MISOPROSTOL USE IN POSTABORTION CARE

A Service Delivery Toolkit

Ipas
Protecting women's health
Advancing women's reproductive rights

VSI Venture Strategies Innovations

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Overview

What is the service delivery toolkit?

Misoprostol for use in postabortion care: A service delivery toolkit provides information and tools to help district or national-level clinicians, facility managers or program managers to (1) ***initiate*** the use of misoprostol as a **medical treatment for incomplete abortion** or (2) ***integrate*** misoprostol into existing postabortion care (PAC) services that already use manual vacuum aspiration (MVA). The toolkit aims to facilitate the ability of all types of health facilities (such as hospitals, health centers, clinics and maternity homes) to offer misoprostol for treatment of incomplete abortion so as to increase women's access to PAC services. The toolkit can be adapted at the country level. Users should determine the level of clinician who can deliver misoprostol for treatment of incomplete abortion at the local level, based on clinicians' ability to perform core competencies.[1]

Who should use this toolkit?

This toolkit is meant for three audiences: program managers at the national/district levels, facility managers and clinicians. **Note: Providing misoprostol for treatment of incomplete abortion is a simple procedure. This toolkit is not intended to make these services seem complicated but, rather, to support a range of professionals for both programmatic and clinical implementation.** For minimum service delivery requirements, please see **Tool 3A: Minimum requirements for treatment of incomplete abortion with misoprostol**.

Not all modules or tools will be useful for all readers. **Figure 1** suggests the modules that may be most relevant to each target audience. However, depending on your role, you may find tools or information from other modules helpful as well.

1. For more information, please consult Ipas and Gynuity Health Projects' forthcoming training manual on misoprostol for incomplete abortion at www.ipas.org or www.gynuity.org

Figure 1:

Program managers at the national/district level

- **Module 1:** Introduction
- **Module 2:** Planning for service delivery
- **Module 6:** Ensuring high quality services

Facility managers

- **Module 1:** Introduction
- **Module 2:** Planning for service delivery
- **Module 3:** Assessing your facility
- **Module 4:** Creating community linkages
- **Module 6:** Ensuring high quality services

Clinicians

- **Module 1:** Introduction
- **Module 4:** Creating community linkages
- **Module 5:** Delivering clinical services
- **Module 6:** Ensuring high quality services

How can the toolkit be used?

Users may use the modules in the toolkit in two ways, either by following the modules in sequential order or by identifying the modules and tools that are most relevant and pulling these sections out of the binder. The tools should be seen as templates you can adapt to local needs and conditions.

Each tool is numbered (for example, 2G) and includes the tool icon . Instructions on how to use the tools are at the beginning of each tool in *italics*. The accompanying CD makes all the tools available for adaptation and use. In addition, each module has a section that contains additional resources for related information. Throughout the toolkit, we highlight special considerations for populations with specific health needs, such as women in crisis or emergency situations, youth, women living with HIV/AIDS, and commercial sex workers.

The toolkit is based on the most recent evidence-based guidelines. Specifically, three key resources informed the development of the toolkit's content, materials, and information on misoprostol for use in postabortion care. The resources include:

- *Misoprostol for treatment of incomplete abortion: An introductory guidebook.* (Gynuity Health Projects 2009).
- *Woman-centered postabortion care: Reference manual.* (Herrick et al. 2004).
- *Postabortion care training materials and clinical guidelines.* (Venture Strategies Innovations 2009).

For updated clinical information and guidance on misoprostol for use in postabortion care, refer to www.gynuity.org, www.ipas.org and www.misoprostol.org. Refer to www.vsinnovations.org for additional information on global misoprostol programs. If you have questions regarding the content of this toolkit or require technical assistance, please contact misoforpac@ipas.org or info@vsinnovations.org.

The full toolkit is available online at http://www.ipas.org/ma/mpac-toolkit.

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(Only available on toolkit CD or online at http://www.ipas.org/ma/mpactoolkit)

List of acronyms

ACOG .....American College of Obstetricians and Gynecologists

AE.....Adverse event

AIDS .....Acquired immunodeficiency syndrome

EmOC.....Emergency obstetric care

FEFO.....First-to-expire, first-out

FIGO.....International Federation of Gynecology and Obstetrics

HIV .....Human immunodeficiency virus

HTSP.....Healthy timing and spacing of pregnancy

IUD .....Intrauterine device

IUFD.....Intrauterine fetal death

LMP .....Last menstrual period

M&E.....Monitoring and evaluation

MIS .....Management information system

MVA.....Manual vacuum aspiration

NGO .....Nongovernmental organization

PAC .....Postabortion care

POC .....Products of conception

PPH.....Postpartum hemorrhage

RH.....Reproductive health

SAE.....Serious adverse event

STI.....Sexually transmitted infection

VA.....Vacuum aspiration

VCAT .....Values clarification and attitude transformation

WHO .....World Health Organization

MODULE 1. Introduction

1.1 What is incomplete abortion?

TARGET AUDIENCES: Clinicians, facility managers and program managers at the national/district levels

Incomplete abortion occurs when there are retained products of conception (POC) after induced abortion (whether by unsafe or safe methods) or after spontaneous abortion, also known as miscarriage.

Typical presenting symptoms of incomplete abortion are:

- vaginal bleeding
- dilated cervix
- uterus smaller than indicated by date of last menstrual period

Symptoms that are sometimes present are:

- cramping or lower abdominal pain
- partial expulsion of products of conception

Incomplete abortion is often closely related to unsafe abortion (Gynuity Health Projects 2009). The World Health Organization (WHO) defines unsafe abortion as termination of an unintended pregnancy either by individuals lacking the necessary clinical skills or in an environment that does not conform to minimum medical standards, or both (WHO 1993). The WHO estimates that 21.6 million unsafe abortions take place each year, nearly all of which occur in developing countries (WHO 2011*a*). Unsafe abortions result in the deaths of an estimated 47,000 women annually, almost all preventable (WHO 2011*a*), and many more women suffer injuries and long-term health problems. Adolescent and young women below the age of 24 are disproportionately affected by unsafe abortion, accounting for 46 percent of deaths from unsafe abortion in the developing world (WHO 2007). The magnitude of unsafe abortion varies by geographic region and, within regions, by country.

It is important to know your country's abortion laws and to be aware of the prevalence of unsafe abortion within your country. However, because postabortion care (PAC) does not fall under the same legal restraints as abortion provision, it can be provided even in settings where abortion is illegal.

1.2 How can incomplete abortion be treated?

The WHO has stated that the prompt treatment of incomplete abortion is an essential element of obstetric care (WHO 1991). Treatment of uncomplicated incomplete abortion can be provided at the primary care level (Gynuity Health Projects 2009).

Active management of incomplete abortion, using either vacuum aspiration or medical methods, is highly effective in treating incomplete abortion. Misoprostol, the most common and thoroughly studied medical method for treatment of incomplete abortion, is a newer option to expand PAC services into places where MVA may not be available. Misoprostol provides a highly effective, non-invasive treatment for incomplete abortion, enabling women to receive appropriate and effective postabortion care from non-surgically trained, mid-level providers (Blum et al. 2007). Whether MVA is available or not, misoprostol is a highly feasible option that can be used as a stand-alone first-line treatment for incomplete abortion. Because misoprostol and MVA are both appropriate methods for postabortion care, women ideally would have a choice between the two methods.[2]

The WHO added misoprostol for incomplete and missed abortion to its Model List of Essential Medicines in 2009, based on the drug's proven effectiveness and safety. The WHO list guides the development of national and institutional medicine lists, with the aim of focusing resources on medicines that help prevent and solve the most critical health problems. The list also shapes humanitarian emergency medical preparedness, guiding organizations that supply medicines for developing countries and those in crisis.

MISOPROSTOL ENDORSEMENTS

Misoprostol is included in the WHO Model List of Essential Medicines for incomplete abortion, as well as in the WHO Priority Medicines for Mothers and Children (WHO 2011*b*, WHO 2011*c*). In addition, it is recommended for use in postabortion care by the International Federation of Gynecology and Obstetrics (FIGO), the American College of Obstetricians and Gynecologists (ACOG), the Latin American Federation of Obstetrics and Gynaecology (FLASOG), the International Confederation of Midwives (ICM), and other international organizations and associations.

Another option for treating incomplete abortion is expectant management (allowing for spontaneous evacuation of the uterus). Although in some cases clinicians prefer not to use expectant management because of the lower rate of efficacy and unpredictable time

MANUAL VACUUM ASPIRATION (MVA)

Vacuum aspiration (VA) is a method by which the contents of the uterus are evacuated through a plastic or metal cannula that is attached to a vacuum source. Manual vacuum aspiration (MVA) uses a hand-held, portable aspirator. MVA is often used in PAC treatment for uterine evacuation (Herrick et al. 2004).

2. MVA remains an important, safe and effective option for treating incomplete abortion. For a full discussion of MVA in postabortion care, see: Herrick, Jeannine, Katherine L. Turner, Teresa McInerney and Laura Castleman. 2004. Woman-centered postabortion care: Reference manual. Chapel Hill, NC: Ipas. http://www.ipas.org/Publications/Woman-centered_postabortion_care_Reference_manual.aspx

interval for expulsion (Clark et al. 2007), a woman should be given this option if she is clinically stable. Expectant management requires careful follow-up, however, to assess whether expulsion has occurred or to ascertain whether the woman needs additional treatment.

1.3 What are postabortion care (PAC) services?

Postabortion care consists of a series of interventions designed to manage a woman presenting after spontaneous or induced abortion (with or without complications). PAC is an important component of comprehensive reproductive health services because it saves women's lives and reduces morbidity.

In 1993, leading reproductive health organizations and donor agencies formed the PAC Consortium (www.pac-consortium.org), in part to promote PAC as an effective strategy to address the global problem of incomplete abortion. The model for postabortion care supported by the PAC Consortium consists of five elements (Winkler et al. 2000):

- **Treatment** of incomplete and unsafe abortion and abortion-related complications that are potentially life-threatening;
- **Counseling** to identify and respond to women's emotional and physical health needs and other concerns;
- **Contraceptive services and information** to help women prevent an unwanted pregnancy or practice birth spacing;
- **Reproductive and other health services** that are preferably provided on site or via referrals to other accessible facilities in clinicians' networks;
- **Community and service-provider partnerships** to prevent unwanted pregnancies and unsafe abortion, mobilize resources to help women receive appropriate and timely care for complications from unsafe abortion, and ensure that health services reflect and meet community expectations and needs.

1.4 Why use misoprostol in the provision of postabortion care?

Misoprostol has been used safely for incomplete abortion in many different countries and has not been associated with any long-term effects on women's health (Gynuity Health Projects 2009). Moreover, **misoprostol treatment has very minimal service delivery requirements and can be provided almost anywhere** (see **Tool 3A: Minimum requirements for treatment of incomplete abortion with**

misoprostol). There is an increasing body of evidence on the use of misoprostol to treat incomplete abortion:[3]

- The average efficacy rates of misoprostol for postabortion care reported in the literature are 91-99 percent, depending on the regimen used and the study.
- Misoprostol is becoming increasingly recognized as a low-cost and easy-to-use means of uterine evacuation (Blum et al. 2007).
- Misoprostol is a simple technology that is easy to store (no refrigeration required and a long shelf life) and use in a range of settings, by a range of clinicians. Misoprostol for postabortion care can stand alone where MVA is not feasible, or complement MVA where there are existing PAC services.
- Misoprostol for the treatment of incomplete abortion has been clinically studied in settings as diverse as the United States, the United Kingdom, and in low-resource countries such as Burkina Faso, Egypt, Ghana, Mozambique and Tanzania (Bique et al. 2007, Dabash et al. 2010, Dao et al. 2007, Shwekerela et al. 2007, Taylor et al. 2011).

In studies reviewing acceptability, more than 90 percent of women have reported being satisfied or very satisfied with misoprostol for their postabortion treatment (Dao et al. 2007, Gynuity Health Projects 2009, Ngoc et al. 2005, Shwekerela et al. 2007, Weeks et al. 2005). A feasibility study in Nigeria showed high acceptability to women among a largely Muslim population in the north. The same study showed that participating clinicians (including doctors, midwives and nurses) also reported a high degree of satisfaction (Ipas Nigeria and SOGON 2011a, Ipas Nigeria and SOGON 2011b).

- Data from several studies show that, in many settings, reorganizing services by reclassifying PAC treatment as an outpatient care procedure substantially reduces the resources used for PAC, along with the cost and average length of women's stay in health facilities[4] (Billings and Benson 2005).
- Misoprostol can substantially reduce service costs, allowing women to seek treatment for incomplete abortion at the primary care level and thus reducing the caseload at tertiary care facilities (FLASOG 2007).

3. Abstracts from selected published studies are available at: http://www.ipas.org/ma/mpactoolkit/

4. Please refer to Annex 2: Selected publication abstracts on misoprostol use in postabortion care available on the toolkit CD or at http://www.ipas.org/ma/mpactoolkit/, or at the Venture Strategies Innovations website, www.vsinnovations.org.

MODULE 2. Planning for service delivery

2.1 Introduction

When planning to introduce misoprostol for postabortion care (PAC) services at the facility level, it is often helpful, although not required, to do some broader thinking about service delivery needs, the postabortion care that is currently available (if any), and the policies that will guide service implementation. (For a list of essential service delivery requirements, see **Tool 3A: Minimum requirements for treatment of incomplete abortion with misoprostol**.) In addition to laying the groundwork for new or expanded PAC services, this deliberative process should also establish or increase support for the use of misoprostol for postabortion care. Without wider institutional support, it will be hard to develop and sustain a program.

Module 2 provides you with guidance and tools to conduct an environmental assessment, review current policies and services, and estimate misoprostol supply needs. Where you work, and the planned scope of the misoprostol for postabortion care program, will determine the scope of the assessment and policy/service review. Your estimate of misoprostol supply needs will be based on your caseload and the various uses you plan for misoprostol.

TARGET AUDIENCES:
Facility managers and program managers at the national/district levels

TOOLS IN THIS MODULE:

2A Environmental assessment guide

2B Checklist for planning for change in service delivery

2C Estimating misoprostol supply needs

Tool 2A.

Environmental assessment guide[5]

Use this guide to help deepen your understanding of the environment in which you work, to better develop and implement misoprostol for postabortion care services. The environmental assessment may be as simple as convening a meeting of knowledgeable people to discuss the current situation and perceived needs, or reviewing data to understand the demand for postabortion care services in your setting. As you conduct the assessment, make sure to consider the needs of special populations such as women in crisis/emergency situations, youth, refugees, women living with HIV/AIDS, commercial sex workers, women facing sexual violence, and people impacted by other health conditions such as infectious diseases.

Public health context

- ❑ Understand the size and geographic distribution of the population.
- ❑ Note the maternal mortality rate (at the national, regional or local levels).
- ❑ Note the proportion of maternal mortality attributable to unsafe abortion.
- ❑ Note the extent of maternal morbidity attributable to complications of unsafe abortion.
- ❑ Count the number of women treated for abortion complications monthly and/or annually in the catchment area of the hospital, district, or other location.
- ❑ Review the types of maternal complications most often seen in health-care facilities in the catchment area.
- ❑ Note the unmet need for contraception.

Legal and regulatory context

- ❑ Review existing laws and policies and their effects on the provision of abortion care (both treatment of abortion complications and legal abortion). Laws that are considered "restrictive" sometimes permit legal safe abortions in cases of rape and for other compelling reasons. Pay attention to any regulations that affect care for adolescents or unmarried women.
- ❑ Determine the types of clinicians who can currently treat incomplete abortion.
- ❑ Partner with a nongovernmental organization or other agency to review the status of misoprostol, including its registration and approved indications, inclusion on the national essential medicines list, ministry of health decisions about its use, and current evidence-based use (per label or off-label).

Service delivery context

- ❑ Note the availability of PAC services, including facilities that provide uterine evacuation with MVA and/or misoprostol. Note the facilities' locations, their distribution relative to the number of women of reproductive age, and their staffing levels and hours.
- ❑ Review the ways in which women typically reach the health facilities.

5. This tool is adapted from: Baird, Traci L., M. Virginia Chambers and Charlotte E. Hord. 1998. I*mplementing postabortion care. Technical resources for postabortion care, volume 1*. Carrboro, NC: Ipas.

