowers women to decide when and if to have children.11,12,17
- FIGO, ICM, and ICN have committed to fully collaborate across their professions to optimize the provision of post abortion care.13
- Advocacy is needed with policymakers and governments for ensuring quality post abortion family planning services, promoting task sharing, strengthening professional education, and reducing unmet need for family planning.13
Post Abortion Family Planning: A Key Component of Post Abortion Care (continued)

Committing to action to achieving universal access to post abortion family planning
FIGO, ICM, and ICN have committed to ensuring that their members advocate for high-quality post abortion family planning counseling and services. These health care professionals and the collaborating organizations endorsing this statement recognize the equally important need for family planning among postpartum women and are committed to strengthening contraceptive services as a vital part of both postpartum and post abortion care. The rationale for both comes from the clear evidence that family planning and pregnancy spacing reduce unintended pregnancies and abortions and lower morbidity and mortality among women, neonates, infants, and children.

“If a woman comes to a hospital with an incomplete [induced] abortion, we’ve already failed once to help her avoid an unwanted or a mistimed pregnancy. If she leaves the facility without having any means of preventing another pregnancy in the future that may not be wanted, we’ve failed her twice.”
—Cynthia Steele Verme 1994, Postabortion Care (PAC) Consortium, International Conference on Population and Development (ICPD), Cairo

Providing a wide range of contraceptive methods for post abortion clients
Effective programs need to ensure an adequate supply and wide range of contraceptive methods in treatment rooms, including temporary and long-acting methods. Most contraceptive methods can be initiated in the immediate post abortion period. Training and employing more midwives and nurses in the provision of highly effective long-acting reversible contraceptive methods, such as the intrauterine device (IUD) and hormonal implant, and ensuring that they have the legal authority to provide these methods, will strengthen access to a full range of contraceptive methods.

Ensuring skilled counseling
The post abortion period is an opportune time for health professionals to have a major impact on reproductive health outcomes. Skilled counseling is especially important for younger women whose first interaction with the health system may be for post abortion care. In Africa, 25% of unsafe abortions occur among women 15–19 years old. Trained providers, including midwives, nurses, and ward staff, need to support all women who have undergone an induced abortion in making the best decisions for their health and reproductive intentions.

Supporting contraceptive continuation post-procedure
To reinforce contraceptive continuation, women of all ages should be provided with a plan for obtaining ongoing contraceptive supplies and/or for making follow-up visits. They should receive simple written instructions for the use of their method, along with concise information about common side effects and benefits. Optimally, this information should be provided before treatment begins, especially given that stress, sedation, and anesthetics can inhibit comprehension and recall.
Post Abortion Family Planning: A Key Component of Post Abortion Care (continued)

Advocating and leading for universal access to post abortion family planning

A joint effort by health care professionals, policymakers, donors, faith-based organizations, and governments can ensure optimal practices for post abortion family planning counseling and services, including appropriate sharing of responsibilities among doctors, midwives, nurses and community health workers. Strengthening preservice education for physicians, midwives, and nurses will better prepare them to provide contraceptive counseling and integrated services. All benefit when quality of care is improved, family planning needs are met, staff time is saved, costs are lowered, and lives are preserved.

References

Additional resources are available at the Postabortion Care web site, www.postabortioncare.org
Reminder: Postabortion FP is a critical component of PAC and a proven high-impact practice. Postabortion FP as a component of PAC entails proactively offering voluntary contraceptive counseling and services at the same time and location where clients receive facility-based PAC.

Module 3, Session 2: Sexually Transmitted Infection and HIV Service Provision

Summary

This session provides an overview of sexually transmitted infection (STI) evaluation and treatment using the syndromic approach and referral. The session on HIV and AIDS focuses on information for counseling and referrals to appropriate services for provider-initiated counseling, testing, care, and treatment.

Note: The content contained within this section is largely adapted from the following sources: Guidelines for the Management of Sexually Transmitted Infections,151 Sexually Transmitted and Other Reproductive Health Tract Infections,152 Guidelines for the Treatment of Neisseria Gonorrhoeae,153 Guidelines for the Treatment of Chlamydia Trachomatis,154 Guidelines for the Treatment of Treponema Pallidum (Syphilis),155 and Guidelines for the Management of Symptomatic Sexually Transmitted Infections.156

Learning Objectives

At the end of this session, participants will be able to:

1. Describe the symptoms and complications of common STIs as well as HIV and AIDS.
2. List the essential STI information that all PAC clients should receive before discharge.
3. Explain how to evaluate, treat, and follow up with PAC clients with STIs using the syndromic approach.
4. Provide counseling within the context of STIs and HIV risk.

Sexually Transmitted Infections and Reproductive Tract Infections

STIs

An STI is an infection that spreads from one person to another by sexual contact. STIs are a major public health concern affecting millions of people globally. For instance, the WHO estimates that each year, 131 million people are infected with chlamydia, 78 million with gonorrhea, and 5.6 million with syphilis. STI status is a critical concern for obstetric outcomes as an untreated STI in pregnancy can increase the chance of a stillbirth or newborn death. Similarly, if left undiagnosed and untreated, several STIs—specifically, chlamydia, gonorrhea, and syphilis—can result in serious complications and long-term health problems, such as pelvic inflammatory disease (PID), ectopic pregnancy, and miscarriage. Additionally, untreated chlamydia and gonorrhea can cause infertility in both sexes. A chlamydia, gonorrhea, or syphilis infection can also increase a person’s risk of becoming infected with HIV two- to three-fold.

Common STIs include: chancroid, chlamydia, gonorrhea, herpes, human papillomavirus (HPV), syphilis, and trichomoniasis. These, as well as related complications, are detailed more extensively in the subsequent section.

Reproductive Tract Infections
Most STIs are part of a broader group of infections known as reproductive tract infections (RTIs). While some RTIs may be caused by sexual contact, others may be the result of an overgrowth of bacteria or other organisms in the reproductive tract, such as yeast in the vagina. While some RTIs may cause only mild discomfort, others can be extremely serious. Additionally, any infection that causes skin irritation in or around the vagina increases the risk of HIV infection.

Not All STIs Are RTIs
Though HIV can be contracted through sexual contact, it is not an RTI. Hepatitis B and C are other examples of STIs that are not RTIs. There are limited references to Hepatitis B and C in this training. HIV is included more extensively but not exhaustively. There are numerous resources that address HIV more comprehensively. For information on HIV and hepatitis infections, diagnosis, and treatment, refer to local guidelines or, for HIV information, refer to one of the resources listed below.


Presenting Symptoms
Just as not all STIs are RTIs, not all RTIs are the result of sexual contact. When a PAC client reports symptoms related to the reproductive tract (such as discharge, itching, pain, sores, and/or swelling), the provider must determine if the client has an RTI or an STI (or in some cases, both). Additionally, providers should be alert to the symptoms of RTIs and STIs among PAC clients. However, providers must also recognize that telling a client they have an STI can have serious and often negative consequences for the client as well as their sexual partner(s), and therefore should only provide such a diagnosis when it is absolutely certain.

The table below and on the following pages outlines common RTI and STI pathogens and symptoms. A client presenting with one of these symptoms may or may not have an RTI and/or STI; further evaluation is essential to determining the diagnosis. Further, sometimes clients with viral infections and female clients with chlamydia and gonorrhea may be asymptomatic.

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>Symptoms and Associated Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bacterial Infections</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Chlamydia Trachomatis | Chlamydia Infection  
*Women:* Cervicitis, endometritis, infertility, PID, perihepatitis, preterm rupture of membranes, salpingitis; also commonly asymptomatic  
*Men:* Epididymitis, infertility, orchitis, urethral discharge (urethritis)  
*Both sexes:* Pharyngitis, proctitis, reactive arthritis (Reiter’s syndrome) |
### Reproductive Tract and Sexually Transmitted Infections: Pathogens and Symptoms (continued)

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>Symptoms and Associated Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bacterial Infections (continued)</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Chlamydia Trachomatis Serovars L1–L3** | Lymphogranuloma Venereum  
*Both sexes*: inguinal swelling (bubo), proctitis, ulcer |
| Haemophilus Ducreyi | Chancroid  
*Both sexes*: painful genital ulcers; may be accompanied by inguinal swelling |
| Klebsiella (Calymmatobacterium) Granulomatis | Donovansiosis (Granuloma Inguinale)  
*Women*: Cervicitis, endometritis, PID  
*Men*: Urethral discharge (nongonococcal urethritis)  
*Both sexes*: Nodular swellings, ulcerative lesions on anogenital and inguinal areas |
| Mycoplasma Genitalium |  
*Women*: Cervicitis, endometritis, PID  
*Men*: Urethral discharge (nongonococcal urethritis) |
| Neisseria Gonorrhoeae | Gonorrhea  
*Women*: Cervicitis, endometritis, infertility, PID, perihepatitis, preterm rupture of membranes, salpingitis; also commonly asymptomatic  
*Men*: Epididymitis, infertility, orchitis, urethral discharge (urethritis) |
| Treponema Pallidum | Syphilis  
*Women*: Pregnancy wastage (abortion, stillbirth), premature delivery  
*Both sexes*: Bone, cardiovascular, and neurological damage; condylomata lata; primary ulcer (chancre) with local adenopathy; skin rashes |
| **Viral Infections** | |
| Cytomegalovirus | Cytomegalovirus Infection  
*Both sexes*: Diffuse lymph node swelling, liver disease, nonspecific or subclinical fever |
| Hepatitis B Virus | Viral Hepatitis  
*Both sexes*: Acute hepatitis, liver cancer, liver cirrhosis |
| Herpes Simplex Virus (HSV) Type 2  
HSV Type 1 (less common) | Genital Herpes  
*Both sexes*: Anogenital vesicular lesions and ulcerations |
### Reproductive Tract and Sexually Transmitted Infections: Pathogens and Symptoms (continued)

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>Symptoms and Associated Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Viral Infections (continued)</strong></td>
<td></td>
</tr>
<tr>
<td>HIV (human immunodeficiency virus)</td>
<td>AIDS (Acquired Immunodeficiency Syndrome)</td>
</tr>
<tr>
<td></td>
<td><em>Both sexes: HIV-related diseases, AIDS</em></td>
</tr>
<tr>
<td>Human Papillomavirus (HPV)</td>
<td>Genital Warts</td>
</tr>
<tr>
<td></td>
<td><em>Women: Anal, cervical, and vulval carcinoma; anal, cervical, and vulval warts</em></td>
</tr>
<tr>
<td></td>
<td><em>Men: Anal and penile warts, penile carcinoma</em></td>
</tr>
<tr>
<td>Kaposi Sarcoma-Associated Herpesvirus (human</td>
<td>Kaposi Sarcoma</td>
</tr>
<tr>
<td>herpesvirus type 8)</td>
<td><em>Both sexes: Aggressive cancer in immunosuppressed persons</em></td>
</tr>
<tr>
<td>Molluscum Contagiosum Virus</td>
<td>Molluscum Contagiosum</td>
</tr>
<tr>
<td></td>
<td><em>Both sexes: Genital or generalized umbilicated, firm skin nodules</em></td>
</tr>
<tr>
<td><strong>Protozoal Infection</strong></td>
<td></td>
</tr>
<tr>
<td>Trichomonas Vaginalis</td>
<td>Trichomoniasis</td>
</tr>
<tr>
<td></td>
<td><em>Women: Low-birth-weight babies, preterm birth, vaginosis with profuse frothy vaginal discharge</em></td>
</tr>
<tr>
<td></td>
<td><em>Men: Urethral discharge (nongonococcal urethritis); also commonly asymptomatic</em></td>
</tr>
<tr>
<td></td>
<td><em>Infants: Low birth weight</em></td>
</tr>
<tr>
<td><strong>Fungal Infection</strong></td>
<td></td>
</tr>
<tr>
<td>Candida Albicans</td>
<td>Candidiasis</td>
</tr>
<tr>
<td></td>
<td><em>Women: Vulval itching or burning, vulvo-vaginitis with thick curd-like vaginal discharge</em></td>
</tr>
<tr>
<td></td>
<td><em>Men: Superficial infection of the glans penis</em></td>
</tr>
<tr>
<td><strong>Parasitic Infection</strong></td>
<td></td>
</tr>
<tr>
<td>Phthirus Pubis</td>
<td>Pubic Lice Infestation</td>
</tr>
<tr>
<td>Sarcopes Scabiei</td>
<td>Scabies</td>
</tr>
</tbody>
</table>


**Although some vaginal discharge is normal, an RTI can alter normal vaginal discharge (for example, changes in amount, color, consistency, and odor), in addition to causing vaginal burning, itching, or pain.**
The table below provides additional information on case definitions, including presumed causes and guidance for recording notes.

<table>
<thead>
<tr>
<th>Case Definition</th>
<th>Presumed Cause</th>
<th>Notes on Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Genital Ulcer Disease</strong></td>
<td>Genital ulcer disease syndrome can be caused by chancroid, granuloma inguinale, herpes, lymphogranuloma venereum, or syphilis.</td>
<td>All primary syphilis cases (etiological reports meeting case definition) should also be reported as genital ulcer disease, unless the chancres are extra genital.</td>
</tr>
<tr>
<td><strong>Lower Abdominal Pain</strong></td>
<td>Lower abdominal pain—when accompanied by abnormal vaginal discharge, cervical motion tenderness, and pelvic tenderness (with or without fever) can suggest PID.</td>
<td>Gonorrhea cases among female clients (etiological reports meeting case definition) should also be reported as lower abdominal pain if that is the presenting syndrome.</td>
</tr>
<tr>
<td><strong>Urethral Discharge</strong></td>
<td>Urethral discharge syndrome is commonly caused by chlamydia trachomatis or neisseria gonorrhea. Other infective and infection agents associated include mycoplasma genitalium, trichomonas vaginalis, and ureaplasma urealyticum.</td>
<td>Most cases of gonorrhea in male clients (etiological reports meeting case definition) should also be reported as urethral discharge.</td>
</tr>
<tr>
<td><strong>Vaginal Discharge</strong></td>
<td>Vaginal discharge syndrome is normally caused by bacterial vaginosis, trichomoniasis, or vulvovaginal candidiasis. It is less frequently caused by cervical chlamydia or gonorrhea infections.</td>
<td>Gonorrhea among female clients (etiological reports meeting case definitions) should also be reported as genital ulcer disease.</td>
</tr>
</tbody>
</table>


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### Overview of Common Reproductive Tract Infections and Sexually Transmitted Infections

This section provides an overview of common RTIs and STIs, including cervical infections (such as chancroid, chlamydia, genital herpes, genital ulcers, gonorrhea, HPV, PID, and syphilis) as well as vaginal infections (such as bacterial vaginosis, candidiasis, and trichomoniasis). **Note:** The content contained within this section is largely adapted from *Guidelines for the Management of Symptomatic Sexually Transmitted Infections.*

**Self-Collection of Samples for Testing**

Self-collection of samples for laboratory STI screening is gaining popularity. The WHO recommends self-collection of samples for chlamydia, gonorrhea, HIV, HPV, syphilis, and trichomonas to support demand for and uptake of STI services. Laboratory tests include molecular testing (a new standard in high-income countries) as well as culture methods and microscopy.


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Bacterial Vaginosis

Bacterial vaginosis is an overgrowth of normally occurring bacteria in the vagina. While the cause of this RTI is unclear, it is generally not considered an STI. Bacterial vaginosis is often referred to by other names, such as gardnerella and haemophilus, two of the common microorganisms found in this infection. Because bacterial vaginosis can lead to other reproductive issues (see Complications), diagnosis and treatment are important. While it is an infection of the vagina, men can also spread bacterial vaginitis from one partner to another.

Signs and Symptoms

While some people do not experience symptoms, bacterial vaginosis typically causes a grey-colored, foul-smelling (“fishy”) vaginal discharge, which may or may not be accompanied by itching or irritation. While bacterial vaginosis is an infection of the vagina, men can spread this infection but are typically asymptomatic.

Complications

Bacterial vaginosis can lead to problems in pregnancy (including spontaneous abortion, premature birth, and low birth weight) and PID, and can increase the risk of contracting STIs.

Treatment

Preferred treatment options include:

- Metronidazole, 2 g administered orally, as a single dose
- Metronidazole, 400 or 500 mg administered orally, twice daily for seven days

**Note:** Do not give metronidazole to pregnant clients before the fourth month of pregnancy.

Alternative treatment options include:

- Clindamycin cream 2%, one full applicator (5 g) administered intravaginally, once daily at bedtime for seven days
- Clindamycin, 300 mg administered orally, twice daily for seven days

Treatment for clients who are pregnant (after the first trimester for metronidazole) or breastfeeding include:

- Clindamycin, 300 mg administered orally, twice daily for seven days
- Metronidazole, 200 mg or 250 mg administered orally, three times daily for seven days
- Metronidazole gel 0.75%, one full applicator (5 g) administered intravaginally, twice daily for five days

Infections Discussed in this Section

- Bacterial Vaginosis
- Candidiasis
- Chancroid
- Chlamydia
- Genital Herpes
- Genital Ulcers
- Gonorrhea
- Human Papillomavirus (HPV)
- Pelvic Inflammatory Disease (PID)
- Syphilis
- Trichomoniasis
Candidiasis (Vulvovaginal Candidiasis)
Candidiasis—commonly known as a yeast infection—is an overgrowth of normally occurring organisms in the vagina. Common causes of this RTI include pregnancy, use of antibiotics, use of oral contraceptives, frequent exposure to semen over a short period of time, and diabetes. Immunocompromised persons and those with metabolic conditions also have a higher risk of this RTI than their peers. Rarely, candidiasis can be spread sexually.

**Signs and Symptoms**
Common vaginal symptoms of candidiasis include burning, itching, and irritation, as well as thick white discharge. Candidiasis can similarly appear as an itchy rash on male genitalia.

