Guideline on Postabortion Care for Public Sector Health Facilities

Ministry of Health
Department of Public Health
Maternal and Reproductive Health Division

2014

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1. Purpose

The objective of Postabortion care (PAC) is to strengthen the management of miscarriage and post-abortion complications as an integral component of comprehensive reproductive health services. This guideline is intended to improve the availability and quality of care for management of miscarriage and post-abortion complications given by non-specialist doctors within the health system at Station Hospitals, Township Hospitals or District Hospitals. Postabortion care (PAC) is a series of medical and related interventions designed to manage miscarriage and complications of unsafe abortion, and to address women's related health care needs. The ultimate goal of PAC is to reduce the maternal morbidity and mortality and to improve women's sexual and reproductive health and lives.

2. Scope

This Guideline includes the essential care and emergency care for women with miscarriage or abortion and its related complications. This guideline focuses more on the management of women who are experiencing only light to moderate vaginal bleeding. It also includes a series of medical and related interventions designed to manage the complications of miscarriage and abortion, in hospitals that have the facilities. An outline of emergency care provided by midwives and other staff working at health centres before referral to higher level care for further management of complicated cases is included. It also addresses other related health-care needs of women.

The Guideline includes information on identifying abortion, assessing for shock, conducting a complete clinical assessment, obtaining voluntary informed consent and developing a treatment plan, including pain management. Considerations for assessing and treating special populations of women for PAC are also presented.

Components of PAC

The Postabortion Care Consortium in 2002 expanded the three elements of post abortion care to five essential elements. These are:

1.Treatment of abortion and abortion-related complications that are potentially life-threatening;

2. Counseling to identify and respond to women's emotional and physical health needs and other concerns;

3. Post abortion family planning counseling and service provision to help women prevent unwanted pregnancy and practice birth spacing;

4. Reproductive and other health services that are preferably provided on-site or via referrals to other health facilities; and

5. Community and service-provider partnerships for healthy timing and spacing of pregnancy, and care and timely referral of women who experience miscarriage or complications of abortion.

High-quality woman-centered PAC is a comprehensive approach to meeting each woman's medical and psychosocial needs at the time of treatment for abortion complications. Health-care workers can give woman-centered PAC by:

- Providing respectful, confidential services;
- Involving women in their treatment;
- Offering as many choices as possible;
- Explaining the woman's condition and management to her in simple language and obtain her voluntary, informed consent prior to initiating care; and
- Ensuring that women's rights to high-quality care are honored.

Service providers need to be trained, technically competent, and use appropriate clinical technologies in order to provide high-quality care. Legal, regulator, policy and service delivery contexts will vary from country to country. Providers should be aware of the local policies such as reproductive health policy and laws related to abortion. Within the framework of national laws and policies, postabortion care services should be promoted.

3. Identifying abortion cases

Women of reproductive age who develop vaginal bleeding after delayed menses or a period of amenorrhoea with positive Urinary Chorionic Gonadotrophin (UCG) test (in places where the test can be carried out) can be identified as having an early pregnancy loss. The causes may be miscarriage, abortion, ectopic pregnancy or Hydaditidiform mole (H mole). After rapid initial assessment and stabilizing the patient's condition, providers should screen women to confirm the diagnosis of the type of abortion and to exclude ectopic pregnancy and H mole during the history and physical examination.

3.1 Miscarriage or abortion

If miscarriage or abortion is the possible diagnosis, it may be in one of the following stages of the abortion process.

- **Threatened miscarriage**: vaginal bleeding in a woman with a viable intrauterine pregnancy that may or may not continue.
  - Presents with light vaginal bleeding
  - Cramping and/or lower abdominal pain may be present
  - Cervical os: closed
  - Uterine size: equal to menstrual age

  Intra-uterine gestational sac, fetal pole and fetal cardiac activity seen on ultrasound scan (USS).

- **Inevitable miscarriage/abortion** – miscarriage is imminent or in the process of happening
  - Bleeding becomes heavy with cramping lower abdominal pain
  - Cervical os: open with tissue at os or inside the uterine cavity
  - Uterine size: equal to menstrual age

  Intra-uterine gestational sac is seen on USS. Fetal pole and fetal cardiac activity might or might not be seen on USS.

- **Incomplete miscarriage/abortion:** An abortion - whether spontaneous or induced - in which some pregnancy tissue passes out of the uterus but some remains.
  - Light to heavy bleeding
  - Cramping/pain
  - Open cervix
  - May see tissue at the cervical os
  - Uterine size corresponds to or is smaller than period of amenorrhoea
  - History of expulsion of products of conception is present

  USG: Heterogenous tissue with or without a gestational sac with distorted endometrial midline echo on USS.

- **Uncomplicated complete miscarriage/abortion**: a miscarriage/abortion in which all of the pregnancy tissue has passed.
  - History of expulsion of products of conception (POC)/"tissue" present
  - After expulsion of tissue per vagina
    - Little or no more vaginal bleeding,
    - Cramping and pain can still be present
    - Cervical os closed
    - Uterine size smaller than menstrual date

  Empty uterus and endometrial thickness of <15 mm on USS.

- **Missed Miscarriage:** A kind of miscarriage; the pregnancy ends, but the POC/tissue remains in the uterus.
  - May be asymptomatic
  - Uterus size: smaller than menstrual age
  - Cervical os: closed
  - May be diagnosed by USS - fetal pole with crown – rump length (CRL) >6 mm with no fetal heart beat or if CRL ≤ 6mm with no change on a rescan taken 7 days later.

- **Blighted ovum or Anembryonic pregnancy:**
  - May be asymptomatic
  - May be diagnosed by USS - Gestational sac diameter more than 20 mm with no fetal pole or yolk sac.

Miscarriage or abortion with complications

In some cases, the miscarriage/abortion can present with signs of complications such as: shock, infection or sepsis and intra-abdominal injury.