- ❑ Assess the adequacy of referral and transportation systems between facilities for treatment of abortion complications. Consider patient assessment, stabilization and referral to higher-acuity treatment when necessary.
- ❑ Assess the training, if any, currently offered to health personnel on treating incomplete abortion and abortion complications.
- ❑ Assess the availability of contraceptive services to women after an incomplete abortion, including whether the services are in the same space and facility as PAC services, or obtainable by referral.
- ❑ Assess current contraception provision practices as part of postabortion care, and prevailing contraceptive acceptance rates of women treated at PAC facilities.

2.2 Standards, guidelines and protocols

It is important to review prevailing standards, guidelines and protocols to ensure that they facilitate access to care and that they encompass the use of misoprostol. If developing or updating national standards and guidelines is beyond the scope of your project, consider documenting the results of the use of misoprostol for postabortion care in just one facility or geographic area. You can then use the results to encourage a broader review and updating of national documents and drug usage policies.

National standards are very different from local or institutional protocols. In general, national standards are not reviewed regularly once they are approved. Thus, national standards should be as broad and non-specific as possible, so that local institutions can freely implement up-to-date clinical protocols as science evolves. For example, where a national standard might approve misoprostol for postabortion care, it would be left to the local or institutional protocol to lay out the specific regimens, contraindications, eligibility and so forth.

Issues to consider when developing or reviewing standards, guidelines and protocols:[6]

- **Do <u>not</u> overmedicalize.** There is a strong tendency to require more than is necessary, such as specialized equipment, laboratory testing, or proof of a woman's age, or to attempt to address extremely rare procedural complications. Misoprostol for use in **postabortion care can be provided by primary care providers in remote areas; complicated equipment, testing, and procedures are not necessary for high quality care.**
- **Include only evidence-based practices.** Do not describe practices that "seem like a good idea" or "have always been done that way" if they are not backed up by evidence.
- **Provide an appropriate level of detail** about service delivery**,** but allow for modification. Make sure that specific clinical protocols, such as the timing of repeat doses of misoprostol, are not codified in documents that are hard to update if the evidence base changes. Ensure that documents reflect the concerns of the primary care and community levels of the health-care system and the full range of health-care delivery settings, such as mobile units and private clinicians' offices.
- **Do not add restrictions that are not required by law.** This includes barriers such as special clinician or site certifications or permitting only physicians to provide services.
- **Include public, private, and nongovernmental organization (NGO) sectors.** Unpublished experience has shown that provision of care through integration of the public and private sectors

6. From: Ipas. 2005. *Standards and guidelines toolkit.* Chapel Hill, NC: Ipas. Unpublished. To request a copy of this toolkit, please contact misoforpac@ipas.org.

and NGOs eventually results in improved access, lower costs and higher quality services. Be sure that standards are the same for all three sectors.

- **Incorporate the elements of woman-centered care.** Woman-centered care is a comprehensive approach to meeting each woman's medical and psychosocial needs, independent of age or marital status, at the time of service. Its core components include providing respectful, confidential services; involving women in their treatment; offering as many choices as possible; and ensuring that women's rights to high quality care are honored.

2.3 Step-by-step planning[7]

Whether planning for the introduction of new services with misoprostol or integrating misoprostol for postabortion care into existing PAC services, planning should be a careful and thoughtful process. The planning process outlined in the checklist below can guide you in understanding the needs of your community and patients, and help you design appropriate and feasible services to meet those needs.

Different people will have different ideas about how to improve services or create a new program. It is therefore important during the planning phase to elicit all relevant perspectives and ideas — especially from key leaders whose support is important to the program's success and from the people your program will serve, including adolescents and other special populations.

Planning for changes in service delivery involves six key steps: identifying priorities, setting objectives, developing a workplan, training staff at all levels, planning for high quality, and planning for sustainability (**Tool 2B: Checklist for planning for change in service delivery**). The checklist will help you make sure that you are considering all the various elements that are essential in developing service delivery with misoprostol. As planners work through the checklist, they should take the following considerations into account:

1. **Identify priorities**

   Identify priorities for your community or patient population. Once you have a list of priorities, rank them based on urgency, impact and feasibility. In a rural area, for instance, the identified need might be to improve women's access to postabortion services because the nearest existing clinician may be two hours away by vehicle.

7. This section and Tool 2B are adapted from: McInerney, Teresa, Traci L. Baird, Alyson G. Hyman and Amanda B. Huber. 2001. *A guide to providing abortion care. Technical resources for abortion care.* Chapel Hill, NC: Ipas.

2. Set specific objectives

Objectives should reflect the needs of women and the community. It is also important that objectives be achievable within the given time frame and with available resources. These objectives should help define your next steps for introducing or integrating misoprostol into postabortion care services.

3. Develop a workplan

Think through the steps that must be taken to accomplish each objective. Assign responsibility for each activity and develop a timeline for completion. Think about the "who, what, when, how and where" of each step. You will also need to develop a budget for your workplan and plan funding for your activities and services.

4. Train staff at all levels

All site training should be conducted with your staff, including values clarification exercises that will help reduce stigma and discrimination at the facility level. In addition, all staff should have a general understanding of how postabortion care services are provided to women. Finally, clinicians should receive specific training on the provision of PAC and misoprostol use in PAC.

5. Plan for high quality

You should identify ways to monitor the program and ensure high quality (see Module 6: Ensuring High Quality Services). In a facility-based program, involve the staff and patients in defining indicators of high quality service.

6. Plan for sustainability

To guarantee the effectiveness of services, it is critical to plan changes in such a way that they will endure over time. Different programs will require different actions to achieve sustainability, but certain elements are universally important:

- Obtaining the support of key decisionmakers
- Updating service standards
- Providing confidential and respectful care to all women
- Integrating postabortion care services with other reproductive health services
- Ensuring that funding mechanisms are in place
- Ensuring that supply, management and training systems function well

- Maintaining required equipment and the physical space where services are provided
- Maintaining supplies of consumables
- Monitoring services

Tool 2B.

Checklist for planning for change in service delivery

Whether you are planning to initiate new or improved clinical services, or launch an information campaign or other activity, here are the steps to follow and issues to consider when implementing services.

Identify priorities

- ❑ Consider how to increase access to services.
- ❑ Determine if you need to increase the number and types of postabortion care providers.
- ❑ Evaluate the quality of services.
- ❑ Consider increasing the range of reproductive health services available.
- ❑ Reflect on expanding PAC services to encompass as wide a range of procedures as possible.
- ❑ Explore attitudes and values of staff regarding provision of abortion and postabortion care and identify related training needs.

Set objectives

- ❑ Make sure that objectives are specific, measurable, achievable, realistic and time-bound.
- ❑ Consider the who, what, where, when, how and how much of each objective.
- ❑ Establish a clear timeline for achieving the objectives and plan a systematic evaluation of progress at specified times.

Develop a workplan

- ❑ Identify and define each main activity and list sub-tasks for each.
- ❑ Assign responsibility for each sub-task and a reasonable timeline for completion.
- ❑ Contact other interested partners and stakeholders in the community or government who can help achieve the objectives.
- ❑ Obtain necessary financial and material resources and determine ways to obtain sustainable resources.

Train staff at all levels

- ❑ Carry out values clarification exercises with all staff.
- ❑ Provide all staff with a general overview of postabortion care services.
- ❑ Provide specific training for medical staff to provide PAC and misoprostol for postabortion care.

Plan for high quality

- ❑ Decide on a system for monitoring the quality of programs and services.
- ❑ Develop a team approach to quality improvement with clear roles and responsibilities for all participants.

Plan for sustainability

- ❑ Obtain the support of key decisionmakers.
- ❑ Include program or service costs in the regular budget of the facility to ensure that you cover costs required for sustainability.
- ❑ Develop funding mechanisms, including cost recovery systems that reflect women's ability to pay.
- ❑ Integrate or link postabortion care with existing reproductive health services.
- ❑ Devise an ongoing training program for clinical, administrative and management staff that introduces new skills and updates existing skills.
- ❑ Have regular meetings with staff to discuss progress and review suggestions for program improvement.

2.4 Ensuring sustainable supply of misoprostol[8]

A discussion of contraceptive supply management in *The Family Planning Manager* (Management Sciences for Health 1992) highlights four key pieces of data as the basis of supply-related decisions:

1. Average monthly consumption – the amount of stock used each month
2. Losses – the amount of stock that is lost or otherwise not usable due to damage, expiration, or other reasons
3. Inventory – how much stock is on hand
4. Lead time – time between placement of an order and receipt of supplies at the service delivery point

It is important to use good supply management practices. The **FEFO (first-to-expire, first-out) system** explicitly tells managers to consume products based on expiration dates, ensuring that the oldest unexpired products are used first. Another commonly used and efficient system for supply management of contraceptive commodities is the **maximum/minimum system**. In this system, the minimum stock level is the level below which stocks should never drop without first having placed a new order. The maximum stock level is set to guard against oversupply and the loss of stock to expiration.

Storage costs for misoprostol are minimal, as it is the most stable of the uterotonic drugs (POPPHI 2008). Misoprostol should be stored in a clean, dry, pest-free space. No refrigeration is necessary. Misoprostol should be protected from heat and humidity (POPPHI 2008) and stored at normal room temperature (15-30° C or 59-86° F)) in a closed container (POPPHI 2007). Both in the pharmacy and at the facility, effectiveness of misoprostol will decrease if it is exposed to excess heat and moisture (POPPHI 2007).

Because of the possibility of counterfeit drugs, it is best to use reliable distributors so you can be confident that manufacturers are complying with high standards in producing misoprostol for your market.

If your facility uses misoprostol for other indications (such as for the management of postpartum hemorrhage, the treatment of missed abortion, or labor induction), calculate the amount needed for each use separately. The uterus becomes more sensitive to misoprostol as pregnancy advances, so different regimens are required for different indications; much lower doses of misoprostol are given in advanced pregnancy (i.e., to induce labor).

8. The information contained in this section and Tool 2C is adapted from: Ipas. 2008. *MVA sustainable supply workbook*. Chapel Hill, NC: Ipas. These tools have not been field-tested for use in estimating supply needs for misoprostol use in postabortion care.

Tool 2C.

Estimating misoprostol supply needs

*Determining the total amount of misoprostol required by a program or facility will depend on the indications for which misoprostol is being used, the typical expiration period on the product, product waste due to various reasons (e.g. expiry), storage conditions (which should be dry and at room temperature), and length of time to receive ordered supplies. You can use the formula in this tool to obtain a rough estimate of your supply needs. Please consider the misoprostol regimen you are using for each indication to calculate the final number of tablets needed. An excel spreadsheet to help you complete the calculations has been included on the CD accompanying this document (***Annex 3 — Tool 2D: Estimating misoprostol supply needs spreadsheet***) or can be requested via e-mail by contacting* misoforpac@ipas.org.

Continued on next page ...

	Please enter the data below					Calculated for you*					
	Number of service days per month	**Average daily caseload**	**Percentage of caseload using misoprostol**	**Misoprostol tablets needed per dose**	**How long does it take to receive misoprostol after you order it?**	**Average daily misoprostol caseload**	**Buffer to avoid stockout**	**Number of tablets forecasted to use per day**	**Number of tablets forecasted to use per month**	**Minimum misoprostol inventory level to maintain**	**Maximum misoprostol inventory level to attain**
	Record the number of days services are provided.	Determine caseload based on last six months (if starting new services, base on two months of data to capture changing uptake; once more established, average based on six months of data).	Determine anticipated caseload percentage managed with misoprostol (may be 100 percent if only misoprostol is used for PAC; may be less if other methods are also available, such as MVA).	Based on indication and regimen used. # of pills per dose equals # of 200mcg misoprostol tablets needed per dose.	Record the number of weeks that typically elapse between order placement and delivery to your facility.	Equals (*Average daily caseload*) × (*% of caseload using misoprostol*)	Equals (*Average daily misoprostol caseload*) × (*Misoprostol tablets needed per dose*) × (*7 days*) × (*How long it takes to receive misoprostol after you order it*)	Equals (*Average daily misoprostol caseload*) × (*Misoprostol tablets needed per dose*)	Equals (*Number of tablets forecasted to use per day*) × (*Number of service days per month*)	Equals (*Number of tablets forecasted to use per month*) + (*Buffer to avoid stockout*)	If it takes less than 4 weeks to receive misoprostol after you order it, your maximum inventory level will equal 2 × (*number of tablets forecasted to use per month*). If it takes 4 weeks or longer, your maximum inventory level will equal 3 × (*Number of tablets forecasted to use per month*).
Example of data and calculations	30	4	65	3	2	3	126	9	270	396	540
Enter your facility's data in this row											

** See Annex 3 on the accompanying CD for an excel spreadsheet that will help you complete the calculations.*

2.5 Additional resources

Centers for Disease Control and Prevention (CDC). 2008. *Pocket guide to managing contraceptive supplies.* Atlanta, GA: CDC. http://www.cdc.gov/Reproductivehealth/ProductsPubs/PocketGuide.htm.

EngenderHealth. 2009. *COPE® for comprehensive abortion care service: A toolbook to accompany the COPE® handbook.* New York: EngenderHealth. http://www.engenderhealth.org/files/pubs/qi/cope-for-abortion-care.pdf

Herrick, Jeannine, Katherine L. Turner, Teresa McInerney and Laura Castleman. 2004. *Woman-centered postabortion care: Reference manual.* Chapel Hill, NC: Ipas. http://www.ipas.org/Publications/Woman-centered_postabortion_care_Reference_manual.aspx

Inter-agency Working Group on Reproductive Health in Crises. 2010. *Inter-agency field manual on reproductive health in humanitarian settings.* http://www.iawg.net/IAFM%202010.pdf

International Federation of Gynecology and Obstetrics (FIGO). 2009. *Misoprostol Safe Dosage Guidelines.* http://www.figo.org/news/misoprostol-safe-dosage-guidelines

Management Sciences for Health. *The family planning manager.* http://erc.msh.org/TheManager/

Postabortion Care Consortium. 2002. *Essential elements of postabortion care: An expanded and updated model.* http://www.pac-consortium.org/site/PageServer?pagename=Themes_PAC_Model_Resources

USAID Postabortion Care Resources. http://www.usaid.gov/our_work/global_health/pop/techareas/pac/index.html

Wood, Damian, Gill Turner and Fiona Straw. 2010. *Not just a phase: A guide to the participation of children and young people in health services.* London: Royal College of Pediatrics and Child Health. http://www.crin.org/docs/RCPCH_Not_Just_a_Phase.pdf

MODULE 3. Assessing your facility

3.1 Introduction[9]

To implement a successful program using misoprostol for the treatment of incomplete abortion, a facility assessment can ensure that minimum requirements for service provision are met, regardless of the type of facility. In addition, a facility assessment can help determine the current quality of care and systems in place, which then can be compared to the minimum standards to see what, if anything, needs to be improved before starting a misoprostol program.

Module 3 provides guidance and tools for conducting the facility assessment, including examining the management and delivery of services, staffing, record keeping, equipment, supplies and facility infrastructure. If a facility already provides PAC services using other technologies such as manual vacuum aspiration (MVA), then many of the basic requirements may already be met. If your facility does not yet provide PAC services, review **Tool 3A: Minimum requirements for treatment of incomplete abortion with misoprostol** and determine what you need to meet the requirements. Remember that **misoprostol treatment has very minimal service delivery requirements and can be provided almost anywhere.**

If resources permit, a thorough assessment of your facility can also help you identify ways to improve quality of care. This includes

ATTITUDINAL OBSTACLES

Abortion-related stigma is a social phenomenon based on values, beliefs and biases that may influence how clinicians treat women for incomplete abortion. Delays in care for the complications of unsafe abortions can cause death (Mayi-Tsonga et al. 2009). It is necessary to address root causes of abortion-related stigma to positively impact attitudinal obstacles to postabortion care. Values Clarification and Attitude Transformation (VCAT) interventions engage stakeholders to identify and address stigma-related barriers to service provision, as well as barriers to access and quality of care stemming from misinformation, values conflicts, negative attitudes and lack of respect for women's rights. The facility assessment provides an opportunity to determine the VCAT needs of personnel at a particular site. For more information, see *Abortion attitude transformation: A values clarification toolkit for global audiences* (Turner and Page 2008) in the Additional Resources section at the end of this module.

TARGET AUDIENCE:
Facility managers

TOOLS IN THIS MODULE:

3A Minimum requirements for treatment of incomplete abortion with misoprostol

3B Facility assessment

9. This section is adapted from: Baird, Traci L., M.Virginia Chambers and Charlotte E. Hord. 1998. *Implementing postabortion care. Technical resources for postabortion care, volume 1*. Carrboro, NC: Ipas.

reviewing the facility's written policies, procedures and standards for all aspects of service delivery. You should also examine the financial and budgeting system in order to determine how you will purchase supplies and medicines related to the treatment of incomplete abortion with misoprostol (such as misoprostol, MVA, contraceptive supplies, and infection prevention supplies). Finally, determine the availability and schedule of staff able to provide postabortion care.