**Complications**
Candidiasis does not infect the fallopian tubes or uterus and does not affect fertility. However, it may cause severe irritation, damage the skin, and can be uncomfortable enough to require treatment.

**Treatment**
Treatment options for female clients include:
- Nystatin, 100,000-unit tablet administered intravaginally, once daily for 14 days
- Miconazole, 200 mg suppository administered intravaginally, once daily for three days
- Miconazole, 100 mg suppository administered intravaginally, once daily for seven days
- Clotrimazole, 500 mg tablet administered intravaginally, as a single dose
- Clotrimazole, 100 mg tablet administered intravaginally, once daily for seven days
- Clotrimazole, two 100 mg tablets administered intravaginally, once daily for three days

Treatment options for male clients include:
- Clotrimazole, miconazole, or nystatin, administered topically (as a cream or ointment) to the infected area twice daily for seven days

Chancroid
Chancroid, also called soft chancre, is an STI caused by Haemophilus ducreyi (H. ducreyi) bacteria. Chancroid cases are more common in countries where HIV prevalence is high; however, cases have been declining globally overall.

**Signs and Symptoms**
The most common symptoms are soft, painful blisters or sores (ulcers) on the anus, genitals, lips, and/or mouth. Additionally, swollen lymph glands containing pus in the groin area may occur and may open, drain, and cause scarring.

**Complications**
Chancroid is curable and complications are rare. However, if left untreated, chancroid may lead to fibrosis (scarring), rectovaginal fistulae, and/or swollen lymph glands in the groin that can rupture and drain pus.

**Treatment**
Chancroid ulcers are often confused with those of herpes or syphilis (although they are more similar to herpes ulcers, which are also usually painful, as compared to syphilis ulcers, which typically are not painful), so treatment for both is often given. Symptomatic treatment is not recommended for people with anogenital ulcers unless surveillance shows reported or emerging cases.

Chlamydia
Caused by Chlamydia trachomatis, chlamydia is one of the most common STIs, especially among adolescents and youth.
**Signs and Symptoms**

Many people with chlamydia (approximately 75% of women and up to 50% of men) are asymptomatic. Some women may experience an unusual vaginal discharge, bleeding after intercourse, or bleeding between menstrual periods and some men may present with a clear penile discharge, pain or burning with urination, or swollen and tender testicles. Additionally, the same bacteria that causes chlamydia can cause lymphogranuloma venereum, the symptoms of which include genital sores (ulcers) and swollen lymph nodes (buboes).

**Complications**

If inadequately treated or if left untreated, chlamydia can spread to the pelvic area and infect the fallopian tubes, ovaries, and uterus leading to PID and can be passed from mother to baby during birth, infecting the baby’s eyes (and potentially causing serious damage including blindness). Untreated chlamydia can also affect the testicles and cause sterility in men. If left untreated, chlamydia can also increase the risk of HIV.

**Treatment**

Preferred treatment options include:

- Azithromycin, 1 g administered orally, as a single dose
- Doxycycline, 100 mg administered orally, twice daily for seven days (*Note: Do not give doxycycline to pregnant or breastfeeding clients.*)

Alternative treatment options include:

- Erythromycin, 500 mg administered orally, four times daily for seven days
- Ofloxacin, 200 to 400 mg administered orally, twice daily for seven days
- Tetracycline, 500 mg administered orally, four times daily for seven days (*Note: Do not give tetracycline to pregnant or breastfeeding clients.*)

Treatment options for clients who are pregnant, breastfeeding, or less than 16 years of age include:

- Azithromycin, 1 g administered orally, as a single dose
- Amoxicillin, 500 mg administered orally, three times daily for seven days
- Erythromycin, 500 mg administered orally, four times daily for seven days

*Note: Azithromycin is the preferred treatment because it is less expensive than erythromycin and, since it is administered as a single dose, may result in better adherence and therefore better outcomes. However, it may not be available in some settings.*

For additional guidance, refer to the WHO Guidelines for Treatment of Chlamydia Trachomatis.159

**Genital Herpes**

A herpes infection is typically contracted through direct contact with the painful ulcers that the infection causes, but can also be contracted after the ulcers have healed or before an outbreak has occurred. Herpes can be transmitted from genital to genital during vaginal and anal sex as well as between mouth and genital during oral sex. While the initial herpes ulcers will heal within one or two weeks, the virus will remain in the body afterward, causing recurring outbreaks in which the sores return. These recurring outbreaks can happen weeks, months, or even years apart.

**Signs and Symptoms**

The most common symptoms are painful blisters or sores (ulcers) on the anus, genitals, lips, and/or mouth. The ulcers may last for weeks at initial infection and scab; repeated outbreaks typically do not last as long. Other symptoms include pain or burning with urination and itching or tingling sensations in the genital area.

**Complications**

In addition to the repeated—and often painful—outbreaks, genital herpes can be transmitted to a baby during pregnancy and delivery, which can cause the baby to become sick and possibly die.

Prevention

To prevent spreading the infection, clients should avoid sex when blisters are present, this includes avoiding sex and using a condom when engaging in sexual activity. As herpes can be spread when no blisters are present, using a condom is important for providing limited protection.

Treatment

While there is no cure for herpes, there are ways to relieve pain caused by the ulcers and to shorten the duration of symptoms, if treatment begins early in the outbreak. Self-care approaches that can help include keeping the infected area clean, not touching the sores, and using an antibiotic ointment. In addition to treating the client directly, it is important that the client’s sex partner(s) also seeks counseling, testing, and (if needed, particularly if symptomatic) treatment. Options for treating the first infection versus recurrent infections differ.

Preferred treatment options for a first episode include:

- Acyclovir, 200 mg administered orally, five times daily for seven days
- Acyclovir, 400 mg administered orally, three times daily for seven days

Alternative treatment options for a first episode include:

- Famciclovir, 250 mg administered orally, three times daily for seven days
- Valaciclovir, 1 g administered orally, twice daily for seven days

Preferred treatment options for a recurrent infection include:

- Acyclovir, 200 mg administered orally, five times daily for five days
- Acyclovir, 400 mg administered orally, three times daily for five days

Note: For clients who are pregnant, breastfeeding, or less than 16 years of age, only use acyclovir (at the same dosage as for primary infection) when the benefit outweighs the risk.

Alternative treatment options for a recurrent infection include:

- Famciclovir, 125 mg administered orally, three times daily for five days
- Valaciclovir, 500 mg administered orally, twice daily for five days

For clients who experience more than six outbreaks a year, treat with acyclovir, 400 mg administered orally, twice daily for one year and then reassess.

Genital Ulcers

Herpes simplex virus 2 (HSV-2) has become the most frequent cause of genital ulcer disease in many parts of the world. The other two most common genital ulcer diseases are chancroid and syphilis; chlamydia may also cause genital ulcers. In settings where HIV is prevalent, an increasing proportion of genital ulcer disease is likely to be due to HSV-2. HSV-2 in clients living with HIV may persist for a longer time than in other clients.

Diagnosis

Laboratory diagnosis of genital ulcer disease is rarely useful at the initial client visit and may even be misleading. Differential diagnosis of genital ulcers using clinical features is often inaccurate, especially where several types of genital ulcer diseases are common. In settings where syphilis is prevalent, a client may have a reactive serological test from a previous infection, even when chancroid or herpes is the cause of the present ulcer. Clinical manifestations and patterns of genital ulcer disease may also be different in people living with HIV.

Treatment

If the client evaluation confirms the presence of genital ulcers, providers should ideally provide treatment at the initial visit, following local protocols, to ensure adequate therapy in case the client does not return for follow-up care. General recommendations for treating clients presenting with signs of genital ulcers include:

- Treat for chancroid and syphilis in settings where both conditions are prevalent.
- Provide HSV-2 management, if available, where HSV-2 prevalence is 30% or greater. Note: While there is no
cure for HSV-2, antiviral treatment can shorten the duration of active disease and may help reduce transmission. In settings where antivirals are scarce, treatment should be reserved for clients with severe HSV-2 or herpes zoster infection—both of which are associated with HIV infection.

- Follow local guidelines for adding treatment for granuloma inguinale and/or lymphogranuloma venereum.
- Refer clients with any fluctuant glands for aspiration (avoid surgical incision).
- Provide clients with self-care guidance, including keeping the lesion clean and dry and observing proper hygiene (especially handwashing after touching the genital area), and provide counseling on treatment protocols (as relevant) and risk reduction.
- Provide condoms and provide or refer clients for HIV counseling and testing, as appropriate.

Additional treatment guidance for different infections causing genital ulcers is included in each infection summary section.

Gonorrhea

The bacteria that cause gonorrhea, Neisseria gonorrhoeae, grow in the warm, moist parts of the body, such as the cervix, rectum, and urethra. Gonorrhea can also infect the throat as a result of oral–genital sexual activity with a partner who is infected. Laboratory testing (molecular testing [nucleic acid assay], microscopy, and culture) is recommended to confirm a diagnosis.

Signs and Symptoms

Many people with gonorrhea do not experience any noticeable signs or symptoms. Common symptoms among women include purulent vaginal discharge (which is often yellow-green in color and is sometimes referred to as mucopurulent) and painful (burning) urination. Common symptoms among men include a cloudy or pus-like penile discharge, pain or burning with urination, as well as swollen, tender testicles. Infections in the rectum often have no symptoms, whereas infections in the throat may cause sore throats.

Complications

If inadequately treated or if left untreated, gonorrhea can spread to the pelvic area and infect the fallopian tubes, ovaries, and uterus. Signs that the infection has spread include abdominal or lower back pain, pain during intercourse, bleeding between periods, and fever. These types of pelvic infections can become serious, including creating fertility issues and even sterility, and therefore require immediate medical care. The infection can also be passed from a mother to baby during birth, infecting the baby's eyes (and potentially causing serious damage including blindness). Untreated gonorrhea can also infect the epididymides and cause sterility in men. If left untreated, gonorrhea can also increase the risk of HIV.

Diagnosis

PAC clients should be screened for gonorrhea during the assessment stage. A gonorrhea test is useful for ruling out an infection; however if testing is not possible, chlamydia and gonorrhea infections can be treated empirically and simultaneously.

Treatment

There are dual therapy and single therapy options for treatment. Treatment should be determined based on local resistance data related to antimicrobial susceptibility. Dual therapy options include:

- Ceftriaxone, 250 mg administered via intramuscular injection, as a single dose combined with azithromycin, 1 g administered orally, as a single dose
- Cefixime, 400 mg administered orally, combined with azithromycin, 1 g administered orally, as a single dose

Single therapy option includes:

- Ceftriaxone, 250 mg administered via intramuscular injection, as a single dose
- Cefixime, 400 mg administered orally, as a single dose
- Spectinomycin, 2 mg administered via intramuscular injection, as a single dose
Treatment options for clients who are pregnant, breastfeeding, or less than 16 years of age include:

- Ceftriaxone, 250 mg administered via intramuscular injection, as a single dose
- Cefixime, 400 mg administered orally, as a single dose

**Re-Treatment after Reinfection or Treatment Failure**

Before initiating re-treatment, it is important to distinguish between reinfection and treatment failure and to obtain resistance data, where available. For suspected reinfection cases, re-treat according to the treatment regimen detailed previously, reinforce sexual abstinence or condom use, and provide treatment to the client’s partner. If treatment failure occurred and resistance data are available, re-treat according to susceptibility.

It is important to follow the WHO-recommended treatment regimen; if treatment failure occurred after treatment with a different regimen, re-treat with a WHO-recommended regimen. If treatment failure occurred after treatment with one of the WHO-recommended single therapy regimens, re-treat with a WHO-recommended dual therapy regimen. If treatment failure occurred after treatment with a WHO-recommended dual therapy regimen, re-treat with one of the following dual therapies:

- Ceftriaxone, 500 mg administered via intramuscular injection, as a single dose combined with azithromycin, 2 g administered orally, as a single dose
- Cefixime, 800 mg administered orally, as a single dose combined with azithromycin, 2 g administered orally, as a single dose
- Gentamycin, 240 mg administered via intramuscular injection, as a single dose combined with azithromycin, 2 g administered orally, as a single dose
- Spectinomycin, 2 mg administered via intramuscular injection, as a single dose (if not an oropharyngeal infection) combined with azithromycin, 2 g administered orally, as a single dose

For additional guidance, refer to the WHO Guidelines for Treatment of Neisseria Gonorrhoeae.160

**HPV**

Human papillomavirus, commonly known as HPV, is the most prevalent STI in the world. Human papillomaviruses are a group of more than 100 viruses and are called papillomaviruses because certain types can cause warts (condylomata acuminatum), or papillomas, which are typically benign (noncancerous) tumors. There are several types of HPV and both sexes can become infected.

An active infection is typically controlled by the immune system and, with time, becomes dormant. It is not possible to predict whether or when the virus will become active again. HPV can be transmitted when the virus is active. Clients may assume that if no warts are visible, they are not at risk for transmitting HPV; therefore, it is important to emphasize that transmission can occur when there are no visible signs of infection.

**Signs and Symptoms**

Many people with HPV do not experience any noticeable signs or symptoms. The most common symptom of HPV is warts appearing around the anal and/or genital areas. These warts are most commonly associated with HPV-6 and HPV-11. The warts may appear within several weeks of sexual contact with an infected person, may take months or even years to appear, or may never appear. HPV may also cause flat, abnormal growths on the cervix and in the genital area.

**Complications**

Certain types of aggressive HPV can cause abnormal changes in cervical cells, which, if left untreated, can lead to cervical cancer (although this may take up to 15 to 20 years after the initial exposure, or less among people living with HIV). In fact, HPV is now recognized as the primary cause of cervical cancer—with nearly all cervical cancers directly linked to previous infection of one or more types of HPV. Cervical cancer affects nearly half a million people worldwide every year, claiming a quarter-million lives. Therefore, HPV screenings are critical to preventing cervical cancer. Certain types of HPV, if left untreated, can similarly lead to anal and penile cancer. The types of HPV that cause genital warts are different from the types that cause cancer.

Hormonal changes associated with pregnancy can cause warts to bleed and grow in number or size (but will shrink after birth). The warts can also make delivery difficult and can infect the baby during pregnancy or delivery, causing the baby to potentially develop warts around the anus, genitals, or (more rarely) in the throat.

**Prevention**

There are vaccines that can prevent certain strains of HPV, especially those associated with anal, cervical, penile, and head and neck cancers. These vaccines have the potential to help eliminate cervical cancer and are now included in national immunization programs in many countries.

**Diagnosis**

It is important to identify and treat precancerous warts early—before the warts progress to cancer. Molecular testing, visual inspection using a dilute solution of acetic acid, is as an acceptable alternative to Pap smears for diagnosis. Self-test kits are also available to help with early identification.

**Treatment**

Currently, there is no cure for HPV. Although genital warts can be removed, HPV can stay in the body after removal—therefore, once infected, a person is infected for life and it is important to advise clients that warts will often reappear after treatment.

There are several options for treating anal and genital warts. One option involves carefully applying podophyllin 10–25% in a compound tincture of benzoin to the warts, avoiding normal tissue. External genital and perianal warts should be washed thoroughly one to four hours after applying the podophyllin. Podophyllin applied to warts on anal or vaginal epithelial surfaces should dry before the speculum is removed. This approach requires repeat applications at weekly intervals and should not be used during pregnancy. Another option is to carefully apply a trichloroacetic acid (80–90%) to the warts, avoiding normal tissue, and then powdering the treated area with sodium bicarbonate to remove any unreacted acid. This approach requires repeat applications at weekly intervals. Genital warts can also be treated by cryotherapy, electrosurgery, or surgical removal. Cryotherapy, an outpatient treatment that uses a liquid coolant to destroy abnormal cervical tissue, is highly effective and has been used extensively throughout the world for decades. Selection of a removal method will depend on the methods available and the anatomical location of the warts.

For additional guidance, refer to the Sexually Transmitted Infection Treatment Guidelines.161

**PID**

Pelvic inflammatory disease, or PID, is an infection of the internal organs, that can affect the fallopian tubes, ovaries, uterus, and surrounding pelvic tissues, which can become inflamed, irritated, and swollen. PID is caused by several types of bacteria and other microorganisms. Chlamydia causes nearly half of all cases of PID and gonorrhea causes another large percentage of cases.

**Signs and Symptoms**

The primary symptom of PID is lower abdominal or pelvic pain. In mild cases, this may be only slight cramping, while in severe cases the pain may be intense—and physical activity, especially sexual intercourse, may greatly increase this pain. Another common symptom is abnormal vaginal bleeding—including extremely heavy menstrual periods and/or bleeding (or spotting) between periods. In some cases, abnormal vaginal discharge and fever may also be present. Other signs that may present during a physical examination include cervical motion tenderness on vaginal exam and tenderness during palpation of the abdomen.

**Complications**

The complications of PID can be very serious. They include:

- **Repeat PID.** Clients who have had PID previously are extremely likely to become infected again if they are at risk of contracting STIs.
- **Pelvic abscess.** A pelvic abscess is a local collection of pus in the pelvis formed by deteriorated tissue. A pelvic abscess, which can occur in severe cases of PID, requires hospitalization, intravenous antibiotic treatment, and frequently surgery.

• **Infertility.** After the infection heals, scar tissue can form around the pelvic organs, cause blockages and distort the fallopian tubes, and prevent an egg from traveling to the uterus. Tubal factors account for 25 to 35% of cases of female infertility, with PID being the causative factor in more than half. The risk of tubal infertility increases with recurrent PID and, after three episodes, more than 50% of women will have tubal dysfunction.162

• **Chronic pelvic pain.** The scar tissue associated with PID can also distort the pelvic organs resulting in chronic pelvic pain or discomfort. Surgery may be required in severe cases.