3.2 Exclusion of ectopic pregnancy

Providers should screen women for risk factors of ectopic pregnancy during the history and physical examination. A screening checklist should include relevant history, such as a history of previous ectopic pregnancy, tubal ligation, tubal surgery or an IUD in place. The screening checklist should also include signs and symptoms of ectopic pregnancy, such as sudden onset of severe abdominal pain with slight bleeding and marked pallor out of proportion to the amount of bleeding per vaginum, tender abdomen with signs of free fluid. Women with suspected ectopic pregnancy should be referred to higher level care after giving emergency care.

Tenderness in the pelvis with or without adnexal mass may be felt on bimanual examination. However, vaginal examination should be performed with extra caution and only where there are facilities for immediate laparotomy if ectopic pregnancy is suspected because it could easily rupture during examination. Although UCG is positive, an empty uterus with or without adnexal mass and with or without free fluid can be found on ultrasound examination.

3.3 Exclusion of Hydatidiform mole

The health care provider should consider Hydatidiform mole if there is profuse vaginal bleeding with or without passage of vesicles and the uterus may be larger than the period of amenorrhoea. On ultrasound examination, vesicles can be seen.

Diagnosis of a molar pregnancy may also be made upon examination of uterine contents following vacuum aspiration; making inspection of uterine contents following aspiration a critical step.

4. Clinical assessment and treatment of miscarriage/abortion and its related complications

Clinical assessment should focus on the health status of the woman, identify whether she has any abortion-related complications and exclude other causes of bleeding in early pregnancy. Women who present with miscarriage or post-abortion complications need to have a rapid initial assessment for shock. Some women will be haemodynamically unstable or have serious complications that need immediate attention including severe bleeding or hemorrhage, infection or sepsis and intra-abdominal injury.

Once a woman has been stabilized, the clinical assessment should focus on the type of abortion (listed above), whether there are complications that need attention and her eligibility for methods of uterine evacuation.

The assessment should be conducted in private. The components of a complete clinical assessment are:

- Client history
- Physical examination
- Collection of specimens and ordering of any laboratory tests, only if needed.

An important part of the clinical assessment is an evaluation of the woman's emotional state, social and family circumstances, as they have a direct bearing on her clinical experience. Open, supportive communication and a gentle, reassuring manner help ensure that the provider obtains the relevant information needed to offer the best possible care for the woman.

4.1 **Rapid initial assessment**

4.1.1 General condition:
Normal or anxious, restless, sweating, confused, drowsy, unconscious

4.1.2 Color:
Normal and pink or pale or bluish (cyanosis) or flushing

4.1.3 Skin temperature:
Normal or febrile or cold and clammy extremities

4.1.4 Respiration:
Normal or rapid breathing, in distress with working ala nasi, acidotic breathing or noisy breathing with crepitations and rhonchi

4.1.5 Cardiovascular system:
Pulse: normal or rapid, weak pulse

If the patient is in a state of shock, immediate resuscitation is required in accordance with emergency care guidelines. Signs of shock can include:

- Low blood pressure (Systolic BP <90mm Hg, Diastolic BP <60 mm Hg)
- Rapid pulse
- Pallor or cold extremities
- Decreased capillary refill
- Dizziness or inability to stand
- Difficulty breathing
- Impaired consciousness, lethargy, agitation, confusion
- Low urine output (<30 ml per hour)

When the patient's condition is stable, proceed with complete clinical assessment. (Refer to Annex 1 Chart 1 for Clinical assessment and Chart 2 for Management of shock)

4.2 Complete clinical assessment

4.2.1 History

4.2.1.1 History of present illness:

Period of amenorrhoea or overdue periods

Other signs of pregnancy (for example, nausea, vomiting, breast tenderness)

Vaginal bleeding or foul smelling discharge per vaginum:

Duration

Amount:

- Light to moderate vaginal bleeding: less than or equal to a normal menstrual period.
- Severe vaginal bleeding: Soaking more than two sanitary pads per hour for two consecutive hours, especially if accompanied by prolonged dizziness, and increasing fatigue.

Other associated symptoms:

Lower abdominal pain:

- Onset: Acute or sub acute
- Duration
- Nature: Cramping or continuous dull aching
- Severity
- Passage of products of conception (POC)

Fever and chills

Shoulder tip pain

Frequent passage of mucous stools

Planned pregnancy or not

History of intervention to terminate pregnancy:

Time of intervention

Method used (mechanical, traditional or modern medicines)

History of taking antibiotics or other medication for symptoms

4.2.1.2 Menstrual history:

Date of last menstrual period (LMP)

Pattern of menstrual cycles – regular or not

4.2.1.3 Last contraceptive use:

Type and duration used

4.2.1.4 Obstetric and gynaecological history

Number of pregnancies and miscarriages

History of ectopic pregnancy, STIs

4.2.1.5 Medical and surgical history

Bleeding or clotting disorders, Medical disease, Drug allergies

Psychological assessment

4.2.2 Physical examination

4.2.2.1 Vital signs:

Temperature, Pulse rate, Blood pressure, Respiration rate

4.2.2.2 Examination of cardio-vascular system (CVS)

Examination of respiratory system

4.2.2.3 Abdominal examination

Soft and moves with respiration or distended abdomen or tense and rigid abdomen with guarding

Any tenderness and rebound tenderness

Any palpable mass or uterine enlargement

Any uterine tenderness

Signs of free fluid

Liver dullness obliterated or intact

Decreased bowel sounds or absent bowel sounds

4.2.2.4 Pelvic examination

Vaginal bleeding: bright red or dark color, with or without clots, active bleeding or not

Foul smelling discharge

Passage of tissue: Vesicles or POC

Presence of any foreign body, injuries to vagina or cervix

Cervical os: closed or open with tissue at os or inside uterus

Uterine size: equal to or less than or larger than menstrual age

Uterine tenderness

Fornices: Any palpable masses or fullness in fornices and Pouch of Douglas

Cervical excitation pain

(Refer to Annex 1 Chart 1 for Clinical assessment)

4.2.3 Investigations

History and physical examination are typically sufficient to make a diagnosis of miscarriage/abortion. No routine laboratory tests are required. If there is doubt that the woman is pregnant, the use of a pregnancy test or ultrasound can be performed. Hemoglobin/hematocrit are optional but can be helpful if anemia is prevalent or in the management of severe hemorrhage and/or shock. Other investigations that can be conducted include:

UCG

Blood CP, Grouping and Rh typing

HVS for Culture and Sensitivity if infection is suspected

Posterior colpocentesis (PoD puncture) if pelvic abscess is suspected

If facilities are available

Ultrasound pelvis and abdomen

X-Ray Abdomen for gas under diaphragm if uterine perforation is suspected

4.2.4 Diagnosis

Five main clinical conditions can be categorized according to presenting symptoms as follows.