Program managers, clinicians, and other relevant stakeholders can all participate in using the facility assessment tool. It is generally most productive to establish a small team of people with different skills and perspectives to carry out the assessment; this can maximize the richness of the information gathered. For example, a relief agency may want to introduce misoprostol for treatment of incomplete abortion into health-care services in a refugee camp. In this instance, the facility assessment team might include the camp's nurse manager, logistics and supplies manager, a representative from the refugee women's group, and a staff member of the relief agency.

3.2 Models for integrating misoprostol into postabortion care services

Introduction of misoprostol

Stand-alone primary care services, including family planning clinics, can offer misoprostol for treatment of incomplete abortion whether or not MVA is available. However, there should be a referral link for MVA as a backup when needed. A misoprostol option at the lowest level of the health system allows clinicians to reach new populations of women and thereby expand points of service.

Integration of misoprostol

Integrating misoprostol treatment into **existing PAC services** allows women a choice of preferred technologies and potentially increases the number of clinicians able to offer PAC.

Integrating misoprostol treatment into **emergency services** such as emergency departments may also increase the number of clinicians able to offer PAC. Furthermore, it could decrease facility needs in terms of procedure rooms and equipment for care.

Integrating misoprostol treatment into **basic and emergency obstetric and newborn care services** has the advantage of further expanding the number of clinicians able to offer PAC. Furthermore, it links PAC services to maternal health services, which can capitalize on clinician skill sets and more comprehensively address women's reproductive health needs.

CONTRACEPTION: AN ESSENTIAL ELEMENT

No matter what the model, contraceptive counseling and services are an essential component of PAC services for women who wish to delay or prevent pregnancy. Through the facility assessment, you can assess how contraceptive services can be improved to address women's needs and provide more contraceptive choices. If the institution cannot offer a particular contraceptive method, identify other contraceptive providers in the community to whom women can be referred.

Tool 3A.

Minimum requirements for treatment of incomplete abortion with misoprostol

To implement misoprostol treatment in postabortion care services, it is important to understand the minimum requirements for service delivery. The minimum requirements listed below apply whether you are initiating new services or integrating misoprostol for postabortion care into existing services, and apply regardless of the level of service delivery. Please note that there are different requirements if you are providing MVA services. Any woman coming in with emergency conditions should be referred and treated within the general emergency obstetric care (EmOC) guidelines of your country.

Minimum requirements for treatment of incomplete abortion with misoprostol	
Infrastructure and furniture	❑ Counseling and examination room(s) ❑ Light (electricity not required, can be a flashlight) ❑ Toilet facilities ❑ Clean water supply
Equipment and supplies	❑ Supplies for pelvic and bimanual exam, including speculum and gloves ❑ Disinfection supplies for instruments and gloves
Drugs and contraceptive supplies	❑ Misoprostol ❑ Analgesics and antipyretics (nonsteroidal anti-inflammatory drugs such as ibuprofen and paracetamol) ❑ Contraceptive supplies
Additional requirement for referral facilities: **Emergency treatment supplies**	❑ Emergency resuscitation materials and drugs (including IV lines and fluids, IV antibiotics, blood transfusion and other surgical supplies) ❑ Manual vacuum aspiration (MVA) equipment ❑ Other evacuation equipment if MVA is not available

For further details, see WHO guidance at: http://www.who.int/reproductivehealth/publications/unsafe_abortion/9241544694/en/ or http://www.who.int/reproductivehealth/publications/unsafe_abortion/9241590343/en/

Tool 3B.

Facility assessment[10]

The facility assessment tool facilitates comprehensive site assessment. Conducting a thorough facility assessment will help you gather valuable information needed for introducing misoprostol for postabortion care services. Moreover, identifying and addressing gaps can help you improve quality of care. The tool does not prescribe specific goals but highlights key areas that are important in providing high quality service. However, these elements are ***not essential*** *to providing misoprostol treatment. For example, although having a patient waiting area is preferable from a high quality standpoint (especially in a busy facility), it is not a requirement for service provision.*

Depending on your role, you may use all or part of this assessment tool. You can also divide up sections of the tool among different members of the assessment team, with members addressing particular sections according to their expertise. District health managers may find this approach helpful for assessing primary care centers in their district. A clinician who wants to add misoprostol treatment to a rural health post may use sections of the tool to assess the site's capacity to start services.

I. FACILITY INFORMATION	
Name: _____	
Type (Public/Private): _____	
Assessors: _____	
Date: _____	
Does this facility provide the following services?	
Manual vacuum aspiration (MVA)	Yes ☐ No ☐
Sharp curettage	Yes ☐ No ☐
Pregnancy termination	Yes ☐ No ☐
Treatment of second-trimester abortion	Yes ☐ No ☐
Contraceptive services	Yes ☐ No ☐

10. This tool was adapted from programmatic materials developed by Ipas Africa Alliance and Ipas Nigeria.

II. CLINIC LEADERSHIP AND MANAGEMENT

The support and understanding of facility managers and leaders on the issues and advantages of misoprostol for treatment of incomplete abortion is critical to successful services.

Question	Answer
Are key facility managers supportive of the introduction of misoprostol for treatment of incomplete abortion services?	Yes ☐ No ☐ Don't know ☐ If no, please comment below:
What are clinicians' and administrators' attitudes and beliefs about who – such as doctors, midwives and nurses – should be trained in postabortion care services?	Comment:
What are staff perceptions of women who seek postabortion care – including subpopulations such as adolescent and young women?	Comment:
Are gender sensitivity and/or values clarification sessions needed and, if so, with whom?	Yes ☐ No ☐ Don't know ☐ Comment:

III. POSTABORTION CARE (PAC) SERVICE STATISTICS
The site should have a register for recording services. The record should be improved to capture PAC where this does not already exist.

Question	Answer
Review logs, records and/or patient charts. How many postabortion complications were seen in the facility in the last three months?	Deaths: _____ Severe complications: _____ Minor/moderate complications: _____
Do the records look complete (e.g. logbooks are filled out and up-to-date)?	Yes ☐ No ☐
Is there a surveillance system for monitoring maternal deaths and other adverse events?	Yes ☐ No ☐
What other information is routinely collected in the logbooks?	List: _____ _____ _____
Is there a record or logbook for follow-up services and appointments?	Yes ☐ No ☐
Is there a record of patient contact information for follow-up?	Yes ☐ No ☐

IV. EQUIPMENT AND INFECTION PREVENTION Presence of a laboratory, ultrasound or ability to provide MVA is not mandatory for a site to provide misoprostol for postabortion care services. However, a site without laboratory, sonography or MVA services should ensure that a referral network is in place when the services are required.	
Question	**Answer**
Is functioning manual vacuum aspiration (MVA) equipment available at the site?	Yes ☐ No ☐ If yes, how many? If no, please explain limits to availability below:
Over the last six months, has the facility run out of infection prevention supplies?	Yes ☐ No ☐ If yes, please explain what actions were taken.
Are protocols for processing and storing medical instruments being followed properly?	Yes ☐ No ☐ If no, add additional details:
Does an appropriate system for medical waste disposal exist?	Yes ☐ No ☐ Please describe:
If this is a referral site, does the facility have the following?	STI testing Yes ☐ No ☐ Urinalysis Yes ☐ No ☐ Bacteriologic cultures Yes ☐ No ☐ Hemoglobin and hematocrit Yes ☐ No ☐ Blood grouping and cross-matching Yes ☐ No ☐ Ultrasound Yes ☐ No ☐ Facilities for blood transfusion Yes ☐ No ☐ Intravenous fluids Yes ☐ No ☐

V. PHARMACY AND CONTRACEPTION

The presence of a pharmacy is not mandatory for a site to provide misoprostol treatment for incomplete abortion. Where a pharmacy is lacking, however, the site should have secure cabinets for storing misoprostol as well as analgesics and, preferably, contraceptives.

Question	Answer
Is misoprostol available in the clinic?	Yes ☐ No ☐
Does the clinic provide contraceptives with postabortion care services (in other words, can the woman obtain contraceptive services without having to wait)?	Yes ☐ No ☐ If yes, list all methods available: _____ _____ _____
What instructions do women receive for contraceptive method resupply?	Describe:
Does this site have its own drug storage area where drugs can be dispensed or stored?	Yes ☐ No ☐ **If yes:** › Is the storage area locked? Yes ☐ No ☐ › Who has access to the cabinet/is responsible for drug dispensation? _____ **If no:** › Do they refer to another part of this facility? Yes ☐ No ☐ › Do they refer to a different facility? Yes ☐ No ☐
Do patients pay for drugs or contraceptives?	Yes ☐ No ☐

VI. CLINIC SET-UP Basic standards for providing misoprostol treatment as stipulated by the country's local authorities should be followed. The following are examples of what to check.	
Question	**Answer**
Do women have to pay for PAC treatment?	Yes ☐ No ☐ If yes, what is the cost of PAC treatment? _____ Cost of misoprostol treatment: _____ Cost of MVA treatment: _____ Cost of another procedure (indicate): _____
Is there a waiting area?	Yes ☐ No ☐
What are the typical or likely waiting times for services?	Treatment with misoprostol: _____ MVA: _____ Contraceptive services: _____ Other: _____
Are waiting, treatment and recovery areas private, comfortable and adequate?	Yes ☐ No ☐ If no, please comment:
Does the facility have a space where women can wait after taking the misoprostol tablets, if they choose to stay? *Note: Women may choose (but are not required) to stay in the facility for one to two hours after taking misoprostol.*	Yes ☐ No ☐ If yes, describe the available space:

What, if any, changes or renovations are needed to facilitate smooth patient flow?[11]	Describe:
Is there a patient toilet facility?	Yes ☐ No ☐ If yes, is there a sign to the toilets? Yes ☐ No ☐
Is there clean water?	Yes ☐ No ☐
Are there pads or other supplies for bleeding?	Yes ☐ No ☐
If women are sent home to take the medications, are they given clear written instructions about how to use misoprostol, what to expect, danger signs and where to go in the case of complications?	Yes ☐ No ☐ If yes, are they available in the local language(s)? Yes ☐ No ☐ If yes, are they appropriate to the literacy and education levels of patients? Yes ☐ No ☐
Are trained staff on duty during each shift?	Yes ☐ No ☐
Do service providers have access to a telephone 24 hours a day?	Yes ☐ No ☐ If no, please explain hours or other limitations:
Is there 24-hour coverage at the facility?	Yes ☐ No ☐
Is there an established referral relationship with another facility for complications beyond the facility's capability to manage?	Yes ☐ No ☐ If yes, please write: Name of referral facility: _____ Location: _____ Contact information: _____ _____

11. For additional information on how to conduct a client flow analysis, consult: EngenderHealth. 2009. *COPE® for comprehensive abortion care service: A toolbook to accompany the COPE® handbook.* New York: EngenderHealth. http://www.engenderhealth.org/files/pubs/qi/cope-for-abortion-care.pdf

VII. STAFF CAPACITY AND TRAINING NEEDS

For the site to provide misoprostol, the staff should be well trained. Although staff do not need to be experienced in other uterine evacuation methods, they should receive an orientation to manual vacuum aspiration if MVA is offered at the site.

Ask clinicians whether they perceive the facility to be well prepared in the following areas:	**Present and adequate**	**Present but needs upgrading**	**Absent, training needed**
General experience and training in reproductive health (including STIs, HIV, violence screening, and other areas)			
Experience assessing patients for early pregnancy and incomplete abortion			
Experience with postabortion counseling, including contraceptive counseling and method provision after postabortion care			
Knowledge of procedures for informed consent and referrals in line with women's rights and confidentiality			
Understanding of regulatory issues and the ethical and legal mandate for provision of abortion and postabortion care			
Knowledge and practice of infection prevention standards			
Knowledge of institutional protocols on incomplete abortion			
Knowledge of contraception after misoprostol treatment			
Experience with manual vacuum aspiration (MVA)			

Please list the number of each type of staff trained to use MVA:	_____(#) doctors _____(#) midwives/nurses _____(#) health officers _____(#) other types of clinicians
Please list the number of each type of staff trained to use misoprostol:	_____(#) doctors _____(#) midwives/nurses _____(#) health officers _____(#) other types of clinicians
Please list the number of personnel trained on patient stabilizing and referral for complicated cases:	
Assess the site's training capacity, including current in-service training activities:	

Additional comments and recommendations for misoprostol introduction:

_____

_____

_____

_____

_____

_____

3.3 Using the results of the facility assessment tool

Once your team has used the facility assessment tool to collect information, you should analyze the results to determine the facility's capacity for misoprostol service delivery. It can also be helpful to present the assessment results to the facility staff, highlighting both the positive results and areas that could improve or change. Your team may want to continue to talk with staff to further explore the reasons why gaps exist. This may help to overcome barriers and identify solutions.

Key site leaders and staff providing services at the facility should prioritize needed changes and develop an action plan to strengthen the facility's capacity to provide misoprostol for postabortion care. Teams may want to set specific benchmarks with timelines and goals. For example, if increasing contraceptive commodity choices has been identified as a need, a team could indicate that more method choices should be available by the second quarter, with 25 percent more contraceptive uptake by the fourth quarter. Assigning a specific staff person for the management of selected goals will help ensure that they are addressed.

There are many other approaches to using assessment data to plan for a change, ranging from the simple to the highly complex. Use whatever works best for your site, given the resources, commitment and capacity of all involved. For additional tools, approaches, and resources, see the PRIME II project toolkit on performance improvement: http://www.intrahealth.org/sst/intro.html.

3.4 Additional resources

Alemayehu, Tibebu, Karen Otsea, Aregawi GebreMikael, Selamawit Dagnew, Joan Healy and Janie Benson. 2009. *Abortion care improvements in Tigray, Ethiopia: Using the Safe Abortion Care (SAC) approach to monitor the availability, utilization, and quality of services.* Chapel Hill, NC: Ipas. http://www.ipas.org/Publications/Abortion_care_improvements_in_Tigray_Ethiopia_Using_the_Safe_Abortion_Care_SAC_approach_to_monitor_the_availability_utilizat.aspx?ht

EngenderHealth. 2009. *COPE® for Comprehensive Abortion Care Service: A Toolbook to Accompany the COPE® Handbook.* New York: EngenderHealth. http://www.engenderhealth.org/files/pubs/qi/cope-for-abortion-care.pdf

Hyman, Alyson G. and Laura Castleman. 2005. *Woman-centered abortion care: Reference manual.* Chapel Hill, NC: Ipas. http://www.ipas.org/Publications/Woman-centered_abortion_care_Reference_manual.aspx

McInerney, Teresa, Traci L. Baird, Alyson G. Hyman and Amanda B. Huber. 2001. *A guide to providing abortion care. Technical resources for abortion care*. Chapel Hill, NC: Ipas. http://www.ipas.org/Publications/A_guide_to_providing_abortion_care.aspx

Postabortion Care Consortium. http://www.pac-consortium.org

Turner, Katherine L. and Kimberly Chapman Page. 2008. *Abortion attitude transformation: A values clarification toolkit for global audiences*. Chapel Hill, NC: Ipas. http://www.ipas.org/Publications/Abortion_attitude_transformation_A_values_clarification_toolkit_for_global_audiences.aspx

World Health Organization. 2003. *Safe abortion: Technical and policy guidance for health systems*. Geneva: WHO. Please look for updated version anticipated in 2011. Current version is at: http://www.who.int/reproductivehealth/publications/unsafe_abortion/9241590343/en/index.html.

MODULE 4. Creating community linkages[12]

4.1 Introduction

Community participation is a key component of primary health care. Meaningful participation includes the ability to influence decision-making processes regarding health services. Communities can play a key role in reducing maternal mortality and morbidity when they establish links with facilities that offer reproductive health services, and with clinicians concerned about women's health. Community members — including women, health-care providers, community leaders, family members and others — are generally already invested in the health, safety and well-being of local women and families.

Partnerships between health facilities, trained clinicians and community leaders and groups can greatly strengthen the delivery of high quality, woman-centered postabortion services in the local communities where women live (thereby fulfilling women's rights and saving lives). Such partnerships, though not strictly essential to service delivery, can contribute to implementation of high quality services that meet women's needs. Module 4 is designed to aid you, as a clinician or facility manager, to enhance community-facility relationships to strengthen service delivery. It will help you identify potential partners and explore opportunities for collaborating and working with local communities to make services available, accessible, and high quality.