• **Ectopic pregnancy.** An ectopic pregnancy—a pregnancy that occurs outside the uterus, most commonly in the fallopian tubes—is an extremely serious condition that requires surgery. Because PID can distort and create blockages in the fallopian tubes, clients with a history of PID are at greater risk of ectopic pregnancy.

### Treatment

Treating PID requires treating the underlying causes: chlamydia, gonorrhea, and anaerobic infections. The table below provides outpatient treatment options for PID cases; treatment requires selecting one option for each infection (three medications in total).

<table>
<thead>
<tr>
<th>Infection</th>
<th>Treatment Options (select one for each infection)</th>
</tr>
</thead>
</table>
| Chlamydia  | • Doxycycline, * 100 mg administered orally, twice daily for 14 days  
• Tetracycline, * 500 mg administered orally, four times daily for 14 days |
| Gonorrhea† | • Ceftriaxone, 250 mg administered via intramuscular injection, as a single dose  
• Cefixime, 400 mg administered orally, as a single dose  
• Spectinomycin, 2 g administered via intramuscular injection, as a single dose |
| Anaerobes  | • Metronidazole, ‡ 400 to 500 mg administered orally, twice daily for 14 days |

* Do not give doxycycline or tetracycline to pregnant or breastfeeding clients.

† Consider Neisseria gonorrheae resistance, such as in some parts of Southeast Asia and Western Pacific, when selecting treatment.

‡ Clients taking metronidazole should avoid consuming alcohol. Do not give metronidazole to pregnant clients in the first trimester.

### Syphilis

Syphilis is caused by an organism called Treponema pallidum. Syphilis is curable, but if not treated promptly or adequately, will progress through four stages of increasingly serious symptoms.

#### Signs and Symptoms

Syphilis, if untreated or insufficiently treated, will progress through four stages: primary, secondary, latent, and tertiary—each with its own signs and symptoms.

- **Primary syphilis.** The first symptom of a syphilis infection is usually a small, painless sore in the area of sexual contact (for example, mouth, penis, rectum, or vagina). The sore will typically appear two to six weeks after exposure and then disappear within a few weeks. Because the sores are painless, many people do not realize they are infected at this time.

- **Secondary syphilis.** If left untreated, shortly after the initial sore heals, secondary symptoms may begin. These symptoms include body rash (especially the palms of the hand or soles of the feet, not itchy), fatigue, fever, swollen lymph nodes, or warts. These symptoms may last from two to six weeks and will eventually dissipate, even without treatment—although the infection will remain.

- **Latent syphilis.** If left untreated, the infection will enter a latent phase—a period in which there are no visible signs or symptoms. This period can last anywhere from 2 to 30 years or more.

Note: Nontreponemal tests (such as rapid plasma reagin) and venereal disease research laboratory tests are preferred for syphilis screening during this period. Treponemal tests (such as treponema pallidum hemagglutination assay), if available, can be used to confirm nontreponemal test results.

- Tertiary syphilis. Symptoms at this late stage of syphilis can occur anywhere from 2 years to 30 years or more after the initial infection. Complications during this stage can include blindness, gummas (small bumps or tumors on the bones, skin, and liver or other organs), insanity, and paralysis. If treated during this period, gummas will usually disappear. Though treatment at this phase will treat the disease and stop future damage, it cannot repair or reverse the damage that occurred before treatment.

Complications
As detailed above, untreated or inadequately treated syphilis can progress, producing different symptoms and complications at different stages. Additionally, syphilis can affect pregnancy—causing premature delivery and spontaneous abortion—and can affect the baby during pregnancy or delivery, causing the baby to potentially suffer blindness, severe organ damage, or even death. Clients with recurrent spontaneous abortions or miscarriages should be screened for syphilis, and, if positive, receive the recommended treatment. If left untreated, syphilis can also increase the risk of HIV.

Treatment
Syphilis is curable with antibiotics; however, complications that may develop in later stages cannot be reversed even with treatment. Given the potential severity of the symptoms and complications, all clients with syphilis should be encouraged to ensure that their partner also seeks testing and treatment. Treatment varies depending on the duration of the infection and whether the client is allergic to penicillin (see text box).

The preferred treatment for clients with primary, secondary, or latent syphilis of two years or less who do not have a penicillin allergy is:
- Benzathine penicillin, 2.4 million units administered via intramuscular injection, as a single dose; clients with a positive test but no ulcer should receive two additional doses of 2.4 million units each at one-week intervals

The treatment options for nonpregnant clients (including PAC clients) with primary, secondary, or latent syphilis of two years or less, who are allergic to penicillin include:
- Azithromycin, 2 g administered orally, as a single dose
- Ceftriaxone 1 g administered via intramuscular injection, once daily for 10 to 14 days
- Doxycycline, 100 mg administered orally, twice daily for 14 days

The treatment options for pregnant clients with primary, secondary, or latent syphilis of two years or less, who are allergic to penicillin include:
- Azithromycin, 2 g administered orally, as a single dose (Note: Use only in special circumstances.)
- Ceftriaxone, 1 g administered via intramuscular injection, once daily for 10 to 14 days
- Erythromycin, 500 mg administered orally, four times daily for 14 days

Note: While azithromycin and erythromycin will treat the pregnant client, they will not cross the placental barrier completely and thus do not treat the fetus. It is therefore necessary to treat the newborn within seven days of delivery.

The preferred treatment for clients with late latent syphilis or latent syphilis of an unknown duration, who do not have a penicillin allergy is:
- Benzathine penicillin, 7.2 million units administered as intramuscular injections, in three doses of 2.4 million units each at one-week intervals

Penicillin Allergy
A client with a penicillin allergy will experience symptoms of anaphylaxis including severe abdominal cramps and diarrhea, difficulty breathing and swallowing, dizziness, facial swelling, hives and itching (widespread), mental confusion, nausea and vomiting, sudden drop in blood pressure, weak and rapid pulse, and in some cases, loss of consciousness. These symptoms typically occur within 20 minutes of a penicillin injection. In general, treatment involves maintaining an airway and giving epinephrine and oxygen.
The treatment options for nonpregnant clients with late latent syphilis or latent syphilis of an unknown duration, who are allergic to penicillin include:

- Doxycycline, 100 mg administered orally, twice daily for 30 days (Note: If more than one day of treatment is missed, the entire course must be restarted.)

The treatment options for pregnant clients with late latent syphilis or latent syphilis of an unknown duration, who are allergic to penicillin include:

- Erythromycin, 500 mg administered orally, four times daily for 30 days (Note: If more than one day of treatment is missed, the entire course must be restarted.)

For additional guidance, refer to the WHO Guidelines for Treatment of Treponema Pallidum (Syphilis).163

**Trichomoniasis**

Trichomonas vaginalis is a microscopic organism that causes the STI trichomoniasis.

**Signs and Symptoms**

Some people may be infected for months or even years without experiencing any symptoms. Common symptoms, when they occur, include increased, unusual, and foul-smelling vaginal discharge (which may be bubbly or frothy and green in color) as well as burning, itching, and/or soreness of the vulva. Similarly, men may report penile discharge as well as frequent and burning urination. A pelvic exam may reveal a bubbly or frothy cervical discharge and red spots on the cervix, just as an examination of the penis may reveal some discharge.

**Complications**

Trichomoniasis does not lead to serious complications; however, recent evidence indicates that it may be associated with premature birth. Additionally, trichomoniasis can cause skin irritation in and around the vagina, which can increase the risk of HIV.

**Treatment**

Clients with trichomoniasis should be encouraged to ensure that their partner also seeks testing and treatment and to avoid sexual activity until they (and their partners) have completed treatment and are no longer symptomatic. Preferred treatment options include:

- Metronidazole, 2 g administered orally, as a single dose
- Metronidazole, 400 or 500 mg administered orally, twice daily for seven days

*Note: Do not give metronidazole to pregnant clients in the first trimester.*

Alternative treatment options include:

- Tinidazole, 2 g administered orally, as a single dose
- Tinidazole, 500 mg administered orally, twice daily for seven days

Treatment options for clients who are in their first trimester of pregnancy or who are breastfeeding include:

- Clindamycin, 300 mg administered orally, twice daily for seven days
- Metronidazole, 200 mg or 250 administered orally, three times daily for seven days
- Metronidazole gel 0.75%, one full applicator (5 g) administered intravaginally, twice daily for five days

*Note: Clients taking metronidazole or tinidazole should be advised to avoid drinking alcohol as it may cause nausea and vomiting.*

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Diagnosing Common Reproductive Tract and Sexually Transmitted Infections

Growths, sores, swollen lymph nodes, and ulcers in the genital area; burning and painful urination; and penile and vaginal discharge, irritation, and itching are all common signs and symptoms of RTIs and STIs that require clinical diagnosis. Many PAC clients diagnosed with an RTI or STI are primarily concerned with whether the infection can be cured or treated. In counseling a PAC client with an STI or RTI, it is important to remember the following:

- Most RTIs and STIs can be treated and many can be cured. Treatment varies depending on the specific infection; however, regardless of infection, the client must complete the prescribed treatment regimen, even if symptoms disappear before the treatment is complete. If treatment is discontinued prematurely, there is a potential for any remaining microorganisms to multiply and spread, causing symptoms to reoccur.

- If a client is diagnosed with an STI, their partner(s) is also likely infected, even if they are asymptomatic. Therefore, it is important to counsel clients to encourage their partners to seek testing and treatment. Otherwise, the untreated partner can reinfect the client. Additionally, both partners should complete the prescribed treatment before engaging in sexual activity to prevent reinfection.

- Using condoms correctly and consistently (with every sexual contact) is the best way to lower the risk of STIs. Engaging in a monogamous sexual relationship with a partner who is not infected can also protect against STIs—as long as both partners remain monogamous. The only way to fully protect against STIs is to abstain from all sexual contact.

The table below and on the following page lists typical symptoms associated with common RTIs and STIs.

<table>
<thead>
<tr>
<th>Symptoms Experienced by Females</th>
<th>Symptoms Experienced by Males</th>
<th>Likely Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Grey-colored, foul-smelling (“fishy”) vaginal discharge</td>
<td>Not applicable (N/A)</td>
<td>Bacterial vaginosis</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> While this is a RTI common among female clients, asymptomatic male partners can spread the infection.</td>
<td></td>
</tr>
<tr>
<td>• Vaginal itching or irritation</td>
<td>• Itchy rash in genital area</td>
<td>Candidiasis</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> While this is an RTI common among female clients, male partners may experience symptoms.</td>
<td></td>
</tr>
<tr>
<td>• Thick white fluid vaginal discharge</td>
<td>• Soft, painful blisters or sores on the anus, genitals, lips, or mouth</td>
<td>Chancroid</td>
</tr>
<tr>
<td>• Vaginal itching or irritation</td>
<td>• Swollen lymph glands in the groin that can rupture and drain pus</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Symptoms may not appear for several months after infection.</td>
<td></td>
</tr>
<tr>
<td>• Vaginal discharge</td>
<td>• Pain or burning with urination</td>
<td>Chlamydia and/or gonorrhea</td>
</tr>
<tr>
<td><strong>Note:</strong> Symptoms usually appear soon after infection.</td>
<td>• Penile discharge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Swollen, tender testicles</td>
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<tr>
<td>• Painful blisters or sores on the anus, genitals, lips, and/or mouth and associated scabbing</td>
<td>• Painful blisters or sores on the anus, genitals, lips, and/or mouth and associated scabbing</td>
<td>Genital herpes</td>
</tr>
<tr>
<td>• Pain or burning with urination</td>
<td>• Pain or burning with urination</td>
<td></td>
</tr>
</tbody>
</table>
Symptoms of Common Reproductive Tract and Sexually Transmitted Infections (continued)

<table>
<thead>
<tr>
<th>Symptoms Experienced by Females</th>
<th>Symptoms Experienced by Males</th>
<th>Likely Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syphilis, if untreated or insufficiently treated, progresses through four stages: primary, secondary, latent, and tertiary—each with its own signs and symptoms (as below)</td>
<td>Syphilis, if untreated or insufficiently treated, progresses through four stages: primary, secondary, latent, and tertiary—each with its own signs and symptoms (as below)</td>
<td>Syphilis</td>
</tr>
<tr>
<td>• Primary: small, painless sore in area of sexual contact</td>
<td>• Primary: small, painless sore in area of sexual contact</td>
<td></td>
</tr>
<tr>
<td>• Secondary: body rash, fatigue, fever, swollen lymph nodes, and/or warts</td>
<td>• Secondary: body rash, fatigue, fever, swollen lymph nodes, and/or warts</td>
<td></td>
</tr>
<tr>
<td>• Latent: no symptoms</td>
<td>• Latent: no symptoms</td>
<td></td>
</tr>
<tr>
<td>• Tertiary: blindness, gummas (small bumps or tumors on the bones, skin, and liver or other organs), insanity, and paralysis</td>
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<td></td>
</tr>
<tr>
<td>• Burning, itching, and/or soreness of the vulva</td>
<td>• Frequent, burning urination</td>
<td>Trichomoniasis</td>
</tr>
<tr>
<td>• Increased, unusual, and foul-smelling vaginal discharge</td>
<td>• Penile discharge</td>
<td></td>
</tr>
</tbody>
</table>

Approaches to Diagnosis

There are several possible approaches to diagnosis—as summarized below. Providers should follow national and/or institutional protocols or guidelines and use what is available and appropriate in the local setting.

**Etiologic Diagnosis.** This is the most traditional and accurate approach. It is based on the results of laboratory or microscope tests (such as cultures). Though this approach is the most reliable, there are several challenges.

- It is expensive and time consuming.
- Depending on the test, it takes one to six days to obtain results, which delays treatment.
- The client must return for a second visit to receive results and treatment.
- It requires substantive resources, including needles and syringes for obtaining cultures, laboratory facilities with a centrifuge and a trained technician for completing testing.

**Syndromic Diagnosis.** In low-resource settings, syndromic diagnosis is often the most appropriate approach. Using the syndromic approach, a diagnosis is based on the identification of syndromes, which are combinations of symptoms that the client reports and signs that the provider observes. This approach uses simple flowcharts or diagrams of symptoms to effectively diagnose and initiate treatment for a client at a single visit. The main disadvantage of this approach is that it does not generally work well for cervical infections. Refer to the section entitled The Syndromic Approach to Management of Sexually Transmitted Infections for detailed information.

**Clinical Diagnosis.** This is the least reliable of the three approaches. With this approach, a provider obtains a client’s history and completes a physical exam but relies solely on their prior clinical experience to make the diagnosis. There are several challenges with this approach, including:

- Prior treatment by another clinician (or traditional provider) may alter the signs and symptoms.
- Providers—even experienced providers—can misdiagnose clients, especially in cases of mixed infections.
- Infections often vary in appearance upon examination and may not appear as identical or standard cases.
- The provider must be skilled in pelvic and speculum exams, differential diagnosis, basic laboratory techniques (such as microscopy), and must have the requisite supplies and equipment.
The Syndromic Approach to Management of Sexually Transmitted Infections

Note: The content contained within this section is adapted from Guidelines for the Management of Symptomatic Sexually Transmitted Infections.164

Rationale
The syndromic approach to management of STIs is commonly used in resource-limited settings because:

- Providers may be constrained by lack of time and resources to diagnose and treat STIs more conventionally.
- Providers may lack equipment or skills to diagnose STIs using laboratory tests and test results may not be available for several days, which makes follow-up care difficult, including in cases where:
  - Laboratory tests or reagents are unavailable.
  - Clients are seeking relief of symptoms immediately and/or may not be willing or able to return later for test results or treatment.
- Clients (and their partners) may not have the resources to present for testing and then again for treatment.

Elements of Success
- A reliable supply of required medications
- Referral clinics
- STI service delivery systems and structures within primary health centers
- Epidemiological surveillance systems to identify the most cost-effective antibiotics
- Readily and cheaply available condoms promoted to the public
- Mass media communication to increase awareness about STIs, promote condom use, support mutual monogamy, and encourage demand for treatment
- Contact tracing and treatment systems
- National standardized treatment protocols for STIs based on international guidelines, including the syndromic approach, that ensure adequate treatment at all levels and facilitate training and supervision

Advantages of Syndromic STI Management
- Improves clinical diagnosis and avoids ineffective treatment
- Can be learned by a variety of providers, including primary health workers, clinical officers, medical assistants, nurses, and/or midwives
- Allows for treatment of symptomatic clients in one visit
- Is effective for diagnosing urethral discharge in men and genital ulcers in men and women
- Can easily be integrated into other health services, such as PAC, assuming the availability of adequately trained providers, infrastructure, and commodities; this makes this approach to health service provision more client-friendly

Disadvantages of Syndromic STI Management
- Represents a missed opportunity to diagnose and treat individuals who are asymptomatic (symptoms may take up to two weeks to appear)
- Works well for detecting vaginal infections, but not for more serious, often asymptomatic cervical infections
- Potential for over-treatment as clients may be treated for multiple potential infections, despite having no or only one infection; this use of unnecessary medications is costly (particularly in low-resource settings) and may cause microorganisms to develop resistance to antimicrobial medications thereby limiting future treatment options

Syndromic STI Management Flowchart 1: Vaginal Discharge

1. Molecular assays for NG, CT or TV available for all patients
   - Conduct test
   - Results available same day?
     - Yes: Treat NG and/or CT based on test result
     - No: No
     - No: Test positive?
       - Yes: Treat NG and/or CT based on test result
       - No: No
       - No: Vaginal discharge present on genital exam

2. Low cost rapid point of care test for NG/CT available for all patients (molecular assays not available)
   - Conduct test
   - Test positive?
     - Yes: Treatment for BV and TV if abnormal vaginal discharge present or according to microscopy examination or molecular assay (for TV); treat for candidiasis if curd-like discharge and/or vaginal itchiness
     - No: No
     - No: Evidence of cervicitis

3. Speculum available and acceptable (molecular assays or rapid point of care tests not available or for some)
   - Perform speculum exam
   - Evidence of cervicitis
     - Yes: Treat NG+CT
     - No:
       - If woman at high risk for STI: Offer HIV testing and syphilis testing, and other preventive services

4. Speculum NOT available or NOT acceptable (tests not available)
   - Vaginal discharge present on genital exam
     - Yes: Offer HIV testing and syphilis testing, and other preventive services

NG, *N. gonorrhoeae*; CT, *Chlamydia trachomatis*; TV, *Trichomonas vaginalis*; BV, bacterial vaginosis.