1. Light to moderate vaginal bleeding with no other complications
2. Severe vaginal bleeding
3. Common signs and symptoms of infection/sepsis
    - Fever with or without chills
    - Foul smelling vaginal discharge
    - Pain and tenderness of the uterus, in the supra-pubic area and/or abdomen
    - Elevated white blood cell count
4. Signs and symptoms of shock
    - Low blood pressure (Systolic BP <90 mm Hg, Diastolic BP <60 mm Hg)
    - Rapid pulse
    - Pallor or cold extremities
    - Decreased capillary refill
    - Dizziness or inability to stand
    - Difficulty in breathing
    - Impaired consciousness, lethargy, agitation, confusion
    - Low urine output (<30 ml per hour)
5. Features of intra-abdominal injury
    - Distended abdomen or tense and rigid abdomen with guarding
    - Tenderness and rebound tenderness
    - Tender uterus
    - Signs of free fluid
    - Liver dullness: obliterated
    - Absent bowel sounds
    - Gas under diaphragm on X-ray of abdomen

4.3 Management

Management depends on the type of abortion, clinical condition, the size of uterus, medical eligibility, availability of equipment and supplies, and a woman's preference. Options include Surgical management (vacuum aspiration), medical management or expectant management.

- Informed consent should be obtained whatever treatment option is desired.
- Contraceptive needs and methods available should be discussed.
- Prophylactic antibiotics are recommended for uterine vacuum aspiration.
- For uterine vacuum aspiration, providers should inspect the evacuated uterine contents to ensure completed abortion or aid in diagnosing ectopic pregnancy, molar pregnancy or infection.
- Women who present for uterine evacuation, medical or vacuum aspiration, should be offered all pain management options and provided these services without delay.

Table 1: Diagnosis and treatment options

Diagnosis	Treatment options
Threatened miscarriage/abortion	• Reassurance • Expectant management • If continued bleeding, further clinical assessment
Inevitable miscarriage/abortion **Incomplete miscarriage/abortion**	• Depending on the clinical condition and the woman's preference, she may be offered expectant, surgical (vacuum aspiration) or medical management • Antibiotics if indicated • Pain control
Missed miscarriage/abortion	• Depending on the clinical condition and the woman's preference, she may be offered expectant management, or medical management or vacuum aspiration
Complete miscarriage/abortion	• Expectant management • Antibiotics if indicated • Pain control

Table 2: Surgical and medical management of post abortion complications by gestation size

For uterine size up to 12 weeks gestation	
Medical management	***Incomplete abortion:*** Misoprostol 600mcg orally in a single dose or 400mcg sublingually in a single dose

	Missed abortion: Misoprostol 600mcg sublingually every three hours for a maximum of 3 doses or 800mcg vaginally in a single dose
Uterine aspiration	• Vacuum aspiration using a manual or electric vacuum aspirator • Where vacuum aspiration is not available, dilatation and curettage (D&C) or evacuation and curettage (E&C) has to be used with care. It should be replaced with vacuum aspiration, to improve the safety. Advantages of MVA over D&C include decreased blood loss, less pain, shorter duration of procedure.
For uterine size greater than 12 weeks gestation	
Medical management Under the supervision of Obstetrician and Gynaecologist	• Treatment for post abortion care, incomplete or missed abortion in the second-trimester, may use the same medication regimens as for recommended second-trimester induced abortion
Dilatation & Evacuation Under the supervision of Obstetrician and Gynaecologist	• Dilatation and evacuation (D&E) is a uterine evacuation method that utilizes a combination of vacuum aspiration with 12–16 mm diameter cannulae and specialized forceps. • Specialized training, experience, and equipment are necessary to use this method safely. • If the cervix is not sufficiently dilated, D&E requires preparation of the cervix using misoprostol.

Expectant management

Expectant management is an effective and acceptable method to offer women who miscarry. Patient counselling is particularly important for those women **with an intact sac** who wish to adopt an expectant approach. They should be aware that complete resolution may take

several weeks and that overall efficacy rates are lower. They may wish to consider a medical approach or to commence expectant management with the option of surgical evacuation at a later date if required. Expectant management for **incomplete miscarriage** is effective.

Expectant management is often followed by minimal bleeding as any retained tissue will usually undergo resorption. Occasionally, the passage of tissue may be associated with heavy bleeding. Expectant management should only be offered in hospitals where women can access 24-hour telephone advice and emergency admission if required.

Pain management

Most women undergoing PAC management will experience pain. Many providers underestimate the amount of pain a woman experiences during vacuum aspiration. Women who present for uterine evacuation should be offered all pain management options and provide these services without delay. In addition, providers should always offer gentle, respectful care and provide appropriate information, which can help women stay calm and reduce anxiety and pain.

During a uterine evacuation, pain can be reduced with a combination of verbal support, oral medications, paracervical block, skilled and gentle clinical technique, and calming environment. Non-steroidal anti-inflammatory drugs should always be offered for both medical and surgical methods of abortion, and provided without delay to women who desire it. Conscious sedation is an option in centers where it is offered. General anesthesia increases the risk of complications and is not recommended for routine procedures.