Involving community members after a facility has initiated services can increase acceptance, use of, and involvement in services. Early community involvement along with ongoing community dialogue can help promote services that are consistent with the community's needs and desires. This type of engagement will help greatly in identifying and addressing the root causes of unsafe abortion in a given community.

DEFINING COMMUNITY

Many diverse communities can exist within a geographic location. They can be defined on the basis of specific, shared interests, or among people with a common history, language, culture, or shared social, political or economic realities or interests. When serving a geographic area, it is important to address the needs and desires of all communities in the area, including, for example, young, poor, migrant and other populations with specific needs.

TARGET AUDIENCES:
Clinicians and facility managers

TOOLS IN THIS MODULE:

4A Quick community assessment guide

4B Potential audiences and topics for information, education and communication on misoprostol use in postabortion care

12. Various sections and tools found in this module are adapted from: Hyman, Alyson G. and Laura Castleman. 2005. *Woman-centered abortion care: Reference manual.* Chapel Hill, NC: Ipas; and Herrick, Jeannine, Katherine L. Turner, Teresa McInerney and Laura Castleman. 2004. *Woman-centered postabortion care: Reference manual.* Chapel Hill, NC: Ipas.

4.2 Partnering to reach communities

In establishing linkages with communities, you should consider partnering with local groups, NGOs and community-based organizations.[13] Successful collaborative partnerships can support community members who champion and advocate for high quality, sustainable programs. In addition, partnering with community-based organizations can give a voice to typically marginalized or disenfranchised populations, such as youth or women living with HIV/AIDS.

By engaging local partners, you can build on existing local networks to disseminate information, mobilize community members and ensure other forms of community buy-in. To begin to create links, identify and talk with key individuals who represent the shared interests of broader communities. These might include:

- Local government representatives
- Health committee members
- Leaders of women's groups
- Leaders of men's groups
- Leaders of youth groups
- Faith-based leaders
- Traditional leaders
- Heads of institutions
- Law-enforcement officials
- Traditional birth attendants
- Traditional medicine healers
- Community-based health workers

PROMOTING UNDERSTANDING OF YOUR LEGAL CONTEXT

Most countries have some legal indications for abortion, even if limited (for example, rape or incest, or to save a woman's life). When you design services or implement partnerships with communities, make sure to adapt your messages to educate community members about the legal indications for abortion as well as information on postabortion services. Communities should be aware of the legal indications for abortion and women must know where to obtain safe services.

13. To build effective partnerships, the roles of each partner must be clearly defined and agreed upon. This is especially useful when defining a plan of action, expectations and desired outcomes. In addition, identifying the most appropriate community group with which to partner is important to the success of the partnership. If you are interested in additional resources or technical assistance to help identify the organizations best suited to improving knowledge of and access to health services, please contact misoforpac@ipas.org.

Tool 4A.
Quick community assessment guide

A focused community assessment can be used to determine where women receive reproductive health information and services, which reproductive health services women have access to, what existing health structures and mechanisms are in place, what is important to women and their families, and what is relevant to their real-life circumstances. This information can then be used to reach women with postabortion care information and services. This short assessment guide outlines some of the key questions to consider when you are designing a community outreach initiative. Partners can help to answer these key questions.

Health information

- ❑ Where do women obtain health-related information?
- ❑ Where do women get information on reproductive health including information on pregnancy, contraception and unwanted pregnancy?
- ❑ Are there any common rumors or myths about contraception?

Contraceptive services

- ❑ What methods of contraception are available in the community?
- ❑ Where do women get contraceptive services?

Unwanted pregnancy

- ❑ What do women in your community do when faced with an unwanted pregnancy?

Abortion and postabortion care practices and services

- ❑ Is abortion legal? Under what circumstances?
- ❑ What are the common abortion methods used by women in the community (for example, herbs, brews, or medicines)?
- ❑ What methods are currently available for treating incomplete abortion in the community?
- ❑ What resources, such as community-based health agents, are available in the community to facilitate access to misoprostol for postabortion care services?

Attitudes and barriers

- ❑ Do community members know where postabortion care services are available?
- ❑ What barriers exist to accessing postabortion services (for example, financial and geographic barriers)?
- ❑ How can access to treatment of incomplete abortion be improved?
- ❑ What are the local beliefs or norms around women having an abortion or treatment for postabortion complications?
- ❑ What are local beliefs or attitudes about clinicians who offer postabortion care services?

- ❑ How does abortion-related stigma influence women's health and what kinds of barriers does it create to accessing services?
- ❑ Which key institutions and players should be involved in addressing abortion-related stigma to overcome stigma-related barriers in the community?
- ❑ Who are the key leaders and change agents in the community?

4.3 Strategies for working with communities

Community linkages are most effective when they are locally driven, and championed by recognized community leaders (who can provide credibility and sustainability) and community members (who will use the services). Working with your community partners, you can use the information gathered in the community assessment to design strategies that will link postabortion services and community members in effective ways. Community partners can help identify community needs and existing structures that can be used to inform these service provision strategies. It is important to be open to implementing **community-generated solutions to identified problems**, recognizing that these solutions may change over time.

Tool 4B: Potential audiences and topics for information, education and communication on misoprostol use in postabortion care offers suggested methods of achieving meaningful community participation, as well as topics for dialogue that may be a useful starting point. Remember:

- Although strategies for involving community members in health care vary, it is important to build community members' capacity not only as beneficiaries of health care, but as **partners and leaders for good health**.
- It is important to **set and prioritize topics with community members**. Make sure the needs of special populations (such as poor, young, HIV-positive, refugee and migrant populations) are taken into consideration, too.
- Preferred methods and prioritized topics may change over time. It is therefore important to **continuously seek community input** when making changes to service delivery or health messages.

ADDRESSING STIGMA

Stigma surrounding pregnancy termination often results in practices shrouded in secrecy and shame. Stigma and its manifestations also represent key barriers to women's access to safe postabortion care. Identifying social norms that stigmatize abortion and postabortion care and reducing abortion-related stigma are essential to ensuring that all women are able to exercise their reproductive health rights. Stigma must be addressed at various levels with gatekeepers and opinion leaders, community groups, abortion care providers and individual women and men to find ways to mitigate its impact, create awareness and understanding of the harm it causes, and block its perpetuation.

Tool 4B.

Potential audiences and topics for information, education and communication on misoprostol use in postabortion care[14]

Audience	Topics	Communication avenues	Media
Community members: Adolescent and adult women; their partners, family members or guardians; teachers, women's groups, men's groups, youth groups, student groups, community groups, unions and apprentice groups, and clubs based on sports, social exchange, theater and arts, and others Taxi drivers or other local informants such as traditional birth attendants and community health workers	**Unwanted pregnancy:** Signs and symptoms of pregnancy, importance of seeking care early, recognizing pregnancy complications, where and when to seek help; the importance of timing and spacing of pregnancies; the dangers of unsafe abortion. **Postabortion care:** Postabortion care laws and service policies; where, how and at what cost postabortion care can be obtained; techniques for postabortion care, particularly misoprostol; how to recognize complications from incomplete abortion and where and when to seek help; quick return to fertility after abortion; community role in recognition and transport for emergency care. **Pregnancy prevention:** Modern methods of contraception; safety and effectiveness; where and how methods can be obtained; the importance of timing and spacing pregnancies; emergency contraception (including when to use it and where to get it).	• Health service facilities • Schools and universities • Workplaces • Youth centers • Women's centers • Group meetings • Village/community meetings *(traditional and formal)* • Markets • Discos, clubs and bars • Health fairs • Internet	• Print and electronic media *(newspapers, magazines, posters, flyers, websites)* • Radio • TV • Interpersonal communication activities *(drama, song, poetry, dance, talks, face-to-face discussions)*
Community leaders: Professional associations *(police, media, legal, medical, pharmacy, faith-based services, and others)* Non-traditional cultural leaders such as film and sports stars Traditional and faith-based leaders	**Unwanted pregnancy:** Importance of leaders educating their communities to prevent unwanted pregnancies, recognize the signs and symptoms of pregnancy, seek care early, identify pregnancy complications, know where and when to seek help, understand the importance of timing and spacing pregnancies, and understand the dangers of unsafe abortion; relative costs to families and the community of maternal morbidity and mortality due to unwanted pregnancy and unsafe abortion. **Postabortion care:** Postabortion care laws and service policies; women's (including adolescents' and young women's) rights regarding postabortion care; relevant postabortion care access issues, including access to and availability of misoprostol, and the impact on health and resources; role of community leaders in facilitating access to PAC. **Pregnancy prevention:** Information about modern methods of contraception (including emergency contraception); safety and effectiveness; where and how contraceptive methods and other reproductive health services can be obtained; the importance of timing and spacing pregnancies.	• Professional meetings and conferences • Village/community meetings *(traditional and formal)* • Workshops conducted by health professionals	• Print and electronic media *(newspapers, magazines, posters, flyers, websites)* • Interpersonal communication activities *(talks, face-to-face discussions)* • Workshops/ presentations

Continued on next page ...

Policymakers: Health system officials, legislators and others	**Unwanted pregnancy:** Prevalence, health and resource impact of unsafe abortion and unwanted pregnancies on women and families; the health impact of timing and spacing of pregnancies; relative costs to families and the community of maternal morbidity and mortality due to unwanted pregnancy and unsafe abortion; importance of educating constituents to prevent unwanted pregnancies, recognize the signs and symptoms of pregnancy, seek care early, identify pregnancy complications, know where and when to seek help, understand the importance of timing and spacing pregnancies, and understand the dangers of unsafe abortion. **Postabortion care:** Postabortion care laws and service policies; women's (including adolescents') rights regarding postabortion care; relevant postabortion care access issues, including access to and availability of misoprostol, and the impact on health and resources; relative costs of providing emergency treatment for unsafe abortion compared with those of safe induced abortion and contraception; availability of drugs (misoprostol) to treat incomplete abortion; need to legislate for funding of high quality reproductive health services for women, including postabortion care services. **Pregnancy prevention:** Information about modern methods of contraception (including emergency contraception); safety and effectiveness; the importance of timing and spacing pregnancies.	• Conferences • Governmental hearings • In-person meetings	• Research reports for meetings and legislative hearings • Communications to the staff of these officials • Workshops/ presentations • Letter-writing campaigns • News media *(national newspapers, magazines, news broadcasts/current affairs programs)*
Health workers: Clinicians (doctors, midwives, nurses, pharmacists, and others) Traditional healers or practitioners	**Unwanted pregnancy:** Importance of educating and counseling women on preventing unwanted pregnancies, recognizing the signs and symptoms of pregnancy, seeking care early, identifying pregnancy complications, knowing where and when to seek help, understanding the importance of timing and spacing pregnancies, and understanding the dangers of unsafe abortion. **Postabortion care:** Postabortion care laws and service policies; women's (including adolescents') rights regarding postabortion care; legal and ethical obligations regarding provision of abortion and/or postabortion care; integrated provision of PAC services and contraception; emergency contraception; the importance of timing and spacing pregnancies; addressing women's other reproductive health needs; how to obtain and convey information to community groups (such as those listed above); where to refer women with pregnancy complications and/or incomplete abortion; the importance of seeking care early and providing high quality services; ensuring patient confidentiality and providing adequate counseling; where/how to get trained in postabortion care. **Pregnancy prevention:** Information about modern methods of contraception (including emergency contraception); safety and effectiveness; referrals to other reproductive health services; the importance of timing and spacing pregnancies.	• Professional meetings and conferences • Professional publications • Village/community meetings • Workplaces • Trainings	• Professional/peer-reviewed journals • Workshops/ presentations • Print and electronic media *(newspapers, magazines, posters, flyers, websites)* • Interpersonal communication activities *(talks, face-to-face discussions)*

14. This tool is adapted from: McInerney, Teresa, Traci L. Baird, Alyson G. Hyman and Amanda B. Huber. 2001. *A guide to providing abortion care. Technical resources for abortion care*. Chapel Hill, NC: Ipas.

4.4 Additional resources

Billings, Deborah, Leila Hessini and Kathryn Andersen Clark. 2009. *Focus group guide for exploring abortion-related stigma.* Chapel Hill, NC: Ipas. http://www.ipas.org/Publications/Focus_group_guide_for_exploring_abortion-related_stigma.aspx?ht

EngenderHealth. 2002. *Community COPE: Building partnership with the community to improve health services.* New York: EngenderHealth. http://www.engenderhealth.org/files/pubs/qi/toolbook/CommCOPE.pdf

Family Health International in collaboration with Advocates for Youth. 2005. *Youth participation guide: Assessment, planning and implementation.* Arlington, VA: FHI/YouthNet. http://www.fhi.org/en/youth/youthnet/rhtrainmat/ypguide.htm

Hord, Charlotte. 2001. *Making safe abortion accessible: A practical guide for advocates.* Chapel Hill, NC: Ipas. http://www.ipas.org/Publications/asset_upload_file495_3176.pdf

Inter-agency Working Group on Reproductive Health. 1999. *Reproductive health in refugee situations. An inter-agency field manual.* http://www.unhcr.org/refworld/docid/403b6ceb4.html

Save the Children. 2003. *Partnership defined quality: A tool book for community and health provider collaboration for quality improvement.* http://www.k4health.org/sites/default/files/Partnership%20defined%20quality.pdf

UNFPA. 2009. *Guidelines for engaging faith-based organizations as agents of change.* http://www.unfpa.org/culture/docs/fbo_engagement.pdf

Westley, Elizabeth and Anna Glasier. 2010. Emergency contraception: Dispelling the myths and misperceptions. *Bulletin of the World Health Organization*, 88 (4): 243-244. http://www.who.int/reproductivehealth/publications/family_planning/ec_editorial/en/index.html

Wood, Damian, Gill Turner and Fiona Straw. 2010. *Not just a phase: A guide to the participation of children and young people in health services.* London: Royal College of Paediatrics and Child Health. http://www.crin.org/docs/RCPCH_Not_Just_a_Phase.pdf

MODULE 5. Delivering clinical services

5.1 Introduction

Once you have planned to provide care with misoprostol for incomplete abortion, you will need to focus on the practical keys to implementing the service and delivering high quality care. Module 5 provides you with clinical information and tools to integrate misoprostol treatment into existing reproductive health services for women. The module contains information on misoprostol, management of side effects and potential complications, preparing women for what to expect, follow-up care and contraception. **Tool 5A** is an abbreviated, step-by-step clinical protocol to be used as the essential protocol for clinicians.[15]

5.2 Misoprostol: what it is and how it works

Misoprostol is a prostaglandin E1 analogue. It causes the cervix to soften and the uterus to contract. Misoprostol has several uses in obstetrics and gynecology, which include treatment of incomplete abortion and miscarriage; treatment of missed abortion (including intrauterine fetal death); labor induction; prevention and treatment of postpartum hemorrhage; cervical priming; and pregnancy termination (FLASOG 2007, Goldberg et al. 2001, Weeks and Faundes 2007, WHO 2003).[16] Because the uterus becomes much more sensitive to the effects of misoprostol as pregnancy advances, doses of misoprostol for labor induction are *much* lower than doses for first-trimester treatment of incomplete abortion (see **Tool 5E: Dosage card**). For more information on misoprostol's different uses, please visit www.misoprostol.org.

5.3 Regimens and efficacy of misoprostol treatment for incomplete abortion

For the purposes of standardization and to avoid confusion, it is advisable that local experts and authorities select **one misoprostol regimen** for the treatment of incomplete abortion to use in their country. Sublingual and oral routes of misoprostol administration have the quickest onset of action and have been widely studied. Misoprostol 400mcg sublingually and misoprostol 600mcg orally have similar safety and efficacy profiles when used with uterine size less than or equal to 12 weeks LMP (last menstrual period) (see **Table 1** and **Tool 5E: Dosage card**) (Diop et al. 2009, Gynuity Health Projects 2009, Tang et al. 2007).

TARGET AUDIENCE:
Clinicians

TOOLS IN THIS MODULE:

- 5A Misoprostol for treatment of incomplete abortion: Basic clinical protocol
- 5B Clinical flow chart
- 5C Service delivery diagram
- 5D Patient chart
- 5E Dosage card
- 5F Brochure for women (oral and sublingual)
- 5G Managing expected effects, side effects and complications
- 5H Contraceptive pocket guide
- 5I Referral form
- 5J Serious adverse event form

15. "Clinicians", in this context, refers to any trained health-care provider, such as physicians, midwives, nurse-practitioners, clinical officers, physician assistants and others.

16. Please see International Federation of Gynecology and Obstetrics website for dosage guidelines: http://www.figo.org/news/misoprostol-safe-dosage-guidelines.