*If molecular assay was performed and results were not available on same day, revise the syndromic treatment initially provided according to the test results when available.*

*If rapid point of care test or molecular assay is available to confirm NG/CT and treat if positive; if negative do not treat and ask woman to return if symptoms recur.*

*If woman complains of recurrent or persistent discharge refer to a centre with laboratory capacity.*
Syndromic STI Management Flowchart 2: Genital Ulcers including Anogenital Ulcers

**Person with symptom of genital ulcer**
- Take medical and sexual history and assess risk for STIs
- Physical examination of genital and anal areas

**Sore or ulcer present?**
- Yes
  - Resources and capacity for molecular assays (e.g., NAAT)
    - **Perform test**
      - Are results available on same day?
        - No*
          - **TREAT for HSV**
        - Yes
          - **Is test positive for HSV and/or syphilis?**
            - No
              - **TREAT for syphilis**
            - Yes
              - **TREAT for HSV**
      - **Treat based on test results on same day**
  - No
    - **Limited or no laboratory capacity**
      - **Treat for HSV and syphilis**

**Offer HIV and syphilis testing and other preventive services**

**Review in 1 week if symptoms persist or recur**

*HSV, herpes simplex virus*
*If molecular assay was performed and results were not available on same day, revise the syndromic treatment initially provided according to the test results when available*
Syndromic STI Management Flowchart 3: Lower Abdominal Pain

Sexually active woman with symptom of lower abdominal pain

Take medical and sexual history and assess risk for exposure to STIs

Genital examination (including bi-manual palpation) and speculum examination (where feasible)

Any of the following present?
- Missed/overdue period
- Recent delivery-abortion/miscarriage
- Abdominal guarding and/or rebound tenderness
- Abnormal vaginal bleeding
- Abdominal mass

Refer patient urgently for surgical or gynaecological opinion and assessment. Before referral set up an IV line and apply resuscitative measures if necessary

Is there lower abdominal tenderness or cervical motion tenderness?

Yes

Manage for PID
Test for NG/CT/MG if available*
See patient in 3 days

No

Any other illness found?

Yes

Manage appropriately

No

Patient has improved?

Yes

Offer HIV and syphilis testing and other preventive services

No

Refer patient

*to support partner notification.
NG, N. gonorrhoeae; CT, C. trachomatis; MG, M. genitalium.
Sexually Transmitted Infections and Young People (Ages 10 to 24)

Many of the populations most affected by and at risk for HIV are also at increased risk for viral hepatitis and other STIs. Further, many of these populations experience vulnerabilities, or are at risk due to social and structural determinants of health, including multiple forms of discrimination and conditions of marginalization or exclusion. Adolescent girls and young women face risks associated with gender inequalities and exposure to violence, which compound health risks associated with biological sex.\(^\text{165}\)

Generally, young people have higher rates of STIs than older adults. A few of the reasons for this include:

- Young people often have more partners and shorter relationships, increasing opportunities for STIs to spread.
- Young people may find it difficult or embarrassing to use condoms.
- Young people may find it difficult to refuse sex, particularly in situations with unequal power dynamics, such as within family structures or in situations where they must engage in transactional sex in exchange for money or goods (e.g., clothes, food, or school supplies).
- Young people may not recognize situations and sexual partners where risk of infection is high.
- Young people may lack knowledge about the symptoms of STIs and when to seek care.
- Young people may feel uncomfortable using contraceptives and seeking reproductive health services for fear of biased and judgmental responses from staff.
- Young people may not be aware of where to access confidential, private services.
- Young people may be unable to afford health services.

To address the higher risk among young people, we must increase access to scientifically accurate, age-appropriate, culturally sensitive, and comprehensive sexuality education that provides all adolescents and youth with information on sexual and reproductive health consistent with their evolving capacities. This includes providing guidance on STI and HIV prevention, communication and risk reduction skills, and developing respectful relationships—in partnership with young persons, parents or legal guardians and caregivers, educators, and healthcare providers.\(^\text{166}\)

Safer behaviors that providers should promote with young people include:

- Delaying the onset of sexual activity
- Learning how to use condoms consistently and correctly
- Practicing dual protection to prevent unplanned pregnancies as well as STIs
- Limiting the number of sexual partners
- Avoiding high-risk sexual practices (especially unprotected vaginal or anal sex) with any partner
- Recognizing symptoms of STIs and seeking treatment early

Counseling the Client about Sexuality and Sexually Transmitted Infection and HIV Risk

\textbf{Note:} The content contained within this section is adapted from Counseling the Postabortion Client: A Training Curriculum.\(^\text{167}\)

When providing sexual and reproductive health counseling, we often need to ask clients personal, sensitive questions. This can be challenging for the client, who may not be used to discussing personal issues with someone other than a family member (or with anyone at all). This can also be challenging for providers and counselors, who must be able to obtain the information to address the client’s risk of unintended pregnancy and STI and HIV infections, as well as the client’s concerns about sexuality.

\textbf{Getting Started}

It is best to start the conversation with general, open-ended questions. Asking such questions, for instance, asking about a client’s reasons for seeking care or about their general health, will help establish a rapport for the more sensitive questions. Then, asking more explicit questions will be easier. Introduce the discussion in your own way,

\(^\text{166}\) Ibid.
depending on the setting, the client, and the type of service the client seeks or needs.

**Approaches to Starting the Conversation**

- Assure the client that the questions you are asking are routine and that all clients are asked the same questions. For example: “I am going to ask some personal questions now. We ask everyone these questions because we believe that a person's sexual life is an important part of their health.”
- Assure the client that the questions will have a direct bearing on their healthcare and the decisions made during the visit by explaining, “It is important for me to ask you these types of questions so that I can help you to make health decisions that are right for you.”
- Be sure that the client feels comfortable by noting, “If there are any questions you do not feel comfortable answering, please let me know.”
- Introduce the questions within the context of STI and HIV risk. For example: “As you may know, HIV and other STIs are common here. I would like to talk with you more about your situation so that we can determine if you might be at risk. We discuss this information with all our clients to ensure everyone receives the information and contraceptive method that best meets their needs. I will need to ask you some rather personal questions, but I’m asking these questions so I will know how best to help you.”

**Other General Questions to Help Start the Conversation**

Here are some other general questions to help start the conversation. Use one or more of these as appropriate.

- Can you tell me about your spouse, sexual partner, or partners?
- Are you happy with your sex life? Why or why not? Do you talk with your partner about it?
- Tell me about your first sexual experience. **Note:** This is especially important for adolescent clients.

**Getting Specific: Probing Questions**

More sensitive questions may be integrated into a discussion of medical history, demographics, or risk factors pertinent to the service(s) being provided. If the information does not emerge through general discussion, ask probing questions on STI and HIV risk, contraception, or other relevant issues. The list of issues here should not be used as a checklist, but rather as a guide for remembering key issues when obtaining a client’s sexual history. Include questions about the client’s sexual life, sexual practices, sexual risks, and social context as part of a two-way conversation about their individual situation.

**Risks Associated with STIs and HIV**

Try to obtain information about the following to assist the client in determining their risk for STIs and HIV:

- Number and sex of current and past sexual partners
- Knowledge of partner’s or partners’ sexual practices
- Condom use
- History of STIs, reproductive tract infections, and other related infections
- Sexual practices and behaviors

**Contraceptive Concerns**

In addition to obtaining information about contraceptive history and needs, reproductive intentions, and potential contraindications, explore factors associated with sexuality that may affect contraceptive choice and continuation, including:

- Fear of becoming pregnant
- Fear of disease
- Concerns about the negative impact of a method on sexual pleasure
- Diminished sexual response due to the use of hormonal methods
- HIV and STI risk (see above)
Other Possible Issues
- Past surgeries or diseases related to sexual functioning
- Sexual concerns associated with the onset of menopause
- Sexual dysfunction in the client or the client’s partner(s)
- Pain during sex
- Lack of desire, orgasm, or sexual satisfaction
- Insufficient lubrication
- Age of sexual debut
- Experience of recent or past sexual coercion or violence\(^\text{168,169}\)
- Impact of alcohol and/or substance use on sexual activity and associated risks
- Partner’s use of, support for, and communication about contraceptive use and disease prevention

Sample Questions for Counseling a Client about Sexuality and Sexually Transmitted Infections and HIV Risk

Note: The content contained within this section is adapted from Counseling the Postabortion Client: A Training Curriculum.\(^\text{170}\)

The following questions may be useful when counseling clients about STIs and HIV. Choose or adapt questions as needed, avoiding questions that may not be culturally or socially appropriate in your setting or situation. Also note, some questions may not be appropriate or needed for counseling a postabortion client or for clients in other situations.

- When did you first become sexually active?
- Can you tell me how many sexual partners you have had? Were your sexual partners male or female?
- Did you consent or agree to all your past sexual experiences?
- Have you ever used any kind of contraception or FP method in your sexual relationships? If so, which methods? How frequently have you used these methods?
- Have you ever used condoms? If not, would you be interested in using condoms in your current or future relationships?
- To your knowledge, have you or any of your past or current partners ever had an STI?
- Do you have any other partners besides your primary partner? Do you think that your partner may have other partners?
- Have you had more than one sexual partner in the past year? Has your partner had more than one sexual partner in the past year?
- Do you feel any itching, burning, or other discomfort in your genital region? Are you now experiencing, or have you ever experienced, an unusual discharge (from your vagina or penis)?
- Do you have any questions or concerns about your sexual relationship that you would like to discuss?
- Do you think you may be at risk for HIV or other STIs? Do you think that your partner could be at risk for HIV or other STIs?
- What do you do to protect yourself from STIs?
- How would you feel about a (or another) pregnancy at this time? How do you think your partner would feel?


Management of Sexually Transmitted Infections

Carefully Completing Abdominal and Pelvic Examinations
When conducting abdominal and pelvic exams for a postabortion client (either during an initial assessment or follow-up visit), pay close attention for presence of the following potential signs of an STI:

- Lower abdominal pain or tenderness
- Genital sores or ulcers, or swelling (buboes) in the groin
- Pain or tenderness on cervical motion
- Presence of discharge from the urethra
- Presence of a purulent (containing mucopurulent) discharge, a friable (easily bleeds) cervix, or unrecognized vaginal discharge
- Suprapubic, adnexa, or pelvic mass

Using Appropriate STI Treatment Flowcharts
Refer to the Syndromic Approach to Management of Sexually Transmitted Infections section of this session for guidance on vaginal discharge, genital ulcers, and lower abdominal pain. This includes three flowcharts:

- Syndromic STI Management Flowchart 1: Vaginal Discharge
- Syndromic STI Management Flowchart 2: Genital Ulcers including Anogenital Ulcers
- Syndromic STI Management Flowchart 3: Lower Abdominal Pain

Using the Four C’s
The four C’s are: (1) compliance, (2) condoms, (3) counseling and education, and (4) contact tracing.

Compliance
Once clients understand the information regarding their care, they play an important part in making decisions about that care and in completing the agreed-upon treatment, including seeking follow-up care. The following table outlines provider and client roles in compliance.

<table>
<thead>
<tr>
<th>Provider Roles</th>
<th>Client Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give clear, simple instructions regarding relevant medications or treatment using terminology that the client understands.</td>
<td>Take all required medications for the full time prescribed and in the right dosage.</td>
</tr>
<tr>
<td>Emphasize the importance of completing the prescribed course of treatment.</td>
<td>Complete the course of treatment prescribed.</td>
</tr>
<tr>
<td>Explain any side effects and danger signs associated with the treatment and the appropriate response.</td>
<td>Be aware of danger signs and seek care accordingly.</td>
</tr>
<tr>
<td>Encourage the client to ask questions and ensure the client demonstrates understanding of the information by asking the client to repeat information.</td>
<td>Listen carefully and ask questions to be sure you understand the treatment instructions.</td>
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<tr>
<td>Schedule follow-up appointments.</td>
<td>Return for follow-up appointments.</td>
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</tbody>
</table>
Condoms
In addition to preventing pregnancy, condoms (external and internal) can prevent the spread of STIs and HIV, if used properly. It is important to feel comfortable talking about condoms and demonstrating condom use with clients. Discuss and demonstrate the correct use of external and internal condoms with a client according to the client’s preferred type of condom. During the demonstration, show the client how to:

- Ensure that the condom is not expired.
- Ensure that the package and the condom are not punctured.
- Properly open the package.
- For the external condom, pinch the tip to remove residual air and create a reservoir for semen.
- Properly roll the external condom on an erect penis or properly insert the internal condom into the vagina and ensure the external genitalia is appropriately covered.
- Safely remove the condom without self-contamination.
- Safely dispose of the used condom.

Note: Postabortion clients should not insert anything into the vagina immediately after emergency treatment for abortion-related complications and until the bleeding stops (usually after five to seven days). These clients may resume sexual intercourse and use condoms as described only after the bleeding has stopped.

Counseling and Education
Counseling includes providing health information and education. Listening to what clients say and how they say it can help you to provide the information they need. Further, many groups that are at risk of contracting STIs and HIV experience vulnerabilities related to social and structural determinants of health, including multiple forms of discrimination and conditions of marginalization or exclusion. Young people (ages 10 to 24), especially adolescent girls and young women, are particularly at risk. Although each encounter with a client is short, it is important to inform every client of the risks of HIV and AIDS. Refer to the sections entitled Sexually Transmitted Infections and Young People (Ages 10 to 24), Counseling the Client about Sexuality and Sexually Transmitted Infection and HIV Risk, Sample Questions for Counseling a Client about Sexuality and Sexually Transmitted Infections and HIV Risk, and HIV Counseling and Referral to guide counseling sessions about STIs and HIV.

Contact Tracing
Contact tracing is critical for clients who test positive for an STI. Contact tracing requires a strong rapport between the provider and the client. Clients need to understand the importance of discussing STI and HIV risks with their partners and encouraging their partners to seek treatment. Help clients think about how they will discuss the issue with their partner(s), recognizing that this can be an extremely difficult task for some clients, including those who may fear stigma or physical abuse. Let clients know that anyone with whom they have had sexual contact should seek treatment for the STI even if they are asymptomatic. Providers can increase the number of contacts who seek treatment by giving clients appointments for their contacts and offering to discuss the risk with them and their contacts together.

Providing Return Visit and Follow-Up Care
Refer to the Syndromic Approach to Management of Sexually Transmitted Infections section, particularly the appropriate syndromic management flowchart, for return visit guidelines.

Preventing and Addressing STIs: Information for Clients
- To prevent STIs, remember the ABCs:
  - Abstain from sex.
  - Be faithful, stay with one sex partner.
  - Consistently use condoms.
• Protect yourself against HIV by protecting yourself from other STIs, which can increase the risk of contracting HIV.
• Understand that while there may be treatment for some STIs, some STIs cannot be cured, including HIV.
• If you think you may have an STI:
  » Seek care quickly, even if you do not have symptoms.
  » Avoid sex or at least use condoms every time you have sex to reduce the spread of STIs.
• If you are diagnosed with an STI:
  » If you are prescribed medicine for an STI, take all prescribed medicine as directed, even if symptoms cease or you feel better. Additionally, avoid sex until three days after you have taken all of your medication and until you are no longer experiencing any symptoms.
  » Help your sex partner(s) seek treatment by referring them for care and/or accompanying them.
  » Return for care when instructed to ensure you are cured. If you continue to experience symptoms, you can also obtain more medication to cure your infection during a follow-up visit.
  » Protect your baby by attending (or encouraging your partner to attend) an antenatal clinic within the first three months of pregnancy for a physical exam, syphilis test, and voluntary HIV screening test.

HIV Counseling and Referral
HIV prevention counseling should focus on the client’s unique circumstances and risks and should help the client set and reach an explicit behavior-change goal to reduce the chance of contracting or transmitting HIV. Counseling clients about HIV in a nonjudgmental way is critical. Imposing guilt or conveying disapproval does not help people deal responsibly with HIV or any STI. Help clients learn how to prevent transmission to others and how to protect themselves from other infections.

HIV counseling is usually, but not always, conducted in the context of HIV testing. The role of the PAC provider is to provide HIV information and prevention counseling to postabortion clients (as appropriate) and to refer clients to other services for testing and treatment (unless the client declines).

The provider should be familiar with and able to share information about facilities that offer HIV testing and treatment services and the associated costs. Self-testing kits are available in some countries; providers in these settings should inform clients of this option.171

While counseling postabortion clients about HIV, providers should:
• Explain HIV and AIDS and the ways in which HIV is transmitted.
• Discuss ways to prevent the spread of HIV.
• Provide information related to accessing testing and treatment, including pre-exposure prophylaxis, as appropriate.

Detailed information on testing methods is a part of the pretest counseling at the test site. Posttest counseling includes notifying the client of the HIV test results, addressing the client’s reaction to the test results, and offering individualized information related to the client’s results.