Management of severe vaginal bleeding

Rapid initial assessment and resuscitate according emergency care guidelines. If the patient's condition is stable or once the patient is stabilized, look for the underlying cause of bleeding promptly.

- If retained POC is the cause:
  - Removal of tissue at os may stop the hemorrhage. Proper surgical evacuation is necessary as soon as possible if facilities are available. If facilities are not available, refer.
- To help stop bleeding during the procedure:
  - Injection oxytocin 10 units IM followed by infusion of a uterotonic agent such as oxytocin 20 units in 1L IV fluid at 60 drops per minute.
- If vaginal or cervical lacerations are found:
  - Repair under aseptic condition under local anaesthesia or under sedation
  - May need to refer to higher level care

(Refer to Annex 1 Chart 3 for Management of severe vaginal bleeding)

Management of infection or sepsis

- Septicaemic shock with complications such as DIC, acute renal failure
  - Resuscitate according to guidelines for resuscitation of shock and refer
- Therapeutic antibiotics
  - Stat dose parenteral broad spectrum antibiotics should be given before referral (Ampicillin IM 1G, Gentamicin IM 80 mg and Metronidazole 500 mg p.o. at Health Centre, before referral. At Township or Station Hospitals: Ceftriaxone IV 1 G and Metronidazole IV 500 mg).
- Removal of septic foci by surgical method –evacuation of retained products of conception (ERPC), posterior colpotomy, laparotomy and drainage of pelvic abscess may be necessary and refer to higher level care if facilities are not available.

  (Refer to Annex 1 Chart 4 for Management of infection and sepsis)

Management of intra-abdominal injury

- Therapeutic antibiotics: Parenteral broad spectrum antibiotics
- Refer for further management; such as emergency laparotomy for intra abdominal abscess and POD puncture for drainage for pus in the pelvis. Hysterectomy may be required if the uterus is perforated or infected. Resection and anastomosis may be required if there is injury to the bowels.
- Management of septicaemia and associated complications such as acute renal failure and DIC may be required.

(Refer to Annex 1 Chart 5 for Management of intra-abdominal injury)

Special considerations: young women

Most aspects of providing abortion care for young women are the same as for adult women, but there are some special considerations:

- This is likely a young woman's first pelvic examination, and she may be nervous or afraid. Therefore, providers should take special care to:
  - Ensure that there is at least visual and preferably auditory privacy.
  - Explain what is being done at each step.
  - Perform the examination as gently and smoothly as possible. If a range of specula sizes is available, use the size appropriate for the woman and conducive to the examination or procedure.
- Although women of all ages need pain management, the perception of pain and use of analgesia has been found to be higher on average in younger women than in older women.

Young women's life and social circumstances are often very different, requiring care tailored to their unique circumstances, especially concerning counseling and provider attitudes. Providers should make a conscious effort to keep personal beliefs from limiting their ability to give the best care possible to young women.

5. Care and services at different levels

Care for the women experiencing PAC starts at the community level and leads to her contact with the formal health system. Table (3) summarizes the care provided at different levels.

Table 3: PAC at different levels of health care

Level	Care provider	Care provided
Community	Community health workers	• Recognition of symptoms of abortion • Timely referral to formal health care system
Primary care level	Midwives/nurses, Lady health visitors	• Rapid initial assessment • Emergency care and referral ➢ Resuscitation if in shock (including intravenous fluid replacement – Ringer Lactate, Normal saline) ➢ Oxytocics Injection oxytocin 10 units IM ➢ Antibiotic therapy if sepsis present • Birth spacing and counseling
Station Hospital	Non-specialist Doctors	• Emergency care • Evacuation of retained products of conception (Surgical management/MVA or medical management) • Pain control • Referral if severe complications present • Birth spacing and counseling
First referral Township Hospital	Non-specialist Doctors	• Comprehensive emergency care: ➢ Emergency care ➢ Blood cross match and blood transfusion if necessary ➢ Evacuation of retained products of conception ((Surgical management/MVA or medical management) ➢ Pain control ➢ Laparotomy and surgery if facilities are available ➢ Diagnosis and emergency management and referral for severe complications – septicaemia,

Level	Care provider	Care provided
		peritonitis, renal failure • Birth spacing and counseling
Second referral **District Hospital and above**	Specialist (Obstetrician and Gynaecologist)	• Comprehensive care ➢ Blood transfusion ➢ Surgery ➢ Treatment of septicaemia, septicaemic shock, with complications such as acute renal failure, Disseminated Intravascular Coagulation (DIC) or multi-organ failure • Birth spacing and counseling

6. Interaction between patient and provider

From her arrival at the health care centre until her departure, the patient comes into contact with a number of health care workers. Every member of the health care team can contribute to the quality of care women receive by encouraging open, two-way communication, ensuring patient confidentiality, protecting patient privacy, and otherwise maintaining supportive, respectful patient-provider interactions. Improving these aspects of care is not costly and does not generally require additional staff.

Health care workers must recognize that a woman seeking treatment for incomplete abortion often under severe emotional stress, in addition to any physical discomfort. A positive relationship between caring health care providers and patients can help ease the anxiety and concern that patients may feel. Positive interactions with all these staff members will facilitate treatment and improve patient satisfaction with the care received.

It is important to respect the woman's needs and to provide care without expressing judgment of the woman, either verbally or non-verbally. In addition, women should be treated with respect regardless of their reason for seeking care, economic status, culture, marital status, family situation, or religion.

Post abortion care and counseling

During post-procedure care following abortion complications, the provider should:

- Identify and respond to women's emotional and physical health needs and other concerns
- Advise clients about her condition, use of medications, contraceptive methods, and follow-up care
- Counsel clients about any long-term changes resulting from the complications—for example, post-hysterectomy or bowel perforation repair
- Explain what to expect and what to do in emergency situations
- Give written or illustrated materials about her condition

While WHO does not recommend a routine follow-up visit following uncomplicated abortion or women should be advised that follow-up care is available if needed or desired.