Table 1. Misoprostol for imcomplete abortion – doses and regimens

Uterine size	Misoprostol dose	Route	Timing	Success[17]	References
Up to 12 weeks	600mcg	Oral	Three 200mcg tablets taken at once.	91-99 percent	(Bique et al. 2007, Dao et al. 2007, Diop et al. 2009, Shwekerela et al. 2007, Taylor et al. 2011, Weeks et al. 2005)
	400mcg	Sublingual	Two 200mcg tablets under the tongue for 30 minutes, then swallow the remaining pill fragments.	95-98 percent	(Dabash et al. 2010, Diop et al. 2009)

For additional clinical information, please consult Gynuity Health Projects' publication, *Misoprostol for treatment of incomplete abortion: An introductory guidebook*, available on the accompanying CD or at http://gynuity.org/resources/info/guidebook-on-misoprostol-for-treatment-of-incomplete-abortion/, as well as in Ipas and Gynuity Health Projects' forthcoming training manual on misoprostol for incomplete abortion at www.ipas.org or www.gynuity.org.

5.4 Misoprostol for the treatment of missed abortion and anembryonic gestation

Although this toolkit focuses on the indication of misoprostol for the treatment of incomplete abortion, misoprostol, as noted, can also be used for the treatment of missed abortion and anembryonic gestation. Missed abortion is characterized by the arrest of embryonic or fetal development; anembryonic pregnancy (formerly called blighted ovum) is when a gestational sac develops but there is no embryo within it. Embryonic demise occurs when an embryo has no cardiac activity. Both conditions are diagnosed by ultrasound. The dosage for missed abortion and anembryonic gestation is misoprostol 800mcg vaginally or misoprostol 600mcg sublingually every three hours for a maximum of three doses. A single sublingual dose of misoprostol 600mcg may also be effective. However, treatment of missed abortion with sublingual misoprostol has not been widely studied.

Because both types of early pregnancy loss involve little to no bleeding and a closed cervix, misoprostol treatment is not as effective for these indications as it is for incomplete abortion. Reported success rates for misoprostol treatment of missed abortion vary widely. For more detailed information about the reported use of misoprostol for missed abortion, see Gynuity Health Projects' *Misoprostol for treatment of incomplete abortion: An introductory guidebook* at http://gynuity.org/resources/info/guidebook-on-misoprostol-for-treatment-of-incomplete-abortion/.

17. Success is defined as complete uterine evacuation without further intervention with vacuum aspiration or curettage.

Tool 5A.

Misoprostol for treatment of incomplete abortion: Basic clinical protocol

For rapid assessment of patients in emergency, see section VIII of this tool: Emergency assessment and care

I. Eligibility

A. Women with the following conditions are eligible for misoprostol:

1. Open cervical os
2. Vaginal bleeding or history of vaginal bleeding during this pregnancy
3. Uterine size at or under 12 weeks LMP

B. **Contraindications**

1. Known allergy to misoprostol or to other prostaglandins
2. Confirmed or suspected ectopic pregnancy
3. Signs of sepsis or active pelvic inflammatory disease
4. Hemodynamic instability or shock

C. **Precautions** (treatment dependent on clinical judgment and available options for safe postabortion care)

1. IUD in place: remove before beginning the regimen
2. Hemorrhagic disorder or current anticoagulant therapy
   Note: In general, it may be safer for women with hemorrhagic disorder or who are taking anticoagulants to receive care in a health facility where they can be observed and monitored; vacuum aspiration (if available) may be the safer treatment choice.
3. Uterine size larger than 12 weeks
4. Severe anemia
5. Women who are breastfeeding may take misoprostol.

II. Clinical history and examination

A. Obtain history

1. Current medicines used
2. Known allergies
3. Acute or chronic illnesses or conditions
4. Brief obstetric and contraceptive history
5. History of current pregnancy

a. LMP

b. Pregnancy symptoms

c. When bleeding began, bleeding patterns and amount of bleeding

d. Pelvic pain/ cramping

- Is pain/cramping intermittent (like contractions) or constant?
- Severity of pain/cramping on a scale of 1 to 10 (10="worst pain I've ever felt")

B. Carry out ancillary testing (if indicated and available)

1. Hemoglobin or hematocrit
2. Ultrasound: not routinely needed to diagnose incomplete abortion
3. Pregnancy testing: not routinely needed to diagnose incomplete abortion

C. Perform physical exam

1. Obtain vital signs: blood pressure, temperature, pulse
2. Assess general appearance: pallor, level of energy and alertness, ambulatory, no indication of acute distress
3. Perform pelvic exam and assess:

a. Uterine size, tenderness

b. Cervical motion tenderness

c. Adnexal mass suggestive of ectopic pregnancy

4. Perform speculum exam and assess:

a. Cervical os (open or closed)

b. POC protruding from cervix

c. Discharge from os

d. Blood in vaginal vault (color and amount)

III. Assessment

A. Assess whether the woman is in stable condition.

B. Ascertain whether a diagnosis of incomplete abortion is warranted.

C. Assess whether the woman is an eligible candidate for misoprostol treatment.

IV. Treatment

A. Discuss treatment options with women determined to be eligible: misoprostol, MVA, expectant management or other.

B. If the woman decides to use misoprostol treatment:

1. Explain what to expect:
    a. Effectiveness of treatment (91-99 percent)
    b. How misoprostol is used
    c. Range of normal experience
    d. Potential side effects and complications
    e. Warning signs to seek help
    f. Access to emergency care if needed
    g. Contraceptive needs
2. Provide misoprostol. Depending on the space available at the facility, the woman's condition and her preference, she can take the medicines at the clinic and then return home, she can take the misoprostol at home, or (if the facilities permit and this is the woman's preference) she can remain in the clinic for several hours for observation. To avoid confusion, choose one regimen for your program (either one may be given):
    a. **Oral misoprostol: 600mcg**

    OR

    b. **Sublingual misoprostol: 400mcg**
3. Provide additional medicines:
    a. For pain: NSAIDs such as ibuprofen 400-600mg orally every six hours as needed
    b. Other medicines (for example, antiemetics) as needed

V. Warning signs for which women should seek immediate medical care

A. **Heavy bleeding**
    1. **Soaking two full-thickness sanitary pads per hour for two consecutive hours**
    2. **Heavy bleeding that occurs after bleeding had slowed down or stopped**
    3. **Feeling light-headed, dizzy or weak as bleeding continues**

B. **Fever that lasts more than a day or starts any day after the misoprostol is taken**

C. **Severe pain, even on the day of taking misoprostol, that does not get better with medication, rest or a heating pad**

D. **Feeling very sick**

VI. Contraception

A. Oral contraception, contraceptive implants, skin patches, the vaginal ring or contraceptive injectables can be given at the clinic on the day misoprostol is given.

B. Intrauterine contraception can be provided when successful treatment is confirmed at follow-up.

C. Condoms, diaphragm, contraceptive jellies, foam or film can be given on the day misoprostol is given.

D. Emergency contraceptive pills should be given in advance as a back-up method.

E. Sterilization can be provided at the follow-up visit.

VII. Follow-up visit

A. Schedule a follow-up visit one to two weeks following misoprostol administration.

B. History suggestive of successful treatment:

1. Woman experienced bleeding ranging from lighter than a menstrual period to much heavier than a menstrual period after taking misoprostol, usually with passage of clots or tissue.

2. Pregnancy symptoms have lessened or disappeared; she no longer feels pregnant.

C. Physical exam suggestive of successful treatment:

1. Minimal or absent bleeding

2. Normal uterine size (small, firm)

3. Non-tender uterus and adnexae and no cervical motion tenderness

4. Closed cervical os

D. If findings show that abortion may still be incomplete and the woman is clinically stable, she may be offered:

1. Observation with expectant management (one to two weeks)

2. A repeat dose of misoprostol. If the woman is treated with a repeat dose of misoprostol, it is advisable that she be evaluated again in one to two weeks to be sure the abortion is complete.

3. If the patient requests completion or in the event of infection or clinically significant bleeding, vacuum aspiration should be provided.

VIII. Emergency assessment and care

A. Rapid initial assessment for shock if woman appears to be frankly hemorrhagic, losing consciousness, near collapse, septic, etc.

1. Check vital signs (blood pressure, pulse, temperature, respiratory rate)

2. Signs of shock:

a. Fast, weak pulse (rate > 110 beats per minute)

b. Low blood pressure (diastolic <60)

c. Pallor (generally very pale, pallor of palms or around the mouth)

d. Sweatiness

e. Rapid breathing (respiration > 30 per minute)

f. Anxiousness, confusion or unconsciousness

g. Frank, profuse hemorrhage

B. If the woman is in shock or clinically unstable:

1. If woman is conscious or a family member is present, find out:

a. If woman is on current medications

b. If woman has a serious health condition

c. If woman has known allergies

2. Proceed immediately to stabilize the woman

a. IV fluid volume replacement with large-bore IV catheter

b. Oxygen by mask if available

c. If sepsis is suspected, blood and cervical cultures if possible

d. Broad-spectrum IV antibiotics if indicated

e. Uterine evacuation as soon as possible if indicated

f. Determine underlying etiology of shock (for example, a ruptured ectopic pregnancy would require emergency surgery).

C. Transfer to acute-care facility

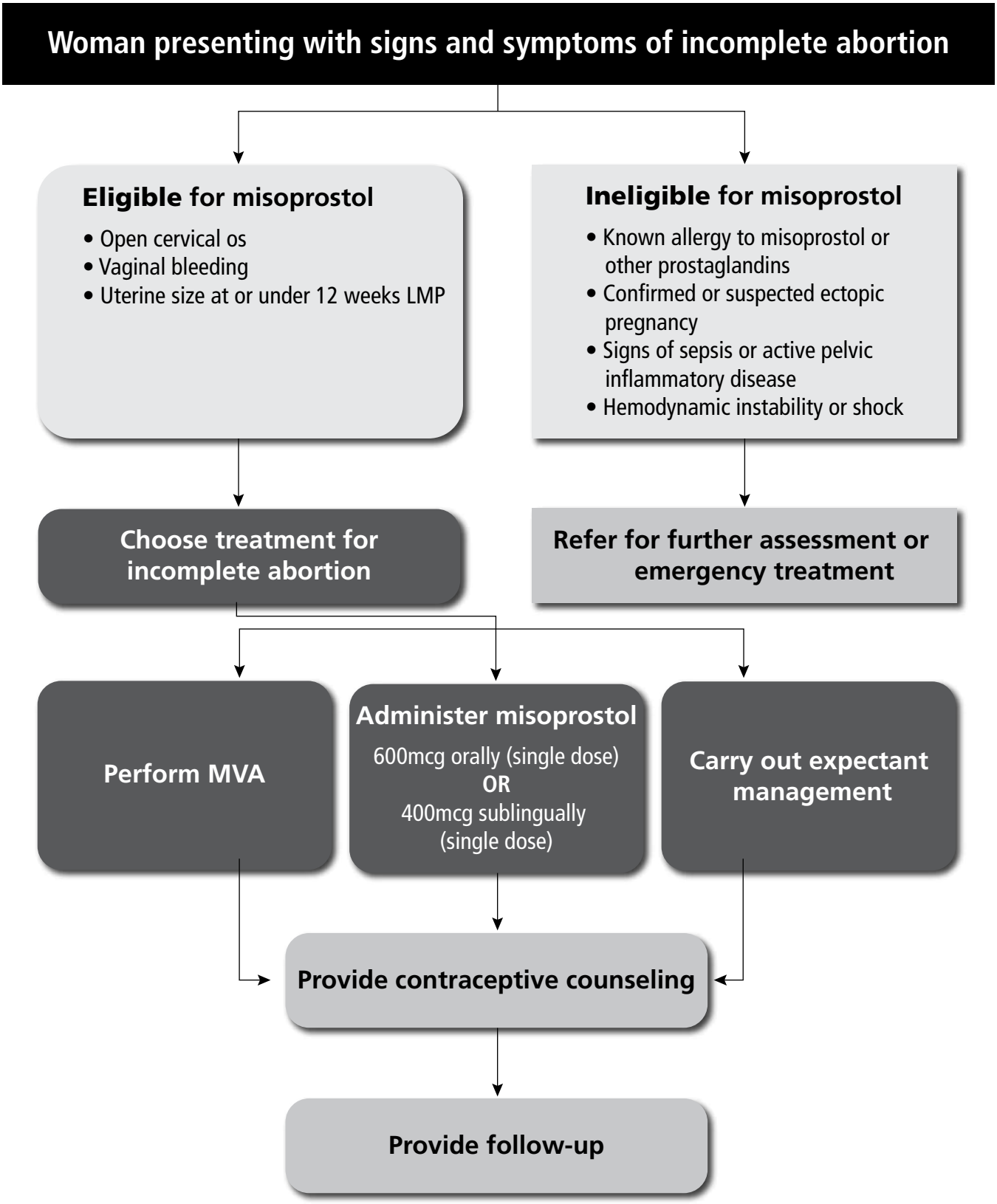
1. If woman requires transfer to facility that can provide higher-acuity care, she may need stabilization and volume replacement with IV fluids before/during transport.

2. Notify referral facility that woman is being transported and give report on her diagnosis and condition.

A longer version of this protocol with references can be found in **Annex 1: Clinical assessment reference guide: Overview of misoprostol for the management of incomplete abortion**.

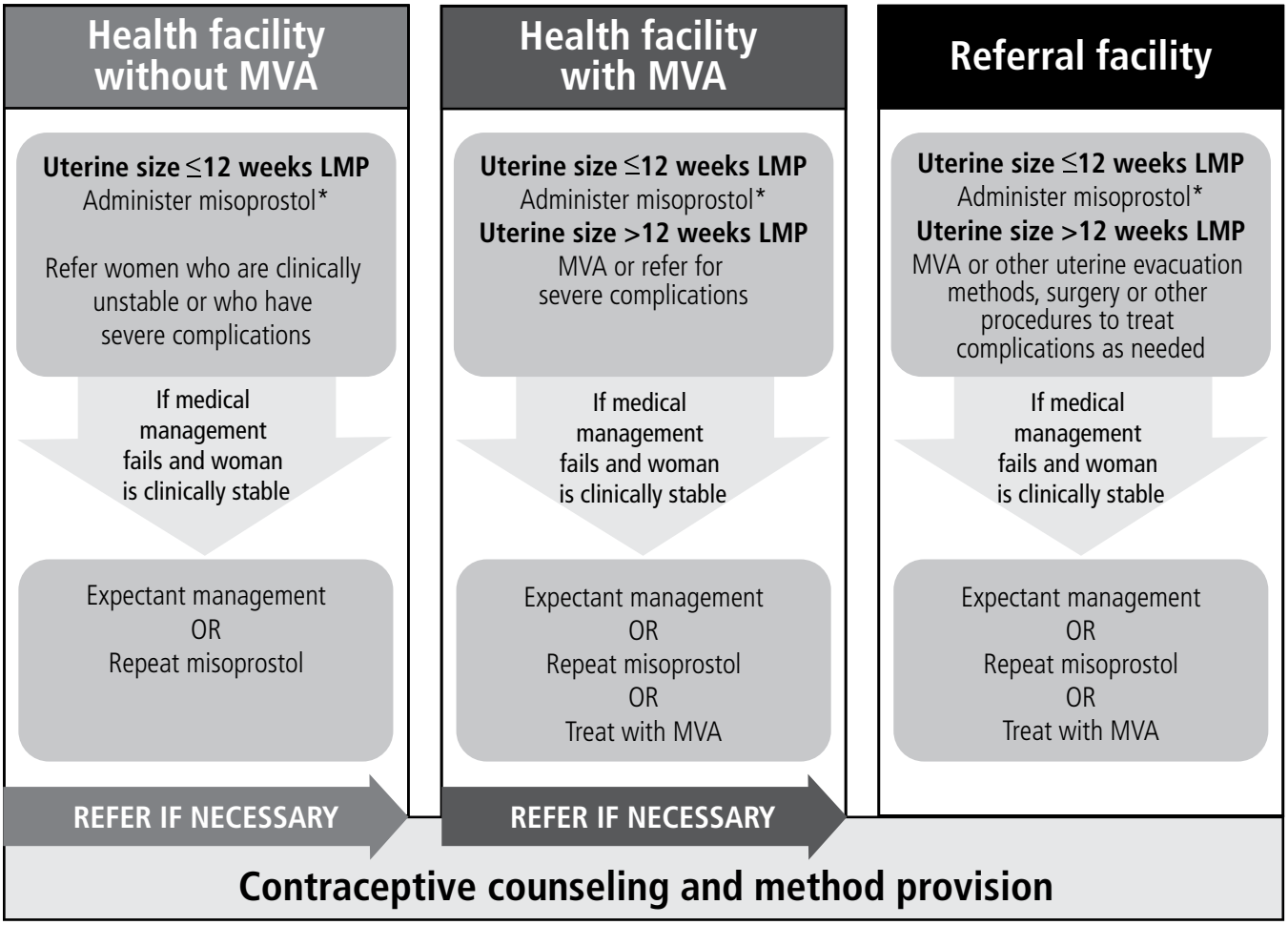
Tool 5B.
Clinical flow chart

*This **Clinical flow chart** can be used to provide a general overview of the key components of postabortion care service provision.*



Tool 5C.
Service delivery diagram

Below is a sample flow chart for the integration of misoprostol into all levels of service delivery with referrals to appropriate facilities based on assessment results.