Refer to the sections entitled Sexually Transmitted Infections and Young People (Ages 10 to 24), Counseling the Client about Sexuality and Sexually Transmitted Infection and HIV Risk, Sample Questions for Counseling a Client about Sexuality and Sexually Transmitted Infections and HIV Risk, and Management of Sexually Transmitted Infections for more information. Additionally, the Basic Facts about HIV and AIDS section on the following pages outlines fundamental information about HIV and AIDS that may be useful in providing pre- and posttest counseling and health information to postabortion clients.

Basic Facts about HIV and AIDS

What Is HIV?

- HIV is an acronym for human immunodeficiency virus.
- HIV is the virus that causes AIDS. Most people who contract HIV will eventually develop AIDS.
- The HIV virus is found in amniotic fluid, breastmilk, blood, semen, pre-ejaculate, rectal fluids, and vaginal fluids of infected persons.
- A person may be diagnosed as HIV-positive or HIV-negative based on a blood test:
  » A person whose blood test result is HIV-positive has been infected by HIV; this person may be described as seropositive, HIV-positive, or HIV-infected.
  » A person whose blood test result is HIV-negative is said to be seronegative, HIV-negative, or not infected with HIV. *Note: If a person with an HIV-negative test result has engaged in behavior that places them at risk for HIV in the past three months, then the test result may not be an accurate indication of the person’s HIV status because the person might be in the window period and should be re-tested later.*
- There is no cure for HIV; however, there are medications that effectively suppress the virus.

What Are the Different Types of HIV?

- HIV-1 and HIV-2 are the two types of HIV; both types are transmitted the same way and both are associated with similar opportunistic infections and AIDS.
- In some cases, a person may become infected with both HIV-1 and HIV-2.
- HIV-1 is more common worldwide. HIV-2 is found primarily in Angola, Mozambique, and West Africa.
- HIV-1 is more easily transmitted than HIV-2 and it is more pathogenic (meaning that the period between initial infection and illness is shorter).
- While HIV-2 can be transmitted from an infected mother to her child, this appears to be rare (0% to 5% transmission rate in breastfed infants in the absence of any interventions).

What Is AIDS?

- AIDS is an acronym for acquired immunodeficiency syndrome:
  » Acquired: differentiating from a genetic or inherited condition that causes immune dysfunction
  » Immuno: the immune system
  » Deficiency: the inability to protect against illness
  » Syndrome: the group of symptoms or illnesses that result from the HIV infection
- AIDS refers to the most advanced stage of HIV infection. Most people who contract HIV will eventually develop HIV-related disease(s) and AIDS.
- AIDS is a group of serious illnesses and opportunistic infections that develop after a person has been infected with HIV for a long period of time.
- A diagnosis of AIDS is based on specific clinical criteria and laboratory test results.

How Do HIV and AIDS Progress?

- HIV is the virus that causes the initial infection.
- HIV destroys specific white blood cells (CD4 cells) thereby weakening the immune system. When the immune system becomes weak or compromised, the body loses its protection against infection and disease.
The progression of HIV is measured by CD4 count and viral load:

- **CD4 count** is the number of CD4 T-lymphocyte cells in the blood. CD4 cells are the type of white blood cells that are the immune system's key infection fighter. The CD4 count reflects the health of the immune system.
- **Viral load** refers to the amount of HIV in the blood. The viral load can be measured by polymerase chain reaction testing. The test can be used to check the person's response to antiretroviral therapy.

When HIV actively multiplies, it infects and kills CD4 cells. The CD4 count is usually expressed as the number of cells per cubic millimeter. The typical CD4 count of a healthy adult is between 500 and 1,400 cells/mm³. As the CD4 count falls below 200 cells/mm³, the risk of opportunistic and serious HIV-related infections becomes higher.

The viral load is extremely high shortly after a person first becomes infected with HIV. A high viral load leads to a higher transmission risk. The viral load falls steeply when the body develops antibodies to HIV. The viral load rises again after several years as the immune system weakens and the CD4 count drops. A high viral load (after the initial infection period) can also be a sign of more severe disease progression.

People infected with HIV usually develop antibodies within four to six weeks of becoming infected, but it may take as long as three months for antibodies to develop.

The period between when a person is infected and when they test positive for HIV is called the window period.

Seroconversion refers to the point at which the result of an HIV test changes from negative to positive. Some people experience a flu-like illness (enlarged lymph nodes, fever, joint pains, and rash) at the time of seroconversion. This is referred to as acute retroviral syndrome.

Without antiretroviral therapy, as time passes, the immune system becomes unable to fight the HIV infection and the infected person may develop serious and deadly diseases, including other infections and certain types of cancer.

As the HIV infection progresses, the infected person becomes susceptible to opportunistic infections.
- An opportunistic infection is an illness caused by an organism that might not cause illness in a healthy person but will cause illness in a person who has a weakened immune system.
- People living with advanced HIV infections may suffer from opportunistic infections of the brain, eyes, lungs, and other organs. For example, coinfection with tuberculosis is common among people living with HIV.
- Other common opportunistic infections in persons living with AIDS include cryptosporidiosis; histoplasmosis; pneumocystis carinii pneumonia; other parasitic, viral, and fungal infections; and some types of cancers, such as Kaposi’s sarcoma.

What Is an Asymptomatic HIV Infection?

- A person who is HIV-infected may have no signs of illness and may look and feel healthy—meaning they do not have physical signs or symptoms of HIV; this person is asymptomatic.
- A person with an asymptomatic HIV infection can still transmit the infection to others.
- The duration of the asymptomatic phase varies greatly from person to person—some may develop HIV symptoms within a few months of primary infection, others may take up to 15 years to develop symptoms.

What Is a Symptomatic HIV Infection?

- A person who has developed physical signs and symptoms of HIV is symptomatic.
- The immune system weakens and CD4 count decreases during this phase.
- The progression of HIV depends on the type of virus and specific host characteristics including general health, nutrition, and immune status.
**When Does HIV Progress to AIDS Infection?**

- As HIV progresses, the CD4 count continues to decrease, and the infected person becomes more likely to develop opportunistic infections and other HIV-related infections.
- Most people who are HIV-infected will eventually develop advanced HIV infection and AIDS. The duration of this progression varies: it may occur within several months or not occur for more than 15 years.
- Even if the symptoms of AIDS develop and then subside for a while, the virus that causes them is still present, and the infected person can still transmit the disease.

**How Is HIV Contracted?**

- HIV can be contracted through sexual contact (anal, oral, or vaginal intercourse) with an infected person, during which semen or vaginal fluids and/or blood come into contact with the penis, the lining of the mouth, rectum, or vagina. The HIV in these fluids can then infect the blood stream. HIV can enter the blood through open genital or oral sores or cuts.
- HIV can be contracted through transfusions or treatments with infected blood products.
- HIV can be contracted through skin-piercing instruments that have been in contact with infected blood or body fluids and have not been properly disinfected; this includes: needles, syringes, and razor blades, as well as instruments used to provoke an abortion and circumcision instruments.
- Infants can contract HIV from an infected mother during pregnancy, childbirth, or breastfeeding. In the absence of intervention, there is a 15 to 45% chance that a mother living with HIV will transmit the infection to their newborn child. A child’s risk of HIV infection must be weighed against the risk of the child dying from other causes if it is not breastfed; for instance, diarrheal disease, which can be fatal, is often attributed to the use of contaminated water and food in place of breastfeeding. A client who is living with HIV (or suspects they are) and wishes to breastfeed should consult a skilled provider for up-to-date information and counseling.

**How Is HIV Not Contracted?**

HIV is **not** contracted through any of the following:

- Insect bites
- Kissing a person living with HIV
- Hugging, shaking hands with, or having other ordinary social contact with a person living with HIV
- Living with a person living with HIV
- Saliva from a person living with HIV
- Sharing clothes with a person living with HIV
- Sharing or touching food or dishes used by a person living with HIV
- Sweat from a person living with HIV
- Tears from a person living with HIV
- Toilet seats used by a person living with HIV

**What Are the Symptoms of HIV and AIDS?**

Persons infected with HIV may be asymptomatic. It can take years between HIV infection and the diagnosis of AIDS. Once symptoms begin to develop, they may include:

- A cough that persists for more than one month
- An unexplained loss of 10% of body weight within one month
- A white coating on the tongue
- Diarrhea for one month or more

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• Enlarged or sore glands in the armpit and/or neck
• Persistent fever of unknown origin
• Persistent symptoms of vaginitis

Since these symptoms may represent other diseases (a persistent cough may be a symptom of tuberculosis, diarrhea may indicate an intestinal illness), a blood test is required to confirm the presence of HIV. People living with HIV may look as healthy as any other person.

**Who Is at Risk?**

Anyone can become infected with HIV, but only through the means described above. Clients who are at high-risk include:

- Sex workers
- Men who have sex with men
- People who have multiple sexual partners, or whose sexual partners have multiple partners
- People who use intravenous drugs
- People who have received unscreened blood products
- Healthcare workers who have direct contact with infected blood

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**Adolescents and HIV**

HIV testing and counseling—with linkages to prevention, treatment, and care—is recommended for adolescents from key populations in all settings. Adolescents should receive counseling about the potential benefits and risks of disclosing their HIV status to others as well as support to determine if, how, when, and to whom to disclose. All forms of HIV testing and counseling must adhere to the five Cs: (1) consent, (2) confidentiality, (3) counseling, (4) correct test results, and (5) connections to treatment, care, and prevention services. Adolescents consistently indicate preferences for compassionate, friendly, and competent staff as well as counseling linked with testing and other services along the continuum of HIV care, including rapid testing, free of charge.

When counseling adolescents about HIV:

- Be open to listening to their needs, emotions, and concerns.
- Encourage and praise behavior(s) that lessens the risk of infection.
- Assist adolescents in identifying alternatives to high-risk behavior(s).
- Be nonjudgmental.
- Explain risks and dispel myths in an objective manner.


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**Are HIV and AIDS Preventable?**

**Strategies to Prevent HIV Transmission through Transfusions or Treatments**

- Screen all blood and blood products for HIV.
- Follow universal precautions, including:
  - Personal protective equipment use
  - Pre- and postexposure prophylaxis
  - Safe disposal of contaminated waste products
  - Safe use and disposal of sharps
  - Sterilization of equipment
Strategies to Prevent HIV Transmission through Sexual Contact

- Promote abstinence or being faithful to one uninfected partner.
- Provide instructions on the consistent and correct use of barrier methods:
  - External or internal condoms for penile-vaginal intercourse
  - External condoms (without lubrication) for oral intercourse on a penis
  - Dental dams, plastic wrap, or latex underwear for oral intercourse on a vagina
  - External condoms for anal intercourse
- Prevent, identify, and provide early treatment for STIs.
- Provide access to HIV testing and counseling.
- Provide access to pre-exposure prophylaxis, as outlined in national guidance documents.173

Note: Condoms provide protection from HIV as well as other STIs when used correctly and consistently.

Strategies to Prevent HIV Transmission through Intravenous Drug Use

- Provide education about the risks of infection via drug use with contaminated needles and syringes.
- Provide referrals for treatment of substance abuse and misuse.

Is there Treatment for People Living with HIV?

- Though there is currently no cure for HIV, there are several different types of medications to treat people living with HIV. These medications attack various aspects of the process used by the virus to replicate itself.
- Because HIV quickly mutates to become resistant to any single medication, people living with HIV must take a combination of medications to achieve maximum suppression. The combination of medications used for this treatment is known as antiretroviral therapy.
- Antiretroviral therapy changes the natural course of HIV infection, significantly extending the period between initial infection and the development of symptoms.
- It is important to start antiretroviral therapy before AIDS symptoms develop. However, even those who start therapy after being diagnosed with AIDS can receive major and long-lasting health benefits.
- Although effective in slowing the progression of HIV-related diseases, antiretroviral therapy is not a cure. Additionally, because there is no cure for HIV, these medications must be taken for life. Antiretroviral medications are also used to prevent HIV infection among clients at risk of contracting HIV or immediately after exposure to the virus. In addition to treatments for HIV itself, therapies exist to prevent and/or treat many HIV-related opportunistic infections.

What Are the Best Contraceptive Methods for Clients with a History of STIs and/or HIV and AIDS?

- People living with HIV who use antiretroviral medications can live similarly to those without HIV but must always be cautious of transmitting HIV to any sexual partners. Therefore, it is critical to emphasize dual-method protection for all clients during STI and HIV counseling.
- Dual method protection—combining condoms with a second, more effective contraceptive method (oral contraceptives, implants, etc.)—increases the level of protection against both STIs and unintended pregnancies—meaning, condoms should be used with all methods.
- When condoms are the primary method, a spermicide should also always be used.
- Clients with chlamydia, gonorrhea, PID, or purulent cervicitis should not have an IUD inserted until the infection is resolved.
- Clients who are extremely high risk of STIs should only use an IUD if there no other appropriate or acceptable methods available; clients who opt for an IUD should be directed to use condoms as well.174

Module 4: Infection Prevention
Module 4, Session 1: Infection Prevention

Summary

Infection prevention is critical to minimizing risks to clients, healthcare workers, and the community during the provision of health services. This session introduces infection prevention procedures, including standard precautions, aseptic techniques (including hand hygiene), the no-touch technique, preparation of the surgical area, use of antisepsis, use of barriers, maintenance of the procedure area, waste management, and processing of medical devices and other items for reuse.

Learning Objectives

At the end of this session, participants will be able to:

1. Explain the principles of infection prevention, including standard precautions.
2. Demonstrate effective hand hygiene procedures.
3. Describe the appropriate use of antiseptics and the no-touch technique.
4. Demonstrate appropriate gloving practices.
5. Demonstrate correct use of personal protective equipment.
6. Demonstrate safe handling of sharps.
7. Demonstrate safe disposal of contaminated waste.
8. Describe recommended housekeeping practices.
9. Demonstrate how to process reusable equipment and other items used in PAC provision.

Introduction to Infection Prevention and Control in Postabortion Care

PAC clients, regardless of treatment facility, are at risk of various infections unless infection prevention and control precautions are in place and upheld. Nosocomial infections (those acquired at a hospital or similar healthcare facility, including those that occur between 48 hours and 30 days after admission\textsuperscript{175}) are a significant and growing problem around the world. Approximately 7 of 100 hospitalized clients in high-income countries may be infected with such infections and this risk is more than doubled (up to 15 clients per 100) in low- and middle-income countries.\textsuperscript{176} Additionally, healthcare workers, laboratory technicians, and support staff (including facility cleaning, maintenance, and transport personnel)—as well as family and community members—who may come in contact with infectious materials are also at risk of such infections. Therefore, it is important that PAC providers and related healthcare workers know and follow recommended infection prevention and control practices to minimize accidental exposure and transmission of infections. The COVID-19 pandemic, for example, presented challenges and risks for PAC clients and healthcare workers.\textsuperscript{177}

Infection prevention practices in PAC serve two primary objectives.

- To prevent major infections when providing PAC
- To minimize the risk of transmitting serious diseases (for example, hepatitis B, HIV, and other disease outbreaks, such as COVID-19) to clients, service providers, other staff, and the community

Microorganisms are the causative agents of infection. They include bacteria, fungi, parasites, and viruses that cause local or general infections and/or infestations. Microorganisms live everywhere in all environments and are even carried normally in our genital, intestinal, and upper respiratory tracts and on our skin. Some organisms are more pathogenic, meaning they are more likely to cause disease, than others. One category of bacteria, endospores, is particularly difficult to kill because of their protective coating, presenting special infection prevention challenges.


Microorganisms are transmitted from blood and other body fluids—such as amniotic fluid, peritoneal fluid, respiratory fluids (mucous, phlegm, saliva, etc.), semen and pre-ejaculate, vaginal secretions, and waste (feces, urine, pus, vomit, etc.)—through an entry point—such as mucous membranes in the eyes, mouth, or nose, or breaks in the skin—in a person lacking effective natural or acquired protection. Given the right circumstances, all microorganisms may cause infection, such as when transmitted to an immunocompromised person, for instance, a person living with HIV. Further, while all humans are susceptible to infection, the dose of organisms needed to produce infection varies with the location. Intact skin, for example, generally provides a strong barrier against organisms, while mucous membranes present a greater risk of infection, requiring fewer organisms for infection to occur than the skin. The risk of infection is highest in normally sterile body sites, such as in the uterus or other internal organs, as only a few microorganisms are needed to produce disease.

Infection prevention largely depends on establishing protective barriers between the microorganisms and a susceptible host (a person lacking effective natural or acquired protection). Protective barriers may be chemical, mechanical, or physical processes that help prevent the spread of infectious organisms from person to person (e.g., client, healthcare worker, staff) and/or from equipment, instruments, and/or environmental surfaces to a person.

**Standard Precautions**

Standard precautions are designed to support the health and safety of all persons, including clients and staff. These precautions are applicable to blood and other body fluids (except sweat) as well as non-intact skin and mucous membranes—including all pathological and laboratory specimens. Because many people with blood-borne viral infections do not experience any symptoms and are not visibly recognizable as infected, it is important to uphold these precautions at all times.

Standard precautions and other recommended infection prevention practices are based on the assumption that every person (client as well as staff) is potentially infectious and susceptible to infection. While it is important to follow national and/or institutional guidelines, standard precautions include the following:

- Practice proper hand washing as the most practical procedure for preventing cross-contamination (person-to-person or contaminated object-to-person).
- Wear gloves before touching any wet material—blood or other body fluids (such as excretions or secretions), broken skin, mucous membranes, soiled instruments, and waste materials—and before performing any invasive procedure.
- Use antiseptic agents for cleansing the skin or mucous membranes prior to surgery, when cleaning wounds, and when performing other types of invasive procedures.
- Use barriers to prevent splashes and spills of any body fluids. Protective barriers, also known as personal protective equipment, include aprons, gowns, and scrubs; caps; eyewear; face masks; footwear; and gloves. Face masks and protective eyewear are particularly important during outbreaks, such as the COVID-19 pandemic.
- Use safe injection practices such as not re-capping or bending needles, and dispose supplies into appropriate receptacles, such as sharps boxes.
- Safely dispose of infectious waste materials to protect staff handling waste and to prevent injury and infection within the community.
- Process medical devices (including blood pressure machines, VA kits, pulse oximeters, stethoscopes, surgical instruments, and other items used for diagnostics and treatment) and soiled linen for reuse in accordance with established infection prevention guidelines.