7. Post abortion contraceptive counseling and services

Post abortion family planning counseling and service provision to help women prevent unwanted pregnancy and practice birth spacing is an essential component of PAC. Comprehensive information on a range of contraceptive methods including long-term, permanent and emergency contraception and availability of services at different levels of the health system is needed.

- A woman may ovulate as early as 10 days after a uterine evacuation. As ovulation can occur almost immediately after a uterine evacuation, contraception should be provided immediately to women who want to prevent or delay pregnancy.
- Effective contraceptive methods, where they are made widely available and consistently used, can help women prevent unwanted pregnancies and therefore significantly decrease the rate of unsafe abortion.
- Every woman presenting for postabortion care should be offered contraceptive counseling and a range of contraceptive methods.

The essential steps for counseling include:

- Establish rapport
- Assess the women's needs
- Assess the women's individual situation
- Give the different options that is medically suitable for her
- Help the women choose her method
- Ensure that she understands how to take selected method and how this selected method works

Provision of contraceptive information and services is an essential part of abortion care, as it helps the woman avoid unintended pregnancies in the future. All women should receive contraceptive information and be offered counseling for and methods of postabortion contraception, including emergency contraception, before leaving the health-care facility.

Following first trimester uterine evacuation

- Immediate initiation of hormonal and non-hormonal contraception and female sterilization[1] following first-trimester aspiration abortion is considered safe.
- Intrauterine contraceptive devices (IUCD) placement or female sterilization can be performed immediately following a successful, uncomplicated abortion. If a woman is experiencing complications, then shorter acting methods like oral contraceptive pills can be used as a bridging method until IUCD or tubectomy/female sterilization can be performed.
- Long-acting contraceptive methods have higher continuation rates and lower repeat pregnancy rates compared to short-acting methods.

Following first trimester medical management

- Hormonal methods including pills, patches, rings, injections or implants may be started on the day of the first pill of medical abortion.
- IUCD insertion and tubectomy/female sterilization can be performed when it is reasonably certain that a woman is no longer pregnant. Shorter acting methods like birth control pills can be used as a bridging method until IUCD or tubectomy/female sterilization can be performed.

Following second trimester miscarriage/abortion

- Immediate initiation of hormonal and non-hormonal contraception following second-trimester dilatation and evacuation (D&E) or medical abortion is encouraged and considered safe.
- Due to the possible increased risk of expulsion, the WHO classifies IUD insertion after an uncomplicated second-trimester abortion as category 2, which means the advantages of using the method generally outweigh the risks.

[1] Tubectomey/female sterilization can be performed if approval for sterilization has been obtained from a sterilization board. If the patient and her husband would like to apply for sterilization, following counselling, the clinical and administrative procedures should be explained.

8. Reproductive and other health services

To ensure a holistic approach to women-centred care, linkages with reproductive and other health services are a component of quality PAC. These include, among others,

- Psychological support and counseling of women and their families
- Correction of anaemia and advice on nutrition
- Prevention and treatment of post abortion pelvic inflammatory disease
- Health information on reproductive health issues: e.g. RTI/STI and HIV, cervical cancer screening

9. Community and service-provider partnership

Postabortion care is available in the basic health system (station and township hospitals) and at higher level facilities. Emergency care is provided at rural health centres and sub-centres. Communities can play a key role in reducing maternal mortality and morbidity by partnering with facilities that offer reproductive health services to ensure that women have the information, support and means to access the care they need. Community-level activities include:

- Prevention of unintended pregnancies and unsafe abortion through counseling and contraceptive services
- Conducting awareness-raising to recognize the signs and symptoms of miscarriage and postabortion complications
- Mobilization of resources for referral to help women receive appropriate and timely care for complications from abortion
- Ensuring health services reflect and meet community expectation and needs

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Annex 1

Clinical management of miscarriage or complications of abortion

(Ref-WHO/FHS/MSM/94.1)