* Check eligibility. Misoprostol regimens are 600mcg oral or 400mcg sublingual.

Tool 5D.
Patient chart[18]

Clinicians may adapt these charts as needed, or integrate the information into existing charts. More information on using data gathered from the charts for monitoring purposes is included in Module 6: Ensuring high quality services. Additional resources for more detailed patient charts at the tertiary level can be found elsewhere.[19]

PATIENT CHART FOR MISOPROSTOL USE IN POSTABORTION CARE

Name: _____Date: _____

Age: _____Contact information: _____

Referred from (facility name and site): _____

Reason for referral: _____

18. This tool was adapted from: Venture Strategies Innovations. 2009. *CAC manual of operations.* Unpublished.

19. Fescina R.H., B. De Mucio, M. Abreu, G. Martínez, J.L. Díaz Rossello, L. Mainero, R. Gómez Ponce de León, M. Rubino and M. Mañibo. 2009. *Perinatal information system (PIS): Perinatal clinical record, complementary form for women undergoing abortion, filling instructions and definition of terms (CLAP/WR. Scientific Publication; 1564.02.)* Montevideo: CLAP/WR. http://www.clap.ops-oms.org/web_2005/BOLETINES%20Y%20NOVEDADES/EDICIONES%20DEL%20CLAP/CLAP1564-02.pdf

Medical and obstetric history

- Date of last menstrual period: _____ / _____ / _____
  DD MM YY
  Uterine size: _____(weeks)_____(days)
- Vaginal bleeding? Yes ☐ No ☐ Duration _____
- Pelvic pain or cramping? Yes ☐ No ☐
- Passed tissue or products of conception? Yes ☐ No ☐
- Was she using a contraceptive when she got pregnant this time?* Yes ☐ No ☐

  Specify type: _____

  **If IUD in place, remove before administering misoprostol.*
- Current medications: _____
- Known allergies to drugs or other agents? Yes ☐ No ☐

  List: _____
- History of anemia or bleeding/clotting disorders? Yes ☐ No ☐

  Describe: _____
- Surgical history? Yes ☐ No ☐

  Describe: _____
- Any other health conditions? Yes ☐ No ☐

  List: _____

Physical exam

- Vital signs:

  Blood pressure: _____ Pulse: _____

  Temperature: _____Respiratory rate: _____
- Uterus:

  Size: _____Tenderness: _____
- Cervical motion tenderness? Yes ☐ No ☐
- Adnexa:

  Masses: _____Tenderness: _____
- Speculum exam done? Yes ☐ No ☐

Specify any abnormal signs (*cervical tears, foreign objects, bleeding visualized, other abnormal sign*)

_____

- Cervix:

  Os: Open ☐ Closed ☐

  Blood in vaginal vault: Amount/color:_____

  Mucopurulent discharge: Yes ☐ No ☐

Treatment

- Diagnosis:

  ☐ Incomplete abortion (uncomplicated case)

  ☐ Incomplete abortion (complicated case: shock, signs of infection, cervical tears, foreign objects, other complication)

  ☐ Other: _____

If incomplete abortion, check method used for treatment.

☐ Misoprostol: _____ Dose: _____ (# of tablets) Route:_____

☐ MVA

☐ Expectant management

☐ Other: _____

☐ Referred

- For referrals:

  Reason for referral (specify):_____

  Place of referral (specify): _____

- Medications provided at discharge (check as appropriate):

  a) Analgesic: _____ _____ _____
  (medication name) (dosage) (route)

  b) Antibiotic:_____ _____ _____
  (medication name) (dosage) (route)

  c) Antipyretic:_____ _____ _____
  (medication name) (dosage) (route)

  d) Other (specify):_____ _____ _____
  (medication name) (dosage) (route)

Plan to confirm pregnancy expulsion and follow-up as necessary.

Date woman will return for follow-up: _____

Contraceptive counseling

- Contraceptive counseling provided? Yes ☐ No ☐

  Contraceptive method provided at this visit (specify): _____

Follow-up – Medical and obstetric history

Date: _____

- History of vaginal bleeding/pain after taking misoprostol: _____

_____

_____

- Passed tissue or products of conception? Yes ☐ No ☐
- Current vaginal bleeding? Yes ☐ No ☐ Amount: _____
- Current pelvic pain or cramping? Yes ☐ No ☐

  Severity: Mild ☐ Moderate ☐ Severe ☐
- Does the woman currently feel pregnant? Yes ☐ No ☐
- Pain medications used: _____
- Other current medications: _____

Follow-up – Physical exam

- Vital signs:

  Blood pressure: _____ Pulse: _____

  Temperature: _____ Respiratory rate: _____
- Uterus:

  Size: _____ Tenderness: _____
- Cervical motion tenderness: Yes ☐ No ☐
- Adnexa:

  Masses: _____ Tenderness: _____
- Speculum exam done? Yes ☐ No ☐

Specify any abnormal signs
(cervical tears, foreign objects, bleeding visualized, other abnormal sign) _____

- Cervix:

  Os: Open ☐ Closed ☐

  Blood in vaginal vault: Amount/color: _____

  Mucopurulent discharge: Yes ☐ No ☐

_____

Follow-up – Treatment

- Diagnosis:

  Successful treatment: Yes ☐ No ☐

  Any complications: Yes ☐ No ☐ If yes, specify: _____

  Abortion still incomplete: Yes ☐ No ☐

- Ongoing treatment for incomplete abortion:

  a) Expectant management (re-evaluate in one to two weeks)

  b) Repeat misoprostol and follow-up in one to two weeks

  c) Misoprostol dose and route: _____

  d) MVA

  e) Other: _____

  f) Referral

- For referrals:

  Reason for referral (specify): _____

  Place of referral (specify): _____

Other notes: _____

Follow-up – Contraceptive counseling

- Contraception already being used (previously provided): Yes ☐ No ☐

  If no,

  Contraceptive counseling provided: Yes ☐ No ☐

  Contraceptive method taken at the end of follow-up visit: _____

Indications and regimens for misoprostol use

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INDICATIONS AND REGIMENS FOR MISOPROSTOL USE

INCOMPLETE ABORTION

Misoprostol dose	Route	Timing
600mcg[1a, 1b, 1c, 1d, 1e]	Oral	Three 200mcg tablets taken at once (single dose)
OR 400mcg[1a, 1d, 1f]	Sublingual	Two 200mcg tablets under the tongue until they dissolve or for 30 minutes; swallow any remaining fragments. (Single dose)

MISSED ABORTION / ANEMBRYONIC GESTATION

Misoprostol dose	Route	Timing
800mcg[1a, 2a, 2b]	Vaginal	Single dose
OR 600mcg[1a, 2a, 3, 4]	Sublingual	Give every 3 hours for a maximum of 3 doses **OR** Single dose*

* Sublingual misoprostol 600mcg sublingually every 3 hours for a maximum of 3 doses is one recommended regimen; a single sublingual dose of misoprostol 600mcg may also be used if left to work for 1-2 weeks (unless there is heavy bleeding or infection)

For citation information, please see Ipas and Venture Strategies Innovations. 2011. *Misoprostol use in postabortion care: A service delivery toolkit.* Chapel Hill, NC: Ipas.

Front of dosage card

PREVENTION OF POSTPARTUM HEMORRHAGE[5]

Misoprostol dose	Route	Timing
600mcg	Oral	To be taken immediately after delivery of newborn. Exclude second fetus (twin)before administration.

TREATMENT OF POSTPARTUM HEMORRHAGE (≥500ml BLOOD LOSS).

Conventional oxytocics should be used over misoprostol, if available.

Misoprostol dose	Route	Timing
800mcg[6,7]	Sublingual	STAT
OR 1000mcg[8]	Rectal	STAT

INDUCTION OF LABOR

Caution with previous cesarean section

Misoprostol dose	Route	Timing
25mcg[9a, 9b]	Vaginal	Every 4 hours (up to 6 doses with careful monitoring)
OR 20mcg (dissolve 200mcg tablet in bottle of 200ml clean water. Give 20ml per dose.)[9a,10,11]	Oral	Every 2 hours (up to 12 doses with careful monitoring). Shake the solution in the bottle well before each dose. Discard bottle after 24 hours.

For more information, please visit www.ipas.org/medicalabortion

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Back of dosage card

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1c. Dao, B., J. Blum, B. Thieba, S. Raghavan, M. Ouedraego, J. Lankoande and B. Winikoff. 2007. Is misoprostol a safe, effective, acceptable alternative to manual vacuum aspiration for postabortion care? Results from a randomized trial in Burkina Faso, West Africa. *BJOG: An International Journal of Obstetrics & Gynecology,* 114: 1368-1375.

1d. Diop, Ayisha, Sheila Raghavan, Jean-Pierre Rakotovao, Rodica Comendant, Paul D. Blumenthal and Beverly Winikoff. 2009. Comparison of two routes of administration for misoprostol in the treatment of incomplete abortion: a randomized clinical trial. *Contraception,* 79: 456-462.

1e. Shwekerela, B., R. Kalumuna, R. Kipingli, N. Mashaka, E. Westheimer, W. Clark and B. Winikoff. 2007. Misoprostol for treatment of incomplete abortion at the regional hospital level: Results from Tanzania. *British Journal of Obstetrics and Gynaecology,* 114 (11): 1363-1367.

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3. Tang, Oi Shan, Charas Y.T. Ong, Ka Yu Tse, Ernest H.Y. Ng, Sharon W.H. Lee and Pak Chung Ho. 2006. A randomized trial to compare the use of sublingual misoprostol with or without an additional 1 week course for the management of first trimester silent miscarriage. *Human Reproduction*, 21:189-92.

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5. Gynuity Health Projects. 2007. *Instructions for use: Misoprostol for prevention of postpartum hemorrhage.* http://gynuity.org/resources/read/misoprostol-for-prevention-of-postpartum-hemorrhage-en/

6. Winikoff, Beverly, Rasha Dabash, Jill Durocher, Emad Darwish, Nguyen Thi Nhu Ngoc, Wilfrido León, Sheila Raghavan, Ibrahim Medhat, HuynhThi Kim Chi, Gustavo Barrera and Jennifer Blum. 2010. Treatment of post-partum haemorrhage with sublingual misoprostol versus oxytocin in women not exposed to oxytocin during labour: a double-blind, randomised, non-inferiority trial. *The Lancet*, 375: 210-16.

7. Blum Jennifer, Berverly Winikoff , Sheila Raghavan, Rasha Dabash, Mohamed Cherine Ramadan, Berna Dilbaz, Blami Dao, Jill Durocher , Serdar Yalvac, Ayisha Diop, Ilana G. Dzuba and Nguyen Thi Nhu Ngoc. 2010. Treatment of post-partum haemorrhage with sublingual misoprostol versus oxytocin in women receiving prophylactic oxytocin: a double-blind, randomised, non-inferiority trial. *The Lancet,* 375(9710): 217-23.

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5.5 Preparing women for what to expect

Counseling is an integral part of woman-centered PAC services, and preparing women for what to expect before, during and after treatment with misoprostol is a key part of the clinician's counseling role. Using simple, non-technical language, health-care staff should help women understand the entire treatment and follow-up process before they take any medications. Any discussion of misoprostol treatment should cover the following topics:

- Choice of misoprostol, vacuum aspiration (if available) or expectant management for incomplete abortion
- Eligibility and effectiveness
- How misoprostol is used
- What the woman is likely to experience
- How long the process typically takes
- Potential side effects and complications
- Warning signs to seek help
- Ensuring access to emergency care
- Contraceptive needs
- Recommended follow-up visit

Drawings often help women understand how medications should be taken. Clinicians may wish to use a pamphlet, card, or handout summarizing the key points. A woman who is unable to read may still find it useful to take written instructions home with her so that a literate relative or friend can read it to her if she has questions.

WHAT IS COUNSELING?

Counseling is "a structured interaction in which a person voluntarily receives emotional support and guidance from a trained person in an environment that is conducive to openly sharing thoughts, feelings and perceptions….effective counseling begins with assessing and addressing each woman's needs, and includes respectful, woman-centered, two-way communication" (Herrick et al. 2004).

Tool 5F.

Brochures for women

*This tool is intended to be given by clinicians to women. It is recommended that facilities pick one route for misoprostol administration that they believe will be most acceptable to communities and easiest to administer. In addition, these materials should be adapted for your local setting.**

Oral administration:

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Using misoprostol pills to treat incomplete abortion

ORAL USE

TREATMENT OF INCOMPLETE ABORTION AND MISCARRIAGE WITH MISOPROSTOL PILLS

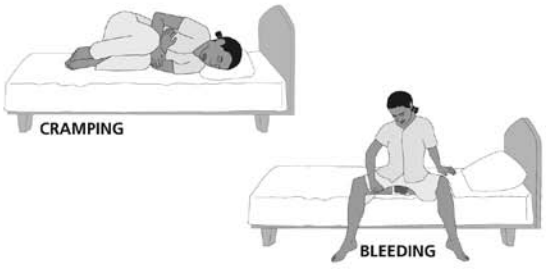
If you are having an incomplete abortion, you can be treated safely and effectively with misoprostol pills.

HOW TO TAKE MISOPROSTOL PILLS

Swallow 3 pills (600mcg) with water.

WHAT WILL HAPPEN WHEN YOU TAKE THE PILLS?

Misoprostol causes the uterus to contract. You will have some vaginal bleeding and cramping and you may see blood clots.

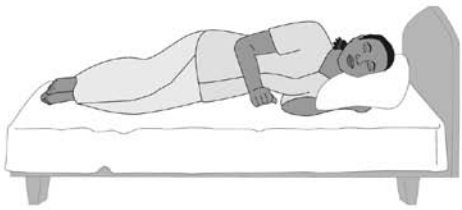


MANY WOMEN DO NOT HAVE SIDE EFFECTS

But some women may experience fever, chills, nausea or diarrhea. These should go away on their own in a few hours.

* For technical assistance regarding material adaptation, please contact misoforpac@ipas.org

HOW CAN YOU MANAGE THE SIDE EFFECTS?
You can take pain medicines for cramps. Fever medicines are rarely needed. Drinking lots of water and getting rest will also help. Most side effects will disappear on their own in a short time.



WHEN SHOULD YOU SEEK HELP FROM A HEALTH-CARE PROVIDER?
You should seek immediate help if you have:

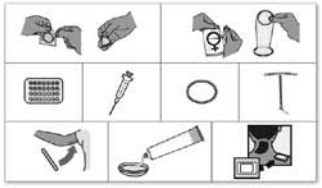
- Heavy bleeding
- Fever which lasts more than a day or starts any day after the day you take misoprostol
- Constant cramping and pain that does not get better with medication, rest, or heating pad
- The feeling of being very sick

HEAVY BLEEDING

CONSTANT CRAMPING

FEVER

WHAT IS THE BEST CONTRACEPTIVE METHOD FOR ME?
You are able to get pregnant again within a couple of weeks. If you would like contraception, it should be started immediately. You can start most methods at the same time you take your misoprostol tablets.



WHEN SHOULD I COME BACK FOR FOLLOW-UP?
Please come back for a follow-up visit in 1 — 2 weeks to ensure that your treatment was successful.

DATE OF YOUR FOLLOW-UP VISIT:

_____ / _____ / _____

LOCATION:

_____

_____

_____

_____

PHONE:

_____

_____

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Sublingual administration:

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Using misoprostol pills to treat incomplete abortion

SUBLINGUAL USE

TREATMENT OF INCOMPLETE ABORTION AND MISCARRIAGE WITH MISOPROSTOL PILLS

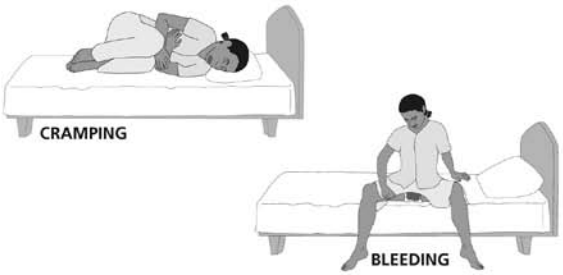
If you are having an incomplete abortion, you can be treated safely and effectively with misoprostol pills.