The text box on the following page provides an illustrative summary of standard precautions.
Summary of Standard Precautions—Key Components

Use of Hand Hygiene
- Health workers cleaning their hands before, after, and at specific moments during patient care and when performing health care tasks. Must be performed consistently using soap and water or alcohol based handrub.

Use of Personal Protective Equipment (PPE)
- Dependent on assessment of health worker’s risk of coming into contact with infectious materials during each task. Risks must be reassessed during the task and PPE added as needed. Includes:
  - Gloves:
    - Before touching anything wet, non-intact skin, and mucous membranes, blood, body fluids, secretions, contaminated items.
  - Use of eye protection, goggles, surgical masks, face shields:
    - Protect mucous membranes of eyes, nose, and mouth from splashes of blood and body fluids or respiratory droplets.
    - Other infectious or hazardous materials.
  - Use of surgical face mask also:
    - Prevents spread of microorganisms from the health workers respiratory system to patients.
    - To cover nose and mouth of patients with infectious organisms transmitted by droplet airborne route.
  - Use of fluid resistant gowns and aprons:
    - Protects health worker’s skin from splashes, blood, or body fluid contact.
    - Prevent soiling of clothing during procedures that may involve contact with blood or body fluids.

Respiratory Hygiene and Cough Etiquette
- To prevent spread of respiratory secretions via droplets by:
  - Covering mouth and nose with tissue when coughing or sneezing and disposing the tissue immediately.
  - Performing hand hygiene immediately after contact with respiratory secretions.
  - Maintaining appropriate distance from and between syndromic patients, approximately 1 meter.
  - Identifying patients/people with symptoms suggestive of acute respiratory infections and teaching them use of protective masks and cough etiquette.
  - During seasons of high transmission, identifying symptomatic patients and isolating them from other patients.

Safe injection practices
- Practices that do no harm to the patient, that do not put the health worker at risk, and do not result in waste that is dangerous to the community. Includes:
  - Use of aseptic techniques.
  - Use of single dose vials.
  - Safe handling and disposal of sharps and needles to prevent sharps injuries and needle sticks.
  - Safe medication storage and handling.

Cleaning and disinfection of patient care equipment, instruments, and environmental surfaces. Includes:
- Cleaning patient care equipment between each use to prevent spread of infection.
- Disinfection and sterilization of instruments and equipment and proper use of single use items to prevent cross infection.
- Clean environmental surfaces around the patient in patient care areas.
- Clean blood and body fluids spills promptly following guidelines.

Process linen in a manner that:
- Removes pathogens from the textile to protect the client.
- Reduces risk of transmission of infections to the health care worker, other patients, and environment.

Waste Disposal involves:
- Proper disposal of sharps and needles in leak proof, puncture resistant sharps containers.
- Segregate waste where it is generated and maintain segregation during transportation.
- Treat waste contaminated with blood, body fluids.
- Follow national guidelines and manufacturer’s instructions for disposal of hazardous waste.
- Follow local guidelines on final disposal of health care waste.

Aseptic Technique

The term aseptic technique refers to all processes and procedures undertaken before, during, and after a surgical procedure to minimize the risk of transmission of infections. The interventions include: practicing hand hygiene, using protective barriers (personal protective equipment), preparing the client (using antiseptics), practicing safe surgical techniques, creating a safe surgical environment, ensuring facility cleanliness and hygiene (including proper waste management and disposal), and correctly processing medical devices for reuse. Most of these practices are relevant in treating PAC clients who opt for, or require, surgical intervention.

Hand Hygiene

Hand hygiene is a general term used to define any action of hand cleansing, including handwashing and use of alcohol-based antiseptic solutions. Proper hand hygiene is the single most important step in infection prevention. Hand hygiene practices can significantly reduce hand-borne infections (including diarrhea, respiratory and skin infections, and trachoma) by removing dirt and debris and inhibiting or killing microorganisms on the skin thereby interrupting the transmission of infectious agents. Handwashing with soap can reduce diarrheal incidence by 30% in communities in low- and middle-income countries. Additionally, a single handwash is associated with a 3% decrease in the daily probability of an acute respiratory infection.

Handwashing

The purpose of handwashing is to remove debris and soil from the skin and reduce the number of transient microorganisms. While handwashing with plain soap and clean water is effective, using antimicrobial soap is the evidence-based recommended practice for surgical preparations.

PAC providers should wash their hands before: examining (or having direct contact with) clients; donning sterile examination gloves prior to clean or aseptic procedures; or eating.

PAC providers should similarly wash their hands after:

- Using the restroom
- Removing gloves, as any tiny holes or tears will allow contaminants to contact the skin and bacteria can rapidly multiply on gloved hands due to the moist, warm environment within the glove
- Any situation in which hands are visibly dirty or soiled with blood or other body fluids
- Any situation in which hands may become contaminated, even if they are not visibly soiled, such as:
  - Handling soiled instruments or wound dressings
  - Touching blood, mucous membranes, or other body fluids
  - Having contact with a contaminated-body site (before moving to a clean body site)
  - Touching a client’s intact skin
  - Having prolonged and intense contact with a client
  - Touching surfaces surrounding the client, client belongings, or other items in the immediate vicinity

Although handwashing has been recognized as an important infection prevention practice for more than 150 years, ensuring healthcare workers practice handwashing remains difficult. Key reasons for this include lack of time, lack of access to running water, skin irritations from frequent washing, beliefs that gloves provide total protection, and doubt regarding the effectiveness of handwashing to prevent infection. While education and behavior change activities have proven effective in improving provider handwashing, ensuring consistent availability of soap, clean water (either from a tap or a bucket), and single-use towels is essential.


Recommended Steps for Handwashing

The handwashing procedure should last between 40 and 60 seconds, following the steps listed below.

- Step 1: Thoroughly wet hands.
- Step 2: Apply plain soap to hands.
- Step 3: Vigorously rub soap over all areas of the hands, especially between the fingers and under the fingernails, for at least 10 to 15 seconds.
- Step 4: Rinse hands thoroughly with clean water.
- Step 5: Dry hands with a paper towel and use the towel to turn off the faucet.

If paper towels are unavailable, dry hands with an individual, clean towel or allow them to air-dry. Shared towels quickly become contaminated and therefore should not be used. Alternatively, PAC providers can carry a personal small towel or handkerchief, which must be washed daily, to help avoid using shared towels.

Because microorganisms grow and multiply in moisture and standing water, the following tips are important for preventing infection.

- When using bar soap, provide small bars and store the bar on racks that drain between use.
- When using liquid soap, do not add soap to partially empty dispensers; this may cause contamination.
- When running water is unavailable, use a bucket with a tap that can be turned off to lather hands and turned on again for rinsing; alternatively use a bucket and pitcher.
- Do not dip hands in basins containing standing water—even with an antiseptic agent, microorganisms can survive and multiply.

Additionally, for PAC providers who wash their hands frequently (30 or more times per shift), hand lotions and creams can reduce irritation of the skin and should be available.

**Hand Antisepsis**

The purpose of hand antisepsis is to remove debris and soil from the skin as well as to reduce organisms (including those that are normally present as well as any others). Hand antisepsis employs a similar technique as handwashing but uses soap containing an antiseptic agent or an antiseptic hand rub.

Hand antisepsis should be used before:

- Examining or caring for highly susceptible clients (for instance, those with advanced AIDS)
- Performing invasive procedures, such as placement of an intravascular line to provide fluids or medications

Antiseptic hand rubs are more effective in killing microorganisms than handwashing with soap (with or without antiseptics). Antiseptic hand rubs also contain emollients that protect and soften skin and are therefore less irritating than antiseptic soaps. Additionally, running water is not required for antiseptic hand rubs, making this method of hand antisepsis quick and convenient. For all these reasons, if antiseptic hand rubs are available, they are preferable to antiseptic soaps.

**Recommended Steps for Hand Antisepsis Using Hand Rub**

- Step 1: If hands are visibly soiled or contaminated with blood or other body fluids, wash with soap and water and then dry before applying the antiseptic hand rub.
- Step 2: Apply enough antiseptic hand rub to cover the entire surface of hands and fingers (about 5 ml or one teaspoon) to ensure effectiveness.
- Step 3: Vigorously rub antiseptic hand rub over all areas of the hands, especially between the fingers and under the nails, until the hands are dry (approximately 15 to 30 seconds).

**Hand Creams and Lotions**

For PAC providers who wash their hands frequently (30 or more times per shift), with or without antiseptics, hand creams and lotions can reduce irritation of the skin. Ensuring such cream or lotion is available can help promote consistent handwashing.

**Hand Rub Formulas**

To make one liter of alcohol hand rub using ethanol, combine the following in a 1,000 cc container:

- Ethanol (96% v/v) 833.3 ml
- Hydrogen peroxide (3%) 44.7 ml
- Glycerol (98%) 14.7 ml
- Top up to 1,000 cc with distilled water (alternatively, water that is boiled then cooled)

To make one liter of alcohol hand rub using isopropyl alcohol (99.8% v/v), combine the following:

- Isopropyl alcohol (96% v/v) 751.5 ml
- Hydrogen peroxide (3%) 44.7 ml
- Glycerol (98%) 14.7 ml
- Top up to 1,000 cc with distilled water (alternatively, water that is boiled then cooled)

https://www.who.int/publications/i/item/9789241597906.
Hand Hygiene with an Alcohol-Based Hand Rub

1a. Apply a palmful of the product in a cupped hand, covering all surfaces;  
1b. Rub hands palm to palm;  
2. Right palm over left dorsum with interlaced fingers and vice versa;  
3. Palm to palm with fingers interlaced;  
4. Backs of fingers to opposing palms with fingers interlocked;  
5. Rotational rubbing of left thumb clasped in right palm and vice versa;  
6. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;  
7. Once dry, your hands are safe.


Note: To prevent a buildup of emollients, wash hands with soap and water after every 5 to 10 hand rub applications.

Surgical Hand Preparation

While handwashing (with plain or antiseptic soap) or using an antiseptic hand rub are generally adequate hand hygiene practices for providing outpatient services (including select postabortion services), surgical procedures that are performed in an operating theater (for instance, treating intra-abdominal injuries or abortion-related complications) require surgical hand preparation. There are two recommended methods of surgical hand preparation, or surgical hand scrub: the use of an alcohol-based hand rub (which the WHO recommends) and the use of a medicated or antimicrobial soap and water. Traditional approaches to surgical hand preparation—including vigorously scrubbing hands with brushes and/or sponges—have proven unnecessary and potentially ineffective. Updated recommended techniques are less harsh and less time-consuming. Providers should use an alcohol-based hand rub between clients; however, it is also important to wash with plain soap and water prior to entering an operating theater or procedure area.
Best Practices and Preparations for Surgical Hand Preparation

- Keep fingernails short.
- Do not use nail polish or wear artificial nails.
- Remove all jewelry.
- Wash hands with soap and water before entering the operating theatre or if hands are visibly soiled.
- Clean subungual areas with nail file.

Surgical Hand Preparation with an Alcohol-Based Hand Rub Formulation

The handrubbing technique for surgical hand preparation must be performed on perfectly clean, dry hands. On arrival in the operating theatre and after having donned theatre clothing (cap/hat/bonnet and mask), hands must be washed with soap and water. After the operation when removing gloves, hands must be rubbed with an alcohol-based formulation or washed with soap and water if any residual talc or biological fluids are present (e.g. the glove is punctured).

Surgical procedures may be carried out one after the other without the need for handwashing, provided that the handrubbing technique for surgical hand preparation is followed (Images 1 to 17).

1. Put approximately 5ml (3 doses) of alcohol-based handrub in the palm of your left hand, using the elbow of your other arm to operate the dispenser

2. Dip the fingertips of your right hand in the handrub to decontaminate under the nails (5 seconds)

3. Images 3–7: Smear the handrub on the right forearm up to the elbow. Ensure that the whole skin area is covered by using circular movements around the forearm until the handrub has fully evaporated (10-15 seconds)

4. See legend for Image 3

5. See legend for Image 3

6. See legend for Image 3

7. See legend for Image 3

8. Put approximately 5ml (3 doses) of alcohol-based handrub in the palm of your right hand, using the elbow of your other arm to operate the dispenser

9. Dip the fingertips of your left hand in the handrub to decontaminate under the nails (5 seconds)
Surgical Hand Preparation with an Alcohol-Based Hand Rub Formulation (continued)

10. Smear the handrub on the left forearm up to the elbow. Ensure that the whole skin area is covered by using circular movements around the forearm until the handrub has fully evaporated (10-15 seconds).

11. Put approximately 5ml (3 doses) of alcohol-based handrub in the palm of your left hand, using the elbow of your other arm to operate the distributor. Rub both hands at the same time up to the wrists, and ensure that all the steps represented in Images 12-17 are followed (20-30 seconds).

12. Cover the whole surface of the hands up to the wrist with alcohol-based handrub, rubbing palm against palm with a rotating movement.

13. Rub the back of the left hand, including the wrist, moving the right palm back and forth, and vice-versa.


15. Rub the back of the fingers by holding them in the palm of the other hand with a sideways back and forth movement.

16. Rub the thumb of the left hand by rotating it in the clasped palm of the right hand and vice versa.

17. When the hands are dry, sterile surgical clothing and gloves can be donned.

Repeat the above-illustrated sequence (average duration, 60 sec) according to the number of times corresponding to the total duration recommended by the manufacturer for surgical hand preparation with an alcohol-based handrub.

Protective Barriers and Personal Protective Equipment

Protective barriers, or personal protective equipment, include aprons, gowns, and scrubs; caps; eyewear; face masks; footwear; and gloves. These protective barriers, used correctly, are crucial in reducing the risk of infection. While it is important to ensure quality and safety, not all items are required for all procedures and it is important to determine which items are relevant in which circumstances to provide cost-effective care.

Aprons, Gowns, and Scrubs

Aprons, gowns, and scrubs all serve to protect the health worker from blood and body fluids of the client and to protect clients from any microorganisms on the health worker. Aprons made of plastic or rubber serve as waterproof barriers at the front of the body. Aprons may be worn over scrub suits as an additional layer of protection, thereby decreasing cleaning costs and improving barrier effectiveness. Healthcare providers and staff should wear aprons during any procedures—inpatient and outpatient—in which blood or other body fluids may spill or splash (including PAC procedures) and when cleaning any instruments and procedure areas contaminated with blood or other body fluids. Scrubs, or scrub suits, and surgical gowns may be worn over or in place of regular clothes to prevent damage (including contamination or staining) of a health worker’s personal attire. Scrubs and gowns are typically made of fabric; therefore, once they become wet or soiled, they become a less effective barrier. Those made of fluid-resistant materials provide more protection than others. Unless a health worker is expected to engage in activities that will likely cause their clothes to become soiled, scrubs may be an unnecessary and excessive expense; aprons may be a more cost-effective measure for these instances.

Caps

Caps cover the head, preventing hair and flakes of skin from the scalp from shedding on clients during surgeries. Caps also serve to protect healthcare workers during any procedures—inpatient and outpatient—in which blood or other body fluids may spill or splash (including during PAC procedures) and when cleaning any instruments and procedure areas contaminated with blood or other body fluids. For instance, caps should be worn during surgical procedures, such as VA and D&E. Caps must cover all of a person’s hair to be effective.

Eyewear

Appropriate eyewear is essential to preventing blood or other body fluid from splashing into healthcare workers’ eyes during inpatient and outpatient procedures, including PAC procedures, and when cleaning contaminated instruments. There are many different types of protective eyewear, including clear plastic face shields, glasses, goggles, and visors. Corrective eyewear, such as prescription glasses, and glasses with plain lenses are also acceptable. Protective eyewear should be worn during surgical procedures. For instance, eyewear worn during VA can protect providers in cases where there are issues with suction and splashing occurs while emptying the syringe.

Face Masks

Face masks protect clients from moisture droplets expelled when health workers speak (or cough or sneeze). Masks also prevent client blood or other body fluid from splashing into healthcare workers’ mouths or noses. Face masks must be made of fluid-resistant material (such as standard surgical masks) and cover the healthcare worker’s mouth, nose, and lower face (including jaw and any facial hair) to be effective in protecting both the healthcare worker and the client. Masks made of cloth or paper are generally ineffective. PAC providers and support staff must assess the risk as well as the availability of face shields or visors when deciding if a mask is needed. Masks are most likely unnecessary for providing medical management for abortion-related complications but are likely needed for performing surgical treatment.

Footwear

Healthcare workers must wear sturdy footwear to protect their feet from injury—for instance from sharps or heavy items that may fall on them. Close-toed rubber or leather boots or shoes are recommended; sandals or thongs and cloth shoes are not. Additionally, footwear must be kept clean and free of blood and body fluid contamination. Shoe covers may provide additional protection but must be removed prior to leaving the surgical area. Shoe covers’ effectiveness decreases when they become soaked with blood or body fluid and when they are
worn outside the operating area, as is common practice. If a healthcare worker has clean, sturdy shoes that they can use only in the surgical area, they do not need shoe covers.

Gloves
There are three types of gloves used in PAC: surgical gloves, examination gloves, and utility gloves.