Chart 1: Clinical assessment

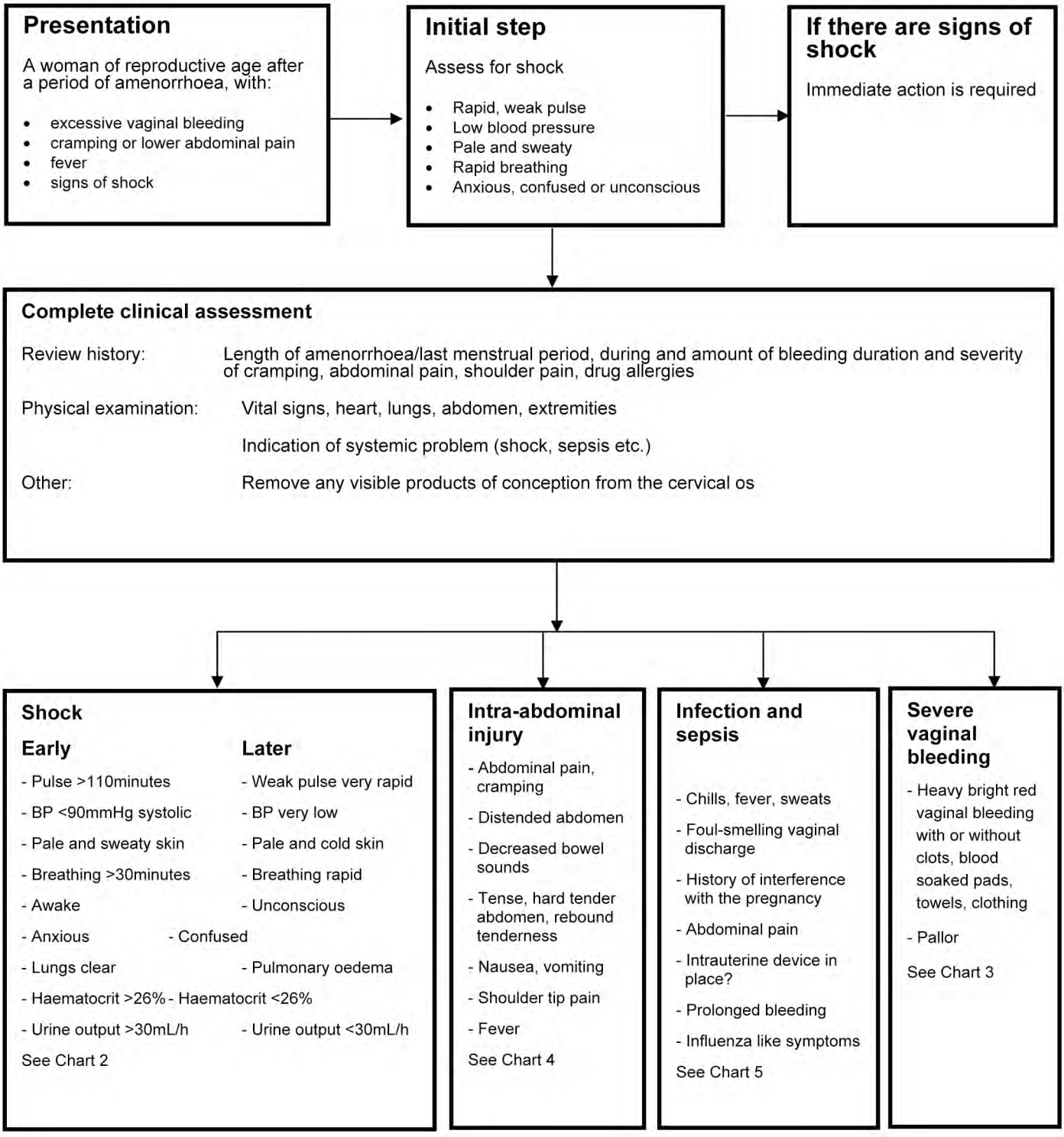


Chart 2: Management of Shock

Shock

Early	Later
- Pulse >110/minutes rapid	- Weak pulse, very
- BP <90mmHg systolic	- BP very low
- Pale and sweaty skin	- Pale and cold skin
- Breathing >30/minutes	- Breathing rapid
- Awake	- Unconscious
- Anxious	- Confused
- Lungs clear	- Pulmonary oedema
- Haematocrit >=26%	- Haematocrit <26%
- Urine output >=30mL/h	- Urine output <30mL/h

Initial treatment

- Make sure airway is open
- Check vital signs, pulse, blood pressure, breathing
- Secure IV line: Ringer's lactate or isotonic solution1L for 15 -20 minutes (16-18 gauge needle). It may take 1-3L to stabilize a patient in shock
- Turn body and head to side, raise legs (however, if this causes difficulty in breathing lower legs and raise head)
- **No fluids by mouth**
- Give oxygen 6-8L.minute (if available)
- Remove any visible products of conception from the cervical os
- **Blood transfusion**: if haemoglobin <5g/dL or haematocrit <15%
- Monitor amount of fluids/blood given – use a chart
- Monitor urine output – colour and quantity
- IV antibiotics – in case of infection
- No medications by mouth
- Laboratory work is helpful but must not cause any delay in treatment. Request haematocrit, blood group, pre-transfusion (type and cross-match), platelet count and, if available, blood electrolytes, pH, urea and/or creatinine

Assess response to fluids after 20-30 minutes

Signs of stabilization

- Increasing systolic BP, >=100 mmHg
- Heart rate < 90/minute
- Conscious, reduced confusion/anxiety
- Skin colour improves
- Respiration rate =<30 minute
- Urine output >100mL/4h

If stable

- Gradually shut off oxygen, if this causes worsening turn oxygen back on 6-8 L/minute
- Clinical assessment
- Uterine evacuation

If not stable

- Continue monitoring oxygen and IV fluids
- Reassess the need of antibiotics
- Treat underlying causes of shock

Assess after two hours

Sign of stabilization

- Increasing systolic BP, > 100 mmHg
- Heart rate < 90/minute
- Conscious, reduced confusion/anxiety
- Skin colour improves
- Respiration rate <30 minute
- Urine output >100mL/4h

- Influenza like symptoms

See Chart 5

If stable

- Adjust IV and oxygen
- Complete clinical assessment
- Continue treating underlying causes of shock
- Uterine evacuation