HOW TO TAKE MISOPROSTOL PILLS

Place 2 misoprostol pills (400mcg) under your tongue. Keep pills under your tongue until they melt, or for about 30 minutes, then swallow whatever is left.

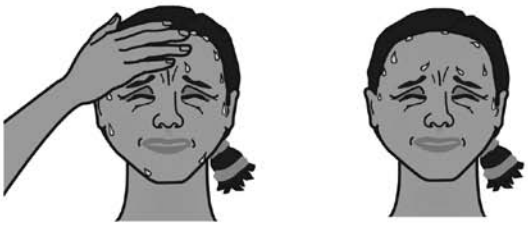
WHAT WILL HAPPEN WHEN YOU TAKE THE PILLS?

Misoprostol causes the uterus to contract. You will have some vaginal bleeding and cramping and you may see blood clots.

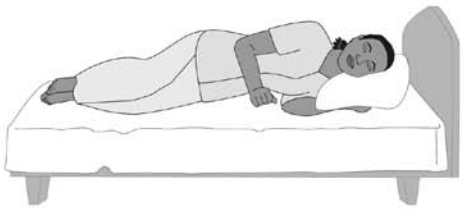


MANY WOMEN DO NOT HAVE SIDE EFFECTS

But some women may experience fever, chills, nausea or diarrhea. These should go away on their own in a few hours.



HOW CAN YOU MANAGE THE SIDE EFFECTS?
You can take pain medicines for cramps. Fever medicines are rarely needed. Drinking lots of water and getting rest will also help. Most side effects will disappear on their own in a short time.



WHEN SHOULD YOU SEEK HELP FROM A HEALTH-CARE PROVIDER?
You should seek immediate help if you have:

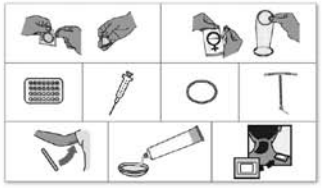
- Heavy bleeding
- Fever which lasts more than a day or starts any day after the day you take misoprostol
- Constant cramping and pain that does not get better with medication, rest, or heating pad
- The feeling of being very sick

HEAVY BLEEDING

CONSTANT CRAMPING

FEVER

WHAT IS THE BEST CONTRACEPTIVE METHOD FOR ME?
You are able to get pregnant again within a couple of weeks. If you would like contraception, it should be started immediately. You can start most methods at the same time you take your misoprostol tablets.



WHEN SHOULD I COME BACK FOR FOLLOW-UP?
Please come back for a follow-up visit in 1 — 2 weeks to ensure that your treatment was successful.

DATE OF YOUR FOLLOW-UP VISIT:

_____ / _____ / _____

LOCATION:

_____

_____

_____

_____

PHONE:

_____

_____

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Tool 5G.

Managing expected effects, side effects and complications[20]

This chart lists expected treatment effects, the most common side effects, possible complications, and related management when using misoprostol for treatment of incomplete abortion.

Expected Treatment Effects of Misoprostol (Women will experience these as a result of the products of conception being expelled)		**Management**
Pain/ cramping	Cramping typically starts within the first few hours and can begin as early as 30 minutes following misoprostol administration. Pain may be stronger than that typically experienced during a menstrual period.	• Sitting or lying comfortably • Hot water bottle or heating pad • Give analgesics (ibuprofen or paracetamol/acetaminophen) when the woman is at the clinic so the woman can take them shortly after taking the misoprostol.
Bleeding	Generally, vaginal bleeding will begin within an hour of misoprostol administration. Bleeding typically lasts an average of 5-8 days but may continue for up to two weeks. Spotting can persist until the next menstrual period.	• Inform the woman that every woman will experience bleeding and cramping differently – describe the normal range of bleeding. • Make sure the woman knows what the warning signs are, and the amount of bleeding that is outside the normal range for which she should seek immediate care.
Possible Side Effects (A minority of women will experience these side effects)		**Management**
Chills/fever	Chills are transient; fever is less common and does not necessarily indicate infection. Temperature elevation generally does not last more than a few hours. Though infection is rare, fever or chills that persist for longer than 24 hours are not normal and may indicate infection.	• Reassure the woman that chills and fever are common side effects on the day that misoprostol is taken. • Antipyretics if needed (NSAIDs such as ibuprofen are both analgesics and antipyretics) • Woman should be instructed to contact a clinician if fever lasts more than a day or starts any day after the day misoprostol is taken.
Nausea/ vomiting	Nausea and vomiting may occur and typically resolve within 2 to 6 hours.	• Reassure the woman that nausea and vomiting are possible side effects. • An antiemetic may be provided.
Diarrhea	If diarrhea occurs after misoprostol is taken, it usually resolves within a day. Remind women to drink plenty of fluids.	• Reassure the woman that diarrhea is sometimes associated with misoprostol use and passes quickly.

Warning Signs (Women experiencing these complications should immediately seek help from a clinician.)		**Management**
Heavy bleeding	Heavy and/or prolonged bleeding that causes a significant change in hemoglobin is uncommon. Signs that the woman has heavy bleeding and needs to seek help from a clinician include: • Soaking two large pads for two hours in a row. • Constant heavy bleeding that makes the woman feel sick or weak. • Sudden, heavy bleeding after bleeding has slowed or stopped for several days. • Weakness, dizziness related to bleeding that starts and stops intermittently for days.	• MVA if bleeding is profuse or prolonged • Oral iron supplements or iron-rich diet recommended (but these are not treatments in themselves for heavy bleeding) • Fluid resuscitation (oral hydration, intravenous fluids or, rarely, transfusion) if experiencing hemodynamic compromise
Infection	Documented endometrial and/or pelvic infection is rare. Signs of infection include some or all of the following: fever any day after the day misoprostol is taken, persistent abdominal pain, foul-smelling or purulent cervical/vaginal discharge, flu-like symptoms, feeling generally ill, sometimes accompanied by nausea and vomiting.	• If infection is suspected the woman should be evaluated. If there are signs of sepsis or severe infection the woman should be given immediate surgical evacuation and antibiotic coverage. • If the woman is not severely ill, infection is typically treated with oral antibiotics. • Severe infections could require hospitalization and IV antibiotics.
Constant pain/ cramping	Constant severe pain, even on the day misoprostol is taken or pain that persists in days following misoprostol use, despite using medication, rest, a hot water bottle or a heating pad.	• Reassess the woman for treatment failure, unrecognized ectopic pregnancy or any other complications. A thorough assessment is necessary to determine the etiology of the pain. Treat accordingly.

20. This tool was adapted from: Gynuity Health Projects. 2009. *Misoprostol for treatment of incomplete abortion: An introductory guidebook*. http://gynuity.org/resources/info/guidebook-on-misoprostol-for-treatment-of-incomplete-abortion/

5.6 Contraceptive services

Contraceptive counseling should be a routine part of postabortion care (see **Tool 5H: Contraceptive pocket guide**). Clinicians should provide information on the rapid return to fertility and offer appropriate contraceptive counseling and a method of the woman's choice.

- Most contraceptive methods should be provided as soon as possible — usually the same day as misoprostol. Highly effective contraception, such as injectables, contraceptive implants and oral contraceptives can be administered on the same day that misoprostol is given.
- The intrauterine device (IUD) may be inserted at follow-up if the misoprostol treatment was successful.
- If there will be more than a 10-day delay before a woman can start a chosen method, another method, such as condoms, should be provided in the interim.
- Emergency contraception can also be provided to women to take in the event of unprotected intercourse.
- Women should be counseled to delay intercourse until contraception is in place if they want to prevent another pregnancy.

Providing timely counseling can help prevent future unwanted pregnancies. Postabortion contraceptive counseling is also associated with a reduction in maternal and child mortality and prevention of mother-to-child HIV transmission (Curtis et al. 2010). Keep in mind that some women will seek contraceptive services while others will be interested in becoming pregnant again in the near future. **Every woman's situation and contraceptive needs differ.**

When contraceptive counseling and methods are offered after postabortion care, contraceptive acceptance has been shown to be high; this is critical, as women can become pregnant again two to three weeks after taking misoprostol.

Discuss each woman's reproductive health history with her to understand the causes of the unwanted pregnancy and any previous method failures. Provision of an appropriate contraceptive method will depend on women's needs and preferences as well as local availability.

A range of reproductive health services should be provided. In addition to receiving contraceptive counseling, women should be screened for sexually transmitted infections (STIs) and sexual violence as part of routine PAC services. All women should be advised on the use of condoms to prevent STIs.

CONTRACEPTIVE COUNSELING FOR POSTABORTION CARE PATIENTS

Effective postabortion contraception is the best way to prevent future unwanted pregnancies. Unfortunately, it is usually one of the weakest links in postabortion care, and the proportion of women who receive a contraceptive method after postabortion care remains low. Therefore, contraceptive counseling and provision of a method should be priorities in all PAC services. In addition, some women may have experienced an unwanted pregnancy while already using a method; it is very important to address the reasons for method failure, and counsel women accordingly.

Tool 5H.
Contraceptive pocket guide

The tool below provides information about when various methods of contraception can be started after misoprostol treatment as well as notes for consideration regarding each method.

CONTRACEPTIVE POCKET GUIDE

Pocket reference for clinicians

CONTRACEPTIVE METHOD	WHEN METHOD CAN BE OFFERED	NOTES
Condoms	At first visit	Can be used as an interim method: for women who cannot decide about a contraceptive, or who cannot be offered their method of choice immediately after treatment of incomplete abortion.
Injectables	At first visit	Can be used even if infection is present.
Oral contraceptives	At first visit	Can be used even if infection is present.
Intrauterine devices	At follow-up visit	Make sure that treatment is successful; should not be used in the presence of active infection. Provide condoms or other temporary methods until the follow-up visit.

Front of Contraceptive pocket guide

Implants	At first visit	Can be used even if infection is present.
Sterilization	At follow-up visit	Provide condoms or other temporary methods until the follow-up visit.
Diaphragm	At first visit	Consider refitting, depending on gestational age.
Contraceptive jellies, foams, tablets or films	At first visit	Can be used even if infection is present.
Skin patches	At first visit	Can be used even if infection is present.
Vaginal ring	At first visit	Can be used even if infection is present.
Emergency contraceptive pills	Anytime	Provide emergency contraceptive pills in advance as a back-up method.

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For more information, please visit www.ipas.org/medicalabortion

MPACTK5H-E11

Back of Contraceptive pocket guide

5.7 Follow-up

A follow-up visit should be scheduled one to two weeks following misoprostol administration if feasible; depending on the local circumstances, clinicians also may suggest alternatives to follow-up.

Follow-up visits should cover the following:

- **Treatment outcome:** To determine if treatment was successful, the clinician should ask the woman about her experience and then conduct a physical exam. *Treatment success is defined as complete uterine evacuation and resolution of all symptoms.*
- **Continued incomplete abortion:** If the evacuation process is not yet finished and the woman is clinically stable, she may be offered close observation with expectant management and be re-evaluated in one to two weeks. Alternatively, a repeat dose of misoprostol may be offered (Blum et al. 2007). If the woman is treated with a repeat dose of misoprostol, it is advisable to re-evaluate her in one to two weeks. In the event of infection or clinically significant bleeding, completion through vacuum aspiration should be considered.
- **Contraception:** If the woman wishes to avoid a subsequent pregnancy, ensure that she is comfortable with her contraceptive method, or offer counseling and a method if these have not yet been provided (see **Tool 5H: Contraceptive pocket guide**).
- **Reproductive health:** Link the woman with other reproductive health services as needed, such as anemia and cervical cancer screening; HIV testing and/or care; referral to a fertility clinic or fertility services; care for sexual and/or domestic violence, STI education, testing and treatment; and assessment of recurrent miscarriage, among others.

5.8 Referrals

Linking misoprostol for postabortion care with reproductive and other health services is important when aspiring to comprehensively address all of women's health needs. Some services, such as HIV testing or domestic violence counseling, may not be available at the facility providing postabortion care and it may be useful to refer the woman to other facilities that do so.

Referrals to higher-level facilities, such as district hospitals, by lower-level facilities that are using misoprostol for postabortion care should be integrated into existing referral systems. In addition, clinical staff should be aware of the referral facilities and the services they provide (such as surgical services, obstetrics and gynecology, infectious disease services, and others). **Tool 5I: Referral Form** has two sec-

tions: one that is left with the referring facility and one that is given to the woman to take to the referred facility.

Tool 5I.

Referral form[21]

When making a rferral, fill out sections A and B; section A stays in the initial facility and section B is given to the woman to take to the referral site.

POST ABORTION CARE REFERRAL FORM
SECTION A: STAYS AT THE CLINIC INITIATING THE REFERRAL

Patient: _____

Contact: _____

Facility name where referral was made: _____

Date of referral: _____ / _____ / _____
DD MM YY

☐ Emergency referral

☐ Non-emergency referral

Reason for referral:

☐ Complicated case (heavy bleeding, uterine perforation, signs of sepsis or other reason)

☐ Pregnancy beyond 12 weeks uterine size, or problems determining uterine size

☐ Service requested by the patient available in the facility

☐ Patient's preference

☐ Other (please specify): _____

POST ABORTION CARE REFERRAL FORM
SECTION B: WOMAN TAKES TO REFERRAL CLINIC (attach to copy of patient chart)

Patient: _____

Contact: _____

Facility name where referral was made: _____

Date of referral: _____ / _____ / _____
DD MM YY

☐ Emergency referral

☐ Non-emergency referral

Reason for referral:

☐ Complicated case (heavy bleeding, uterine perforation, signs of sepsis or other reason)

☐ Pregnancy beyond 12 weeks uterine size, or problems determining uterine size

☐ Service requested by the patient available in the facility

☐ Patient's preference

☐ Other (please specify): _____

Treatment initiated at referring facility (antibiotics, cultures, lab results, other):_____

_____

_____

_____

21. This tool was adapted from: Bottom of FormVenture Strategies Innovations. 2009. *CAC manual of operations.* Unpublished; and Baird, Traci L., M.Virginia Chambers and Charlotte E. Hord. 1998. *Implementing postabortion care. Technical resources for postabortion care, volume 1.* Carrboro, NC: Ipas.

5.9 Learning from adverse events

Adverse events (AEs) are complications that a woman suffers during or immediately after her treatment that need to be investigated further. Investigation focuses on whether the events were treatment-related and whether and how they could have been prevented. A **serious adverse event (SAE)** is one that is life-threatening, results in permanent impairment of body function or permanent damage to body structure, or necessitates medical or surgical intervention to preclude permanent impairment (see **Tool 5J: Serious Adverse Event form**). **Although incomplete abortion inherently leads to some complications, most are easily treated; serious complications are rare in routine postabortion care.**

Adverse events may result from patient factors, human error or institutional problems, but usually occur after multiple factors come together during a single event.

When an adverse event has occurred, the first step is to care for the woman involved, and also hold an initial conversation with the patient and/or her family. In this conversation, you should state very briefly what is known about the complication, express regret that the woman experienced a complication, and provide assurance that the event is being taken seriously and will be thoroughly analyzed.

Most AEs involve system failure. Even if an individual clinician demonstrates lack of judgment or inadequate skill, the system likely has not provided the training, monitoring or mentoring needed to support quality of care. In a just culture, the goal is therefore to support rather than blame the involved staff, while learning from the event. Solutions that focus on systems improvement rather than individuals are more likely to lead to AE reporting, prevention and improved outcomes. Moreover, involving the entire team in case studies of AEs can help staff understand the cascade of events that led to the complication and whether and how it could have been averted. However, some complications cannot be foreseen or averted.

All health services create opportunities to learn invaluable lessons, especially when the services are new. It is important, then, to provide opportunities for staff to debrief after implementation of services offering misoprostol for postabortion care has begun, so that staff can learn from case studies, review data, monitor trends, raise questions and address areas of confusion. If a system exists that allows local and national health services to access this information, these entities can use the information to understand trends, identify needs and support local services.

ANALYZING ADVERSE EVENTS

Analyzing why an adverse event (AE) occurred is a necessary step to reduce the risk of recurrence. This type of analysis is best achieved by approaches that support rather than blame the staff involved. During the course of the analysis, the site evaluates the system in which the AE occurred, identifies possible causes for the event, and recommends changes to the system to improve care in the future. In a "just culture," the entire team is involved in reporting and understanding the analysis of AEs.