- **Sterile surgical gloves** are used when performing invasive medical or surgical procedures, such as those involving contact with tissue deep under the skin. Surgical gloves are also necessary for handling instruments that enter the uterine cavity, including during VA and D&E procedures, insertion and removal of implants and IUDs, and provision of sterilization. Surgical gloves are usually made of latex rubber because of its durability, elasticity, sensitivity, and user-comfort. Increases in latex allergies have led to the development of a synthetic, rubber-like material, nitrile; however, nitrile surgical gloves are not yet widely available in many countries. Surgical gloves are sized to fit the wearer, permitting greater movement during procedures, but are therefore quite expensive and thus should not be used for tasks where other types of gloves will provide adequate protection.

- **Examination gloves** provide protection during routine duties involving contact with mucous membranes and skin, for instance, when performing pelvic examinations and providing injectable contraceptives. Most examination gloves are vinyl, making them relatively inexpensive compared to surgical gloves. Because vinyl is inelastic, these gloves fit loosely (only available in small, medium, and large sizes) and can tear easily. Higher quality examination gloves made of latex may be available in some settings.

- **Utility gloves** should be worn when processing instruments or other contaminated equipment and items, handling contaminated waste, and cleaning contaminated surfaces. These heavy-duty household gloves are made of thick rubber, so they are less flexible and sensitive than surgical and examination gloves, but they provide maximum protection. The thick rubber is especially effective in protecting cleaning personnel and waste handlers. Utility gloves are also inexpensive and can be washed, rewashed, and reused many times.

**When to Wear, or Not Wear, Gloves**
In general, healthcare workers should wear gloves when:

- Completing any task in which there is a reasonable chance of hand contact with blood or other body fluids, mucous membranes, or non-intact skin (for instance, during many PAC procedures)
- Performing invasive medical procedures
- Processing instruments and equipment for reuse (for instance, in provision of PAC)
- Handling contaminated waste or touching contaminated surfaces

It is also important that healthcare workers only wear gloves when needed. It is not uncommon for healthcare workers to wear gloves when they are not needed—when there is no contact with blood or other body fluids—for example, when checking a client’s blood pressure, writing notes in charts, or using the telephone. Wearing gloves all the time may make some health workers feel more protected but doing so can increase the spread of microorganisms as these workers may not change their gloves or wash their hands for prolonged periods of time. Further, this practice represents an unnecessary use of an often-scarce resource, leading to potential glove shortages that can affect their availability for tasks where they are required.

The table on the following page lists common activities or tasks associated with PAC, indicates if gloves are typically needed, and if so, which type of glove to use.
### Gloves Recommendations for Common Postabortion Care Procedures

<table>
<thead>
<tr>
<th>Activity or Task</th>
<th>Are Gloves Needed?</th>
<th>Type of Glove Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure check</td>
<td>No</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Temperature check</td>
<td>No</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Blood draw</td>
<td>Yes</td>
<td>Examination gloves</td>
</tr>
<tr>
<td>Injection</td>
<td>Yes</td>
<td>Examination gloves</td>
</tr>
<tr>
<td>Intravenous line insertion or removal</td>
<td>Yes</td>
<td>Examination gloves</td>
</tr>
<tr>
<td>Pelvic examination</td>
<td>Yes</td>
<td>Examination gloves</td>
</tr>
<tr>
<td>VA (no-touch technique)</td>
<td>Yes</td>
<td>Surgical gloves</td>
</tr>
<tr>
<td>D&amp;E</td>
<td>Yes</td>
<td>Surgical gloves</td>
</tr>
<tr>
<td>Laparotomy (for complications such as pelvic abscess or uterine perforation)</td>
<td>Yes</td>
<td>Surgical gloves</td>
</tr>
<tr>
<td>IUD insertion and removal (sterile package; no-touch technique)</td>
<td>Yes</td>
<td>Surgical gloves</td>
</tr>
<tr>
<td>Contraceptive implant insertion and removal</td>
<td>Yes</td>
<td>Surgical gloves</td>
</tr>
<tr>
<td>Sterilization (minilaparotomy, laparoscopic ligation, or vasectomy)</td>
<td>Yes</td>
<td>Surgical gloves</td>
</tr>
<tr>
<td>Cleaning or handling instruments and surfaces</td>
<td>Yes</td>
<td>Utility gloves</td>
</tr>
<tr>
<td>Handling medical waste</td>
<td>Yes</td>
<td>Utility gloves</td>
</tr>
<tr>
<td>Cleaning blood or body fluid spills</td>
<td>Yes</td>
<td>Utility gloves</td>
</tr>
</tbody>
</table>

Double gloving is not recommended for routine PAC. Gloves that become visibly soiled, punctured, or torn during the provision of PAC should be changed as soon as possible. Healthcare workers should don new gloves for each client to avoid cross-contamination; wearing the same gloves and washing gloved hands between clients or between dirty- to clean-body site care is not a safe practice. Washing gloved hands has proven to leave significant amounts of bacteria.\(^{182}\)

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Recommended Steps for Donning Surgical Gloves

There is a correct method to donning surgical gloves (after performing surgical hand hygiene) to minimize risk of contamination. The package encasing sterile gloves is not sterile; therefore another provider will need to unwrap the packaging. Alternatively, the sterile gloves can be unwrapped and placed in a sterile area with the gowns or on a sterile instruments trolley. The text box below illustrates step-by-step how to don sterile gloves.

How to Don Sterile Gloves

1. Perform hand hygiene before an “aseptic procedure” by handrubbing or hand washing.
2. Check the package for integrity. Open the first non-sterile package by peeling it completely off the heat seal to expose the second sterile wrapper, but without touching it.
3. Place the second sterile package on a clean, dry surface without touching the surface. Open the package and fold it towards the bottom so as to unfold the paper and keep it open.
4. Using the thumb and index finger of one hand, carefully grasp the folded cuff edge of the glove.
5. Slip the other hand into the glove in a single movement, keeping the folded cuff at the wrist level.
6-7. Pick up the second glove by sliding the fingers of the gloved hand underneath the cuff of the glove.
8-10. In a single movement, slip the second glove on to the ungloved hand while avoiding any contact/nesting of the gloved hand on surfaces other than the glove to be donned (contact/nesting constitutes a lack of asepsis and requires a change of gloves).
11. If necessary, after donning both gloves, adjust the fingers and interdigital spaces until the gloves fit comfortably.
12-13. Unfold the cuff of the first gloved hand by gently slipping the fingers of the other hand inside the fold, making sure to avoid any contact with a surface other than the outer surface of the glove (lack of asepsis requiring a change of gloves).
14. The hands are gloved and must touch exclusively sterile devices or the previously-disinfected patient’s body area.

**Recommended Steps for Removing Surgical Gloves**

Similar to donning surgical gloves, there is a correct method for removing (or doffing) sterile gloves—either at the end of a procedure or during a procedure, if the gloves become damaged and need to be replaced. Following the correct method is important for minimizing risk of contamination. After removing, discard the gloves immediately and perform hand hygiene. Surgical gloves should never be reused.

**How to Remove Sterile Gloves**

15-17. Remove the first glove by peeling it back with the fingers of the opposite hand. Remove the glove by rolling it inside out to the second finger joints (do not remove completely).
18. Remove the other glove by turning its outer edge on the fingers of the partially ungloved hand.
19. Remove the glove by turning it inside out entirely to ensure that the skin of the health-care worker is always and exclusively in contact with the inner surface of the glove.
20. Discard gloves.
21. Perform hand hygiene after glove removal according to the recommended indication.

NB: Donning surgical sterile gloves at the time of a surgical intervention follows the same sequences except that:
- it is preceded by a surgical hand preparation;
- donning gloves is performed after putting on the sterile surgical gown;
- the opening of the first packaging (non-sterile) is done by an assistant;
- the second packaging (sterile) is placed on a sterile surface other than that used for the intervention;
- gloves should cover the wrists of the sterile gown.

Client Preparation

Surgical procedures—such as VA and D&E as well as IUD and implant insertion and removal—have the potential to cause infection, due to microorganisms on the skin, cervix, or vagina of the client or from the skin of the provider. However, there are certain measures that can reduce the likelihood of such infections. Client preparation begins with cleansing the cervix, perineum, and vagina with an antiseptic solution and applying drapes before beginning the surgical procedure. It also involves cleaning the perineum and vagina at the end of the procedure, before applying the sanitary pad. For PAC clients who request contraceptive implant insertion or removal, client preparation includes cleansing the implant insertion or removal site with an antiseptic solution and then draping the procedure area with a single fenestrated drape. Use of prophylactic antibiotics is not routinely recommended for PAC unless there is evidence of infection or a significantly high risk of infection.

Types of Antiseptics

Many chemicals qualify as safe skin antiseptics. The following antiseptic solutions are commonly available:

- Chlorhexidine gluconate (4%) (such as Hibiclens®, Hibiscrub®, and Hibitane®)
- Chlorhexidine gluconate and cetrimide, various concentrations
- Iodophors, various concentrations (povidones or iodopovidones, such as Betadine®)

Do not use alcohol or alcohol-containing solutions, which can burn, dry, and irritate mucous membranes and, as a result, promote the growth of microorganisms. Similarly, do not use hexachlorophene solutions (such as pHisoHex®), as it is neurotoxic and is readily absorbed by mucous membranes.

Antiseptic Application

For cervical and vaginal preparation, prior to inserting the VA cannula, dilators, or ovum forceps, use an aqueous (water-based) antiseptic solution, such as an iodophor (povidone-iodine) or chlorhexidine gluconate. **Note:** The same antiseptics can be used for preparing the skin before implant insertion or removal procedures. If the perineal area is visibly soiled, clean it with soap and water and dry it before applying an antiseptic solution. Then, after inserting the speculum, apply the antiseptic solution liberally to the cervix and vaginal walls twice, using a soaked sterile gauze. When using iodophor solutions, wait two minutes before proceeding to ensure that full antimicrobial action has occurred.

**Note:** Antiseptic solutions are not adequate for high-level disinfection of inanimate objects, such as surgical instruments. Refer to subsequent sections in this session for more information on which agents are effective for cleaning and disinfecting procedure areas and equipment.

Safe Surgical Technique

Providers should be gentle when performing any surgical procedure and ensure hemostasis is achieved to reduce the risk of sepsis. This includes gently applying traction to the cervix with the tenaculum and exercising care when inserting and removing implants. Roughly handling tissues and/or failing to practice proper surgical techniques may cause hematoma formation or tissue necrosis and increase the risk of infection.

No-Touch Technique

When advancing the VA cannula into the uterine cavity, it is possible to introduce pathogens that can cause infection. Using the no-touch technique throughout the procedure, as well as sterile instruments, can reduce the risk of infection. The no-touch technique means that no part of the cannula or any other instrument that enters the uterine cavity should touch any contaminated surfaces before passing through the cervix. Specifically, the tenaculum or cervical dilator tip (if used) and the cannula itself must not touch the examination table; any
unsterile areas of the instrument tray, gloves, or the client’s vaginal walls; or the speculum or retractor before insertion and providers should only handle the parts of these instruments that will not come into contact with the client. Additionally, providers should take care to insert and remove instruments into and from the uterine cavity through the cervical os as few times as possible.

**Safe Surgical Environment**

Creating a safe surgical environment is important for the health and safety of clients and providers alike. Doing so requires the attention and commitment of staff across the facility.

**Limiting Access to Procedure Areas**

Limiting the number of people who may enter (including those who may come in and out of) procedure areas and operating theaters designated for PAC procedures to only those who serve clear purposes can reduce the risk of infection. Keeping doors and windows closed at all times—and using air conditioning, as appropriate—can similarly reduce the presence of dust, insects, and other potential contaminants and also help minimize the risk of infection.

**Safe Handling of Sharps**

The term “sharps” refers to any sharp instruments or objects used for providing healthcare, including intravenous catheters, needles (all types) and syringes, scalpels, and razor blades. Trocars and other sharp instruments (such as tenaculums) are also considered sharps but are usually reusable. Healthcare providers can accidentally stick themselves, fellow staff, or clients with sharps during clinical procedures. Particularly risky are instances in which staff members with unprotected sharps make sudden movements, clients move suddenly during injections, or when sharps are placed in unexpected areas (such as on or under surgical drapes). Accidents can also happen when cleaning instruments and cleaning areas in which instruments are placed. These sharps-related injuries may result in the spread of hepatitis B and C as well as HIV.

The following precautions can reduce the risk of sharps-related injuries:

- Minimize direct handling of sharp instruments, for instance, by passing sharps on a tray rather than hand-to-hand.
- Do not bend, break, or recap needles before disposal and dispose all sharps directly into a puncture-proof container or sharps box.
- Ensure puncture-proof containers are always available and within easy reach for disposing sharps.
- Disinfect and sterilize reusable instruments (such as tenaculums and trocars) according to local protocols; do not place these in sharps boxes.

While manufactured sharps containers exist, they are not widely available and can be expensive. If availability or cost is a challenge, it is possible to create similar puncture-proof containers using a variety of readily available materials, such as cans, durable plastic bottles and containers, and heavy-duty cardboard boxes. Although some materials offer more safety than others, all provide low-cost, sustainable options for disposable sharps containers. Best practices for using any type of sharps container include:

- Place sharps containers as close to the point of sharps use as possible and ensure they are easy to see and reach; do not place them too high or too low to be readily accessed.
- Mark sharps containers clearly to prevent them from being used for other purposes.
- Do not place sharps containers in high-traffic areas.
- Fill sharps containers no more than three-quarters before replacing; make a visible marking at the three-quarters mark so it is clear when it is time to replace the container.
- Do not shake sharps containers to make more room for additional sharps.
- Encapsulate finished containers by pouring cement, clay, or foam until the container is completely full and
then send the container (after the material has hardened) for disposal, for instance to be buried or sent to a landfill. This is the easiest way to safely dispose of the sharps. If encapsulation is not possible, cap or seal the container and then burn or bury it to reduce the risk that the contents may be accessed and/or reused.

The following actions can reduce the risk of infection in cases of accidental exposure to blood or other body fluids, either by a sharp injury (such as a needle stick) or splash:

- Wash the puncture area or cut with soap and water.
- Flush splashes to the mouth, nose, or skin with water.
- Irrigate splashes to the eyes with water or saline.

**Postexposure Prophylaxis**

Healthcare workers—including PAC providers, support personnel, and maintenance staff—should be familiar with guidelines for postexposure prophylaxis of hepatitis B and HIV and should have access to relevant care at all times. Health facilities should ensure an infectious disease specialist or other provider with expertise in postexposure prophylaxis protocols is available to provide consultations for any staff or clients who become exposed to blood or other body fluids through sharps-related injuries or splashes to the mucous membranes.

Postexposure prophylaxis therapies can reduce the risk of transmission of some blood-borne pathogens. Whether postexposure prophylaxis is indicated depends on a number of factors, including the infection status of the individual whose blood or fluids are involved, the type of exposure (e.g., a splash on the skin versus a deep puncture wound), the vaccination status of the exposed person, the length of time since the exposure, and the availability of relevant medications or other therapy. Potential therapies include:

- **Hepatitis B**: Hepatitis B immune globulin and hepatitis B vaccine can reduce the risk of infection after exposure to blood or other body fluids containing the hepatitis B virus. Anyone at risk of exposure to blood or body fluids should be vaccinated against hepatitis B (assuming vaccine availability).
- **Hepatitis C**: There is no postexposure prophylaxis available for hepatitis C; neither immune globulin nor antiviral drugs have proven to reduce the risk of hepatitis C transmission. Anyone at risk of exposure to blood or body fluids should be vaccinated against hepatitis C (assuming vaccine availability).
- **HIV**: Antiretroviral drug combinations for HIV postexposure prophylaxis include Tenofovir (TDF) with Lamivudine (3TC) or Émitricabine (FCT) with Lopinavir/ritonavir (LPV/r) or Atazanavir/ritonavir (ATV/r).

**Facility Cleanliness and Hygiene**

Health facility cleanliness and hygiene (including waste disposal and management) are vital to the health and safety of staff, clients, visitors, and the community. Routine cleaning is necessary to maintain a standard of cleanliness for all areas of a health facility and is a key component of infection prevention. Health facility administration should develop and circulate or post regular cleaning schedules where staff can readily access them and ensure the staff responsible adhere to those schedules. It is also important to select cleaning products based on their use, efficacy, safety, and cost.

While certain areas of the facility (such as operating theaters) require special cleaning and maintenance, there are some general practices that are applicable to all areas. Ensure all cleaning staff adhere to the following standard practices when cleaning any area of the facility.

- Consistently wear gloves and other necessary personal protective equipment when cleaning.
- Use wet or damp cloths and mops (as appropriate) with decontamination solution to scrub floors, surfaces, and walls instead of dry-dusting or sweeping to reduce the spread of dust and microorganisms.
- Begin the cleaning process by addressing the least soiled areas and progress to the most soiled areas and clean from high to low, so that any dirt or debris that may fall down is cleaned last.
- Change the cleaning solution whenever it appears to be dirty, as it will become ineffective for eliminating microorganisms once it is heavily soiled.

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Cleaning Requirements for Key Facility Areas

Administrative areas and waiting rooms have a low risk of becoming contaminated with infectious microorganisms. Basic cleaning—similar to household cleaning—is typically sufficient for these areas. Cleaning staff should service these areas on a weekly basis as part of a standard schedule but should also be prepared to provide additional services when and if these areas appear to be dirty, following the guidance provided for general facility cleanliness and hygiene.

Areas such as latrines, toilets, and sluice rooms (utility rooms used for disinfection and disposal of equipment, supplies, and waste) are usually heavily contaminated. Cleaning staff should service these areas daily, or more often if they are heavily used. It is important to use different cloths and mops for these areas than those used for client care areas to prevent cross-contamination.