If not stable

Refer to secondary or tertiary hospital

Chart 3: Management of severe vaginal bleeding

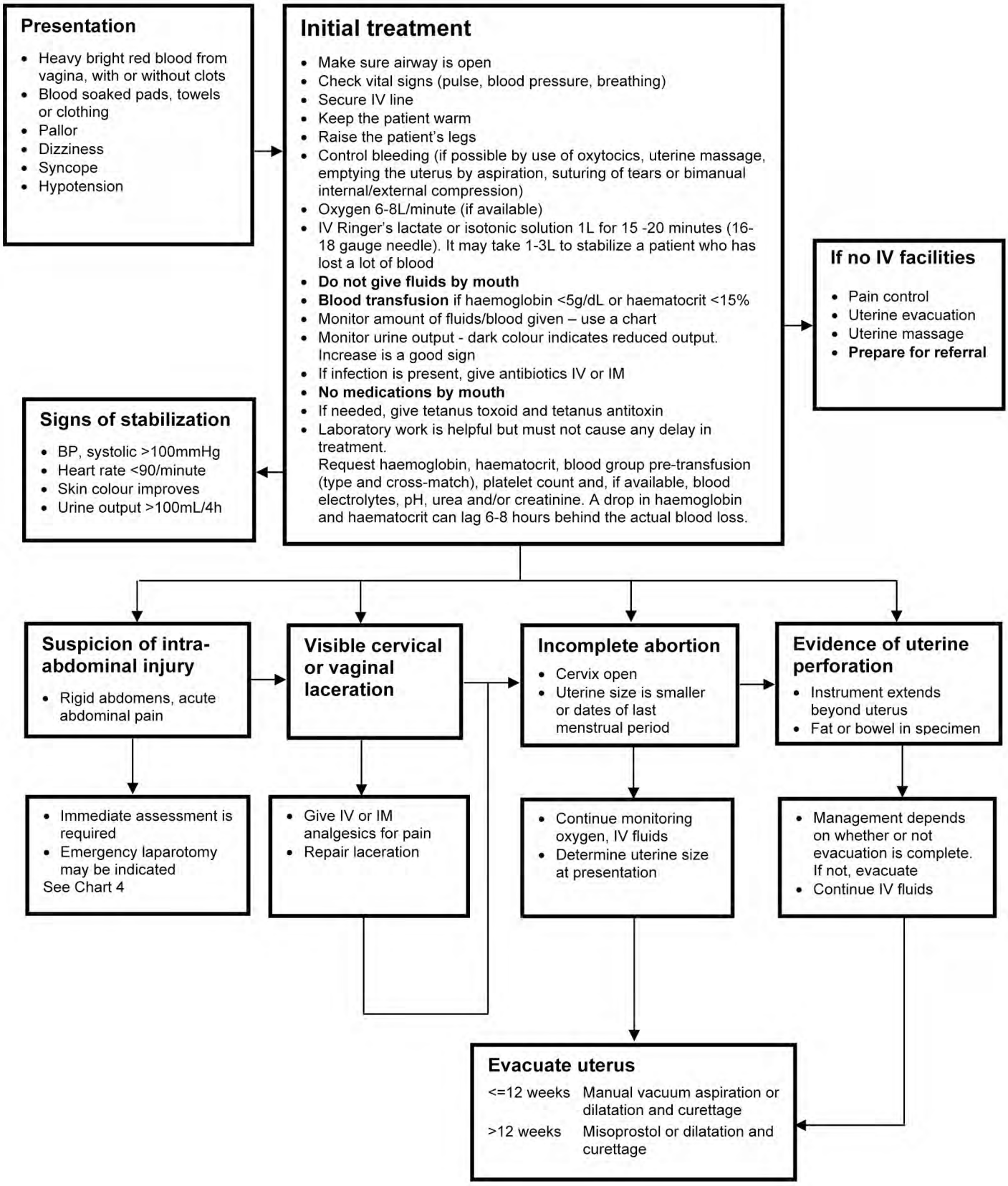


Chart 4: Management of infection and Sepsis

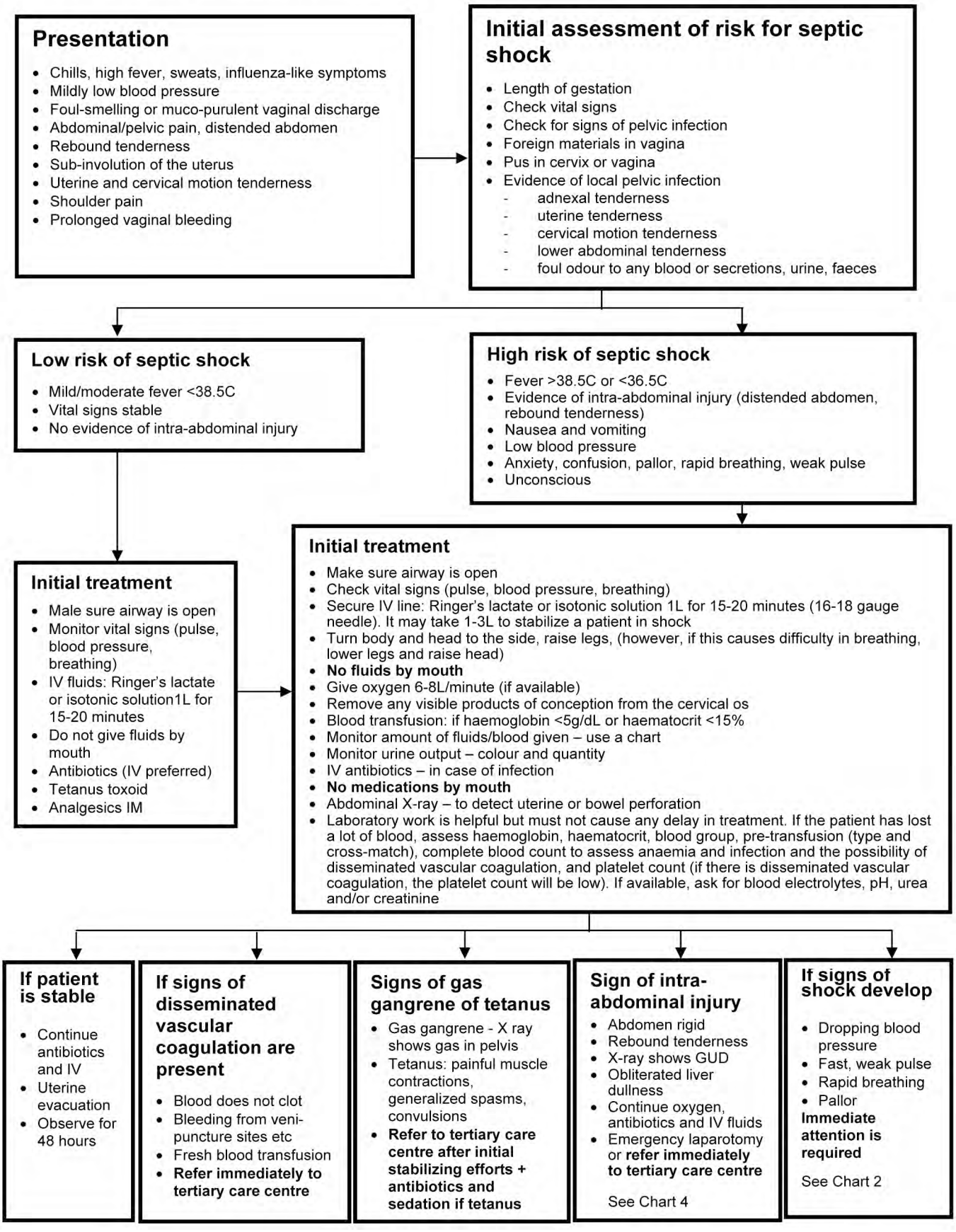
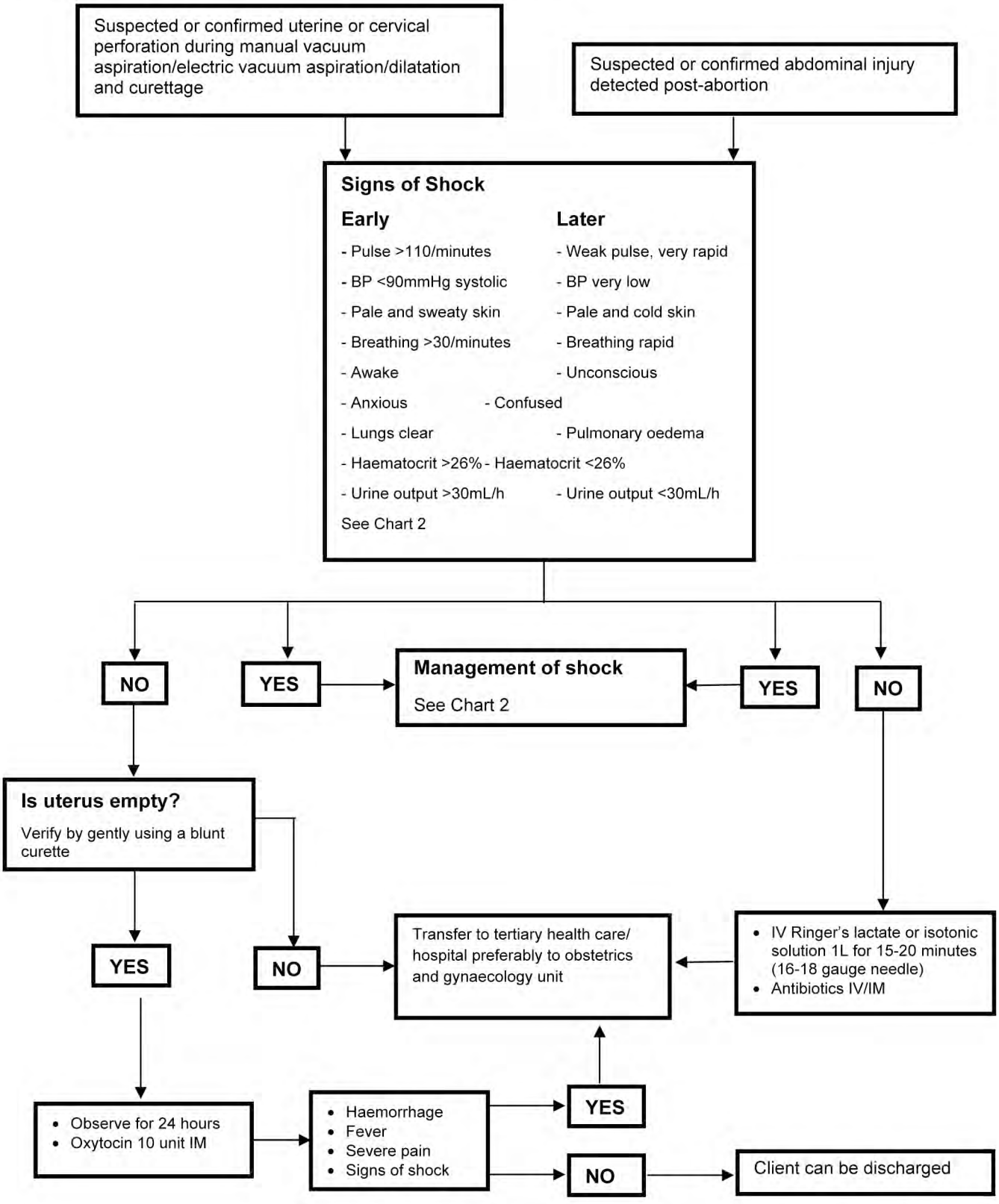


Chart 5: Management of Intra-abdominal injury



Legal and Policy Status for Abortion in Myanmar

- Under the penal code of Myanmar, abortion is generally illegal (Restricted).
- Any person performing an abortion is subject to up to three years' imprisonment and/or payment of a fine.
- A woman who induces her own abortion is subject to the same penalties.
- If the abortion results in the death of the woman, punishment is for 10 years and a fine.

Penalty clauses of the law

MPC 312. Whoever voluntarily causes a woman with child to miscarry shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and, if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.

Explanation. A woman who causes herself to miscarry is within the meaning of this section.

MPC 313. Whoever commits the offence defined in the last preceding section without the consent of the woman, whether the woman is quick with child or not, shall be punished with transportation for life, or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to a fine.

MPC 314. Whoever, with intent to cause the miscarriage of a woman with child, does any act which causes the death of such woman shall be punished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine; and if the act is done without the consent of the woman, shall be punished either with transportation for life, or with the punishment above mentioned.

Explanation. It is not essential to this offence that the offender should know that the act is likely to cause death.

MPC 315. Whoever, before the birth of any child, does any act with the intention of thereby preventing that child from being born alive or causing it to die after its birth, and does by such act prevent that child from being born alive, or causes it to die after its birth, shall, if such act be not caused in good faith for the purpose of saving the life of the mother, be punished with imprisonment of either description for a term which may extend to ten years, or with fine, or with both.

MPC 316. Whoever without lawful excuse does any act knowing that he is likely to cause death to a pregnant woman, and does by such act cause the death of a quick unborn child, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.

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