Tool 5J.

Serious adverse event form[22]

Use this form to document all adverse events occurring during postabortion care (PAC). Contact local authorities if there is a cohesive monitoring system in place or if you are required to do so, and provide the following information within 24 hours of learning of a new serious adverse event or if you are updating information previously reported on this form. In the spirit of learning for improvement, review this information as a team to determine if anything can be changed to improve quality of care and/or outcomes.

Question	Response
1. Patient information	Name: _____ Age: _____
2. Serious Adverse Event	☐ Severe allergic reaction to drug ☐ Shock ☐ Profuse bleeding leading to the need for transfusion ☐ Ectopic pregnancy unrecognized at time of procedure or when misoprostol was given ☐ Prolonged or difficult surgical procedure (for example, uterine perforation) ☐ Signs of infection requiring hospitalization and IV antibiotic treatment Describe signs: _____ ☐ Other diagnosis: _____
3. Outcome of Serious Adverse Event	☐ Death ☐ Life-threatening experience ☐ New or prolonged hospitalization ☐ Persistent/significant disability or incapacity ☐ Uterine perforation Surgical repair required? Yes ☐ No ☐ ☐ Other Specify: _____
4. Resolution	☐ Continuing ☐ Resolved: _____ / _____ / _____ DD MM YY ☐ Death

22. A **serious adverse event** (**SAE**) is one that is life-threatening, results in permanent impairment of body function or permanent damage to body structure, or necessitates medical or surgical intervention to preclude permanent impairment

Question	Response
5. Treatment (mark all that apply)	☐ None ☐ Blood transfusion ☐ New/prolonged hospitalization ☐ Uterine evacuation ☐ IV/antibiotics ☐ Surgery, describe: _____ _____ ☐ Patient referred (specify where) If this woman is returning for evacuation, please indicate her date of initial visit:_____ / _____ / _____ (DD / MM / YY) ☐ Medications (including misoprostol) List date given, name of drug, dose, and route:_____ _____ If misoprostol is given more than one time, list drug dose and date for each administration: _____ ☐ Other treatment Specify: _____
6. Completed by:	Name: _____ Facility: _____ Phone #: _____

TEAM MEETING/CASE REVIEW

To be completed with all relevant facility staff, **conducted in the spirit of learning for improvement**.

a. What happened? ⇨ *Summarize the precise chronology of the event and any associated unsafe actions or omissions.* _____

_____

_____

_____

_____

b. Why did it happen? ⇨ *Ask "Why? Why? Why?"* _____

_____

_____

_____

_____

c. What can be changed to prevent similar events in the future? _____

_____

_____

_____

_____

5.10 Additional resources

Fescina R.H., B. De Mucio, G. Martinez, J.L. Diaz Rosello, R. Gomez Ponce de Leon, L. Mainero, M. Rubino and M. Manibo. 2009. *Perinatal information system (PIS): Perinatal clinical record, complementary form for women undergoing abortion, filling instructions and definition of terms (CLAP/WR. Scientific Publication; 1564.02.)* Montevideo: CLAP/WR.
http://www.clap.ops-oms.org/web_2005/BOLETINES%20Y%20NOVEDADES/EDICIONES%20DEL%20CLAP/CLAP1564-02.pdf

Herrick, Jeannine, Katherine L. Turner, Teresa McInerney and Laura Castleman. 2004. *Woman-centered postabortion care: Reference manual*. Chapel Hill, NC: Ipas.
http://www.ipas.org/Publications/Woman-centered_postabortion_care_Reference_manual.aspx

Ipas. 2010. *Medical abortion in early pregnancy: Information, education and communication (IEC) materials and job aids*. Chapel Hill, NC: Ipas. http://www.ipas.org/Publications_Gateway.aspx?from=%2fPublications%2fMedical_abortion_in_early_pregnancy_Information_education_communication_IEC_materials_job_aids.aspx

Turner, Katherine L. and Kimberly Chapman Page. 2008. *Abortion attitude transformation: A values clarification toolkit for global audiences*. Chapel Hill, NC: Ipas.
http://www.ipas.org/Publications/Abortion_attitude_transformation_A_values_clarification_toolkit_for_global_audiences.aspx.

Wolff, James A., Linda J. Suttenfield and Susanna C. Binzen, eds. 1991. *The family planning manager's handbook: Basic skills and tools for managing family planning programs*. West Hartford, CT: Kumarian Press. http://erc.msh.org/mainpage.cfm?file=handbook.htm&module=enhancement%20other&language=English

World Health Organization (WHO). 1997. *Post-abortion family planning: A practical guide for programme managers*. Geneva: WHO.
http://www.who.int/reproductivehealth/publications/family_planning/RHT_97_20/en/index.html

MODULE 6. Ensuring high quality services

6.1 Introduction

Sites and programs should begin to develop a plan for ongoing monitoring of service delivery and quality at the earliest stages of planning for the introduction or integration of misoprostol for the treatment of incomplete abortion. It is important to decide on a system for continual monitoring and supportive supervision while services are being put into place. This allows facilities to collect all necessary data from the beginning and to compare data to the baseline results of the environmental and facility assessments. Choose monitoring measurements that are directly in line with the specific objectives designed for the introduction or integration of misoprostol, and select indicators that will meaningfully inform service improvements.

Module 6 provides you with a framework and tools for monitoring the quality of postabortion care (PAC) services to ensure that minimum standards of quality are met and to identify ways to improve services.

6.2 Monitoring to assess and improve quality of services

It is important to determine if specific quality objectives are being met. **Monitoring** is a system of information gathering and regular assessment of how a program is functioning. Monitoring is an ongoing process to gather and analyze information in a systematic, routine way. **Ideally, monitoring data lead to insights about how to improve implementation so that women receive high quality services and health-care workers have the resources they need to provide high quality care**.

6.3 Six monitoring areas of misoprostol use in PAC services

For the purposes of this toolkit, there are six aspects of service delivery and use that should be monitored:

1. **Resources:** Are more inputs needed for the misoprostol for postabortion care program to run efficiently? Inputs include trained clinicians and misoprostol supply (please refer to **Tool 3A: Minimum requirements for treatment of incomplete abortion with misoprostol**).

TARGET AUDIENCES:
Clinicians, facility managers and program managers at the national/district levels

TOOLS IN THIS MODULE:

6A Indicators by facility level

6B Service delivery logbook

6C Monthly service report

6D Supervisory and performance quality improvement checklist

6E Patient satisfaction rapid assessment

2. **Service utilization:** What services are being provided and to how many women over what period of time?
3. **Clinical services:** Are services provided per the medical and clinical protocols? These include using appropriate technologies for treatment of incomplete abortion, using misoprostol correctly, and consistently providing women with accurate information, including routine contraceptive counseling and method provision.
4. **Complications and referral:** How many women are experiencing post-procedure complications? How many women are being referred to other facilities?
5. **Recordkeeping and management of services:** Are services properly documented? Are services being run efficiently?
6. **Overall quality:** What are clinicians' perspectives on quality of services? What challenges do they face? What are women's perceptions on quality of services? How do women think that services might be improved?

6.4 Developing a monitoring plan to ensure high quality of services

Creating a quality monitoring plan includes determining the aspects of services to be monitored, deciding on the methods and tools that will be used to gather information, establishing benchmarks and standards of quality, and determining roles and responsibilities for implementing the monitoring plan.

Monitoring plans will vary by level due to resources available and the monitoring objectives themselves. **Tool 6A: Indicators by facility level** provides guidance into what should be included in monitoring plans at the community, health center, hospital, and district/regional health system levels. All of the indicators correspond to one of the six monitoring areas of misoprostol use in PAC services listed in section 6.3.

In general, health centers and larger entities should focus on creating monitoring systems that collect information to improve quality. Larger facilities and health systems might also include measurements of the impact of their services in the community, such as reduced hospitalizations for abortion-related complications. In addition, all facilities should ensure that they are meeting government or donor reporting requirements.

Use **Tool 6A** when designing your monitoring plan to decide which indicators to include and how to collect them. The toolkit also provides templates for the information sources listed in **Tool 6A**.

AN IMPORTANT MESSAGE ABOUT MONITORING

This module provides a framework for developing a monitoring plan for misoprostol use in postabortion care. If a monitoring system already exists in your health facility, use the information in this module to integrate monitoring of misoprostol services into your existing system. Whether you are adapting an existing monitoring plan or creating a new one, be sure to fulfill the reporting requirements as indicated by your facility, district, regional, and/or national guidelines.

For example, you can use **Tool 6B: Service delivery logbook** to collect the data needed to measure the number of incomplete abortion cases treated using each method, the percentage of women receiving the correct dose and route of misoprostol, and the percentage of women receiving a contraceptive method. This information can be summarized monthly for monitoring purposes using **Tool 6C: Monthly service report**. You can also revise your existing logbook to include PAC data. Information for other indicators may come from activities conducted during supervisory visits (see **Tool 6D: Supervisory and performance quality improvement checklist**), by assessments of patient satisfaction (see **Tool 6E: Patient satisfaction rapid assessment**), or from other information such as patient records.

Tool 6A.

Indicators by facility level

As you create your monitoring plan, identify the indicators for which you may already be collecting data as part of your health management information system (MIS). Next, identify indicators you need to collect for your misoprostol for postabortion care program. The indicators in Tool 6A are based on the six monitoring areas of misoprostol for use in PAC services described in section 6.3. Think through the resources needed to collect additional data and weigh the benefits of the information relative to the cost of collecting it. Data should be collected on a routine basis (monthly or quarterly).

Level	Indicators	Information source(s)	Notes
Community (Provider trained in referral and contraceptive provision only)	*Service utilization* • Number of women presenting with incomplete abortion who are referred *Clinical services* • Number of women given contraceptive method (disaggregate by method)	• Review of patient records	Even though community-level providers do not treat incomplete abortion, they can still monitor their PAC-related activities (such as referral and contraceptive method provision).
Health center (Primary health clinics, family planning clinics, or polyclinics)	**Community-level indicators plus:** *Resources* • Number of clinicians trained in misoprostol for treatment of incomplete abortion • Misoprostol stock at the facility *Service utilization* • Number of incomplete abortion cases • Number of incomplete abortion cases treated with misoprostol • Rate of follow-up • Percent of women provided with contraceptive method *Clinical services* • Percentage of cases receiving correct dosage and route of misoprostol *Complications and referral* • Percentage of women who received misoprostol and developed complications, by type of complication • Percentage of women referred to other facilities because of complications	• **Tool 3B: Facility assessment** • Review of patient records (see **Tool 5D: Patient chart**) • **Tool 6B: Service delivery logbook** • **Tool 6C: Monthly service report** • **Tool 6D: Supervisory and performance quality improvement checklist** • **Tool 6E: Patient satisfaction rapid assessment**	At this level, use **Tool 6B: Service delivery logbook** and supply ledgers to regularly collect basic information on the resources needed (such as number of trained clinicians and misoprostol stock) and services provided (number of women treated for incomplete abortion). Also consider using **Tool 6E: Patient satisfaction rapid assessment** if appropriate. Consider conducting supervision of services, adapting **Tool 6D: Supervisory and performance quality improvement checklist** template to include the necessary elements.

	Overall quality • Percent of patients who answer "yes" to eight or more questions in **Tool 6E: Patient satisfaction rapid assessment**		
Hospital (district, regional, or national)	**Health center-level indicators plus:** *Complications and referral* • Number of abortion-related deaths per reporting period and associated type of complication • Number of hospitalizations for abortion-related complications per reporting period • Number of referrals received from other health facilities for complications of incomplete abortion per reporting period	• Review of patient records (see **Tool 5D: Patient chart**) • **Tool 5J: Serious Adverse Event form** • **Tool 6B: Service delivery logbook** • **Tool 6C: Monthly service report**	No additional notes.
District /Regional health system	*Resources* • Facilities with misoprostol in stock as percentage of facilities that treat incomplete abortion • Number of clinicians trained in misoprostol for postabortion care *Service utilization* • Proportion of facilities that have recently provided treatment of abortion complications • Number of women treated for incomplete abortion across all facilities and by type of facility • Number of deaths from abortion complications *Recordkeeping and management of services* • Distribution of methods used for incomplete abortion across all facilities, and by type of facility	• **Tool 2A: Environmental assessment guide** • **Tool 3B: Facility assessment** • Review of patient records (see **Tool 5D: Patient chart**) • **Tool 5J: Serious Adverse Event form** • **Tool 6B: Service delivery logbook** • **Tool 6D: Supervisory and performance quality improvement checklist**	No additional notes.

6.5 Gathering information for monitoring[23]

Programs can use many methods to gather information for monitoring purposes, including document review, observation, and interviews. Basic data collection strategies include:

- Compiling program data (such as supply ledgers, patient records, logbooks) into a monthly summary report
- Conducting supportive supervision visits on a less frequent basis (such as quarterly)
- Conducting exit interviews with patients

Compiling program data

Clinicians and administrators routinely keep records of services provided, using logbooks, clinical records, and supply ledgers. On a routine basis (for example, monthly), these can be used as sources of information for measuring resources and service utilization. For example, using information collected in **Tool 6B: Service delivery logbook**, you can fill out **Tool 6C: Monthly service report**. After you fill out this report each month, you will have a summary, disaggregated by method of treatment of incomplete abortion, of:

- number of women treated for incomplete abortion
- number of women discharged with a contraceptive method
- number of women who returned for a follow-up visit
- number of women with complications
- number of women referred

This information is useful to review on an ongoing basis to better understand your case flow as well as the percentage of women treated for incomplete abortion who are provided with contraception.

Conducting supportive supervision visits

It is important – if feasible – to provide supportive supervision and assess service quality on a regular basis (see **Tool 6D: Supervisory and performance quality improvement checklist**). Checklists can help maintain a focus on key service delivery and quality areas, aid in collecting information in a systematic manner, and establish and assess criteria or standards. The checklist provided in **Tool 6D** may include more items than are necessary to measure the indicators you have chosen for your monitoring plan; remove any questions that are not relevant to reduce the burden on interviewees, supervisors, and clinicians. Supportive supervision visits also typically include opportunities for staff to debrief about the service (especially when it is new) and to share observations about what has been successful

23. Parts of this section are adapted from: Herrick, Jeannine, Katherine L. Turner, Teresa McInerney and Laura Castleman. 2004. *Woman-centered postabortion care: Reference manual.* Chapel Hill, NC: Ipas.

versus problematic and suggest solutions.

Conducting exit interviews with patients

When examining quality of services, it is important to learn how women feel about the services they have received. **Tool 6E: Patient satisfaction rapid assessment** is a quick way to gauge patient satisfaction with services. Depending on a woman's level of literacy, the assessment can be completed by the woman herself or by someone reading the form to her. If someone assists the woman in completing the assessment form, it must be done by someone who did not provide services to the woman on either her initial or follow-up visit. It is advisable to pay particular attention to the needs of special populations, including youth.

Those interested in collecting more in-depth information on patient perspectives of services should use a more detailed questionnaire. The Additional Resources section at the end of this module suggests information and tools that can generate more comprehensive patient satisfaction assessments.

Tool 6B.
Service delivery logbook

Facilities often keep a patient registry that summarizes the treatment received. The Service delivery logbook provides a quick and efficient way for facilities to keep track of postabortion care services. This tool provides a snapshot of service utilization that facilities should monitor and review on a regular (monthly) basis. This tool is intended to be adapted to a facility's needs and local reporting requirements. The logbook can be used for initial visits or follow-up services.

Continued on next page ...

Woman's information				Clinician's information		Treatment method (Check all that apply)					Contraceptive method	Follow-up visit	Complications	Referral	Comments & quality review
						MVA	Misoprostol			Other					
Date (d/m/y)	Patient ID	Age	Uterine size (weeks)	Clinician type	ID/Name		Dosage	Route			Yes/No (Indicate type, for example: pills, condoms, IUD.)	Yes/No (Indicate if this is a follow-up visit.)	Yes/No (Indicate type)	Yes/No (If patient was referred, indicate site and reason for referral.)	(Add any comments about quality of care, needs, resolution of the case, or ideas for quality improvement.)
								sublingual	oral						
Examples: 23/3/10	*12345*	*26*	*10*	*Nurse-midwife*	*Abcdefg*		*600mcg*		*X*		*None provided*	*No*	*Patient returned one week after treatment with heavy bleeding*	*N/A*	*Referred to us by pharmacist with bleeding and cramping