Cleaning staff should service client care areas carefully, using a disinfectant cleaning solution for all surfaces. There is a high risk of contamination in these areas—even when dirt may not be readily visible—presenting a significant concern for the potential transmission of infection to clients and staff alike. The table below outlines key cleaning tasks at various intervals for client care areas.

<table>
<thead>
<tr>
<th>Timing</th>
<th>Key Cleaning Tasks</th>
</tr>
</thead>
</table>
| At the start of each day                  | • Clean horizontal surfaces—counters, examination chairs or couches, lamps, mayo stands or trolley tops, operating or procedure tables, and any other potentially contaminated surfaces—using a cloth dampened with water.  
  • Clean floors with a mop dampened with water. |
| Between clients                           | • Disinfect counters, examination chairs or couches, lamps, mayo stands or trolley tops, operating or procedure tables, and any other potentially contaminated surfaces with a cloth dampened with a 0.5% chlorine solution or by spraying the solution onto the surfaces with a spray bottle and wiping with a cloth dampened with water.  
  • Disinfect blood and other body fluids spills with a 0.5% chlorine solution immediately.  
  • Clean visibly soiled areas of the ceiling, walls, or floor (in that order) using a cloth or mop dampened with a disinfectant cleaning solution.  
  • Place any waste in a leak-proof container; empty the container when three-quarters full. |
| At the end of each clinical session (or day) | • Disinfect all surfaces—counters, door handles or plates, examination chairs or couches, lamps, mayo stands or trolley tops, operating or procedure tables (including the base, sides, and legs), sinks, tables, and walls—with a cloth dampened with a 0.5% chlorine solution or by spraying the solution and wiping with a cloth dampened with water. Rinse sinks with clean water after cleaning.  
  • Clean floors with a mop soaked in a disinfectant cleaning solution.  
  • Check sharps disposal containers; remove and replace when three-quarters full.  
  • Remove medical and hazardous chemical waste and dispose of it (burn or bury) as soon as possible to limit potential contact.  
  • Wash waste containers with a disinfectant cleaning solution and rinse with water. |
| Once a week                               | Clean ceilings using a mop dampened with a disinfectant cleaning solution.                                                                             |

Sources:
Waste Management and Disposal

Waste can be either contaminated (potentially infectious) or noncontaminated. Most waste (such as bottles, boxes, and papers as well as food products) is noncontaminated and can be disposed of using the usual methods or sent to a local dump or landfill. However, contaminated waste—either in liquid or solid form—poses risk of infection and must be disposed of carefully, according to recommended infection prevention practices, in order to protect healthcare providers, staff who handle waste items, clients, and the local community more broadly. Contaminated waste includes blood and other body fluids, as well as items that come in contact with blood and other body fluids, such as used dressings and medical devices.

Recommended practices for managing contaminated waste are listed below.

- Use leak-proof metal or plastic waste containers with tight-fitting lids for contaminated waste. *Note: These containers may be lined with plastic bags to ease emptying and to minimize exposure to the waste.*
- Use separate containers for disposing of burnable and nonburnable contaminated waste to minimize exposure to the waste.
- Use puncture-proof sharps containers for all disposable sharps.
- Place waste containers in convenient locations, in close proximity of where waste is generated.
- Wash all waste containers with a disinfectant cleaning solution and rinse with water regularly.
- Only use contaminated waste containers for contaminated waste.
- Wear utility gloves and other appropriate personal protective equipment (such as aprons, face shields, and closed-toe shoes) when handling contaminated waste.
- Wash hands or use an antiseptic hand rub after removing gloves, after handling waste.

Recommended practices for disposing of contaminated waste are listed below.

- Bury contaminated waste to prevent further handling.
- Pour liquids and other wet waste directly into a safe sewage system; or, if such a system does not exist, pour liquids into a deep hole and cover the hole.
- Incinerate (burn) contaminated solid waste to destroy the item and any microorganisms. *Note: This is the best method for disposing of contaminated waste as it reduces the bulk volume of waste and ensures that items are not scavenged and reused.*

Healthcare workers and housekeeping staff must be trained to keep contaminated and noncontaminated waste separate. Consult local health facility waste management guidelines, as available, for additional instructions.

Processing Medical Devices for Reuse

Appropriate processing of all medical devices for reuse is critical to minimizing the risk of infection for clients and staff. Healthcare workers should employ the Spaulding Classification, a risk assessment comprising three categories (shown in the table on the following page), to categorize reusable medical devices according to their intended use and the level of decontamination required to render the device safe for reuse.  

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Spaulding’s Classification for Decontamination of Reusable Medical Equipment

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Recommended Level of Decontamination</th>
<th>Examples of Medical Devices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High (Critical)</strong></td>
<td>Sterilization</td>
<td>Surgical instruments, implants, rigid endoscopes, syringes, needles, MVA Plus® cannulae</td>
</tr>
<tr>
<td>Items that break the skin or mucous membranes or enter a sterile body cavity</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Intermediate (Semi-Critical)</strong></td>
<td>Disinfection (high-level)</td>
<td>Respiratory equipment, noninvasive flexible endoscopes, bedpans, urine bottles</td>
</tr>
<tr>
<td>Items that come into contact with mucous membranes or body fluids</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Low (Noncritical)</strong></td>
<td>Cleaning (visibly clean)</td>
<td>Blood pressure cuffs, stethoscopes</td>
</tr>
<tr>
<td>Items that come into contact with intact skin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The previous approach for decontamination of medical devices by soaking in 0.5% chlorine solution or other disinfectant before cleaning is no longer recommended for the following reasons:

- A 0.5% chlorine solution corrodes most surgical instruments.
- Blood and body fluids, which may cause microbial contamination or form biofilm, may render the disinfectant inactive.
- Using such a solution could lead to the development of microbial resistance to the disinfectant.
- Transporting contaminated items soaked in disinfectant to other areas for processing may result in accidental damage and/or inappropriate handling, putting health workers at increased risk.

The recommended steps for instruments processing therefore should include the following: (1) cleaning at point of use; (2) inspection, function testing, and packaging; (3) sterilization; and (4) storage.

**Step One: Cleaning at Point of Use**

Physically cleaning to remove dirt, foreign matter, and organic material that can interfere with sterilization or high-level disinfection is the first step. This also reduces the number of microorganisms (including bacterial endospores) on instruments and other items. Cleaning instruments at the point of use is ideal. However, if this is not possible, place the items in clean water or wrap them with a moist cloth to prevent blood and other body fluids from drying and becoming difficult to remove during cleaning later.

Cleaning in this context involves scrubbing the item with a brush, detergent, and water. Detergent is important for effectively removing grease, oils, and proteins. Enzymatic cleaning agents, which are highly effective in breaking down organic matter, are good alternatives to detergent but they are not disinfectants. Do not use hand soap, which can leave a residue or soap scum, or steel wool or other abrasive cleaners, which can damage the items. Other important tips for cleaning at this stage include:

- Always wear utility gloves, a mask, and protective eyewear when cleaning instruments and other items.
- Disassemble instruments, if possible, before cleaning.
- Use a soft brush (or old toothbrush), detergent, and water to scrub items vigorously, and hold instruments and other items under water while scrubbing to avoid splashing.
- Carefully clean grooves, joints, and teeth where organic material can collect and stick.
- Rinse items thoroughly with clean water to remove all detergent, as any detergent that remains can interfere with further processing.
- Allow items to air-dry or dry items with a clean cloth. This is especially important for items that will be processed further with chemical solutions, as residual water can dilute the chemical solution and decrease effectiveness.
Dispose of all sharps in accordance with national and facility waste management guidelines.

Dispose of surgical and examination gloves (where applicable) in accordance with national and facility waste management guidelines.

### Cleaning Reusable PAC Instruments
Dispose of all sharps. Disassemble the syringe completely, including removing the collar stop and the O-ring on the plunger (also remove the O-ring from inside the valve on a double-valve syringe). Wash all parts with detergent and water. Use a soft brush to scrub the syringe. Do not use a brush or other object to remove blood or tissue from the tip of the cannula, as this may create scratches that can trap microorganisms and can damage the tip, increasing the risk of breakage. Dislodge any material on the cannula by flushing with water or flicking the tip with a gloved finger. Rinse the syringe with clean water. Disassemble the speculum, as needed, for thorough cleaning with detergent and water. Open all forceps and clean hinged and serrated surfaces with a brush to remove all organic matter. Once cleaned, allow all instruments to air dry before moving to the next step.

### Step Two: Inspection and Function Testing of Cleaned Instruments
All instruments must be inspected and tested before reuse. The objectives of this step are to ensure that (1) the instruments are clean and no longer contain any organic matter, (2) all parts of the instruments are available (or a set is complete with all instruments), and (3) the instruments are in good working condition, free from any defects that would render them nonfunctional.

The following tasks are included in this step:

- Perform hand hygiene before beginning this activity.
- Inspect each set (e.g., an MVA kit, an implant kit, or an IUD kit) separately. For instance, inspect each part of an MVA kit separately for evidence of deterioration (such as cracks) before reassembling and testing.
- Critically inspect all surfaces—particularly crevices, joints, and serrations—of the instruments for cleanliness.
- Check hinged devices, such as forceps and scissors, for ease of movement. Do not use oil lubricants on hinges during this process.
- Check jaws of instruments for alignment.
- Identify any nonfunctional instruments, remove from the kit or set, replace, and document the replacement.
- Identify any missing instruments, replace, and document the replacement.
- Assemble instruments together (in a dish or on a drape, tray, or other appropriate material) before wrapping, labeling, and preparing for sterilization.
- Package instruments using materials that are compatible with the sterilization process and with the contents; this includes being:
  - Able to be closed and sealed
  - Free of loose fiber and particles
  - Nontoxic
  - Free of non-fast dyes
  - Permeable to steam and gaseous sterilizing agents
  - Resistant to penetration by microorganisms

**Note:** Use of double-layered textile packaging of an instruments tray and use of laminated pouches are the most common systems for packaging PAC-related kits. Do not use metal drums with fenestrations that can be opened and closed manually, as they do not guarantee sterility of the contents.

- Complete documentation, recording all instruments inspected, tested, and replaced (as necessary).
Step Three: Sterilization

The sterilization process kills all microorganisms, including the bacterial endospores that cause gangrene and tetanus. There are three methods of sterilization: steam sterilization (also known as autoclaving or moist heat under pressure), dry heat sterilization (electric oven), and chemical sterilization (cold). The effectiveness of any method of sterilization depends on the amount and type of microorganisms, organic material, and other matter present on the item as well as the amount of protection that the item provides the microorganisms (such as grooves where microorganisms can hide). Therefore, it is important to thoroughly clean items before sterilization (following guidance from Step 1).

Sterilization is the recommended method of decontamination of common PAC instruments (such as MVA kits, implant kits, and IUD kits), which come into contact with the uterine endometrium or tissue under the skin. High-level disinfection is insufficient for these instruments. Do not use dry heat sterilization on MVA equipment or any other instrument made of synthetic plastic. Additionally, boiling is no longer recommended for processing of any instruments irrespective of locality.

Step Four: Storage

Sterilized items should be used or properly stored immediately after processing to prevent contamination. The appropriate storage method depends on whether items have been sterilized, which sterilization method was used, and whether the items are wrapped or unwrapped. The previous steps provide basic directions for storage. It is important to always store instruments dry, as microorganisms can live and multiply in antiseptic and disinfectant solutions.

When retrieving a sterile item from a storage container, use only sterile forceps to avoid contaminating the item or the remaining items within the container. Storing only a small number of items in each container is a best practice for minimizing the risk of contamination during retrieval.

Additional Information on Infection Prevention and Control Practices

The following pages contain a series of figures and tables with additional information to support the guidance provided in this session.
Formulas for Preparation of Dilute Chlorine Solution

**Using Liquid Bleach**

Chlorine in liquid bleach comes in different concentrations. You can use any concentration to make a 0.5% dilute chlorine solution using the following formula:

\[
\frac{\text{% chlorine in liquid bleach}}{\text{% chlorine desired}} - 1 = \text{Total parts of water for each part of bleach}
\]

*Example:* To make a 0.5% chlorine solution from 3.5% bleach:

\[
\frac{3.5\%}{0.5\%} - 1 = (7) - 1 = 1\text{ part of bleach to }6\text{ parts water}
\]

*Therefore:* Add 1 part bleach to 6 parts water to make a 0.5% chlorine solution.

**Using Bleach Powder** (such as calcium hypochlorite 35%)

Using bleach powder, calculate the ratio of bleach to water by using the following formula:

\[
\frac{\text{% chlorine desired}}{\text{% chlorine in bleach powder}} \times 1,000 = \text{Number of grams of powder for each liter of water}
\]

*Example:* To make a 0.5% chlorine solution from calcium hypochlorite powder containing 35% active chlorine:

\[
\frac{0.5\%}{35\%} \times 1,000 = 0.0143 \times 1,000 = 14.3
\]

*Note:* When bleach powder is used, the solution often looks cloudy and the smell is not as strong as when liquid bleach is used.
### Recommended Dilutions of Bleach**

<table>
<thead>
<tr>
<th>Bleach Brand (Country)</th>
<th>Percent Available Chlorine</th>
<th>Dilution Necessary to Achieve 0.5% Concentration (for decontaminating tabletops and other surfaces, blood spills, soiled equipment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>JIK (Africa), Robin bleach (Nepal), Ajax (Jamaica)</td>
<td>3.5%</td>
<td>1 part bleach to 6 parts water, or 160 ml bleach to 1 liter water</td>
</tr>
<tr>
<td>Household bleach, Clorox (United States, Canada), ACE (Turkey), Jif, Red &amp; White (Haiti), Odex (Jordan), Eau de Javel (France, Vietnam), (15° chlorum), Clorox (Peru)</td>
<td>5%</td>
<td>1 part bleach to 9 parts water, or 110 ml bleach to 1 liter water</td>
</tr>
<tr>
<td>Blanqueador, Cloro (Mexico), Hypex (Jordan)</td>
<td>6%</td>
<td>1 part bleach to 11 parts water, or 90 ml bleach to 1 liter water</td>
</tr>
<tr>
<td>Lavandina (Bolivia)</td>
<td>8%</td>
<td>1 part bleach to 15 parts water, or 70 ml bleach to 1 liter water</td>
</tr>
<tr>
<td>Chloros (United Kingdom), Liguria (Peru)</td>
<td>10%</td>
<td>1 part bleach to 19 parts water, or 50 ml bleach to 1 liter water</td>
</tr>
<tr>
<td>Extrait de Javel (France) (48°chlorum), Chloros (United Kingdom)</td>
<td>15%</td>
<td>1 part bleach to 29 parts water, or 30 ml bleach to 1 liter water</td>
</tr>
</tbody>
</table>


**In countries where French products are available, the amount of active chlorine is often expressed as degrees chlorum. One degree chlorum (°chlorum) contains approximately 0.3% active chlorine. Eau de Javel, for example, contains 15°chlorum, which is equal to approximately 5% active chlorine.
### Use of Chlorine and Recommended Solution Strengths*

<table>
<thead>
<tr>
<th>Use</th>
<th>Available Chlorine ppm*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood spills</td>
<td>10,000</td>
</tr>
<tr>
<td>Laboratory discard jars</td>
<td>2,500</td>
</tr>
<tr>
<td>General environment disinfection</td>
<td>1,000</td>
</tr>
<tr>
<td>Disinfection of clean instruments</td>
<td>500</td>
</tr>
<tr>
<td>Infant feeding bottles and teats</td>
<td>125</td>
</tr>
<tr>
<td>Food preparation areas and catering equipment</td>
<td>125</td>
</tr>
<tr>
<td>Eradication of Legionella from the water supply system, depending on exposure time</td>
<td>5-50</td>
</tr>
<tr>
<td>Hydrotherapy pools:</td>
<td></td>
</tr>
<tr>
<td>Routine</td>
<td>1.5–3</td>
</tr>
<tr>
<td>Blood spills</td>
<td>6–10</td>
</tr>
<tr>
<td>Routine water treatment</td>
<td>1.5–1</td>
</tr>
</tbody>
</table>


** Undiluted commercial bleach products are usually available between 5.25% or 6.00% to 6.15% sodium hypochlorite depending upon the manufacturer. Sodium dichloroisocynaurate (NaDCC) tablets are also available and may be used for the preparation of chlorine solutions. There are test strips available for measuring the level of available chlorine in a diluted bleach solution to ensure the desired concentration as outlined above.
## Antiseptic Effectiveness

<table>
<thead>
<tr>
<th>Group</th>
<th>Gram-positive</th>
<th>Most gram-negative</th>
<th>Tuberculosis</th>
<th>Viruses</th>
<th>Fungi</th>
<th>Endospores</th>
<th>Speed</th>
<th>Relative Speed of Action</th>
<th>Affected by Organic Matter</th>
<th>Surgical Scrub</th>
<th>Skin Preparation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol (60 to 90%) (Ethyl or isopropyl)</td>
<td>Very Good</td>
<td>Very Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>None</td>
<td>Fast</td>
<td>Data Varies</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Not for use on mucous membranes</td>
</tr>
<tr>
<td>Chlorhexidine (4%) (Hibitane, Hibiscrub)</td>
<td>Very Good</td>
<td>Good</td>
<td>Fair</td>
<td>Fair</td>
<td>Fair</td>
<td>None</td>
<td>Slow</td>
<td>Slight</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Has good persistent effect</td>
</tr>
<tr>
<td>Iodine preparations (3%) (Iodine and alcohol tincture of iodine)</td>
<td>Very Good</td>
<td>Very Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Poor</td>
<td>Intermediate</td>
<td>Slight</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Not for use on mucous membranes</td>
</tr>
<tr>
<td>Iodophors (1:2.500) (Betadine)</td>
<td>Very Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>None</td>
<td>Slow</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Can be used on mucous membranes</td>
</tr>
</tbody>
</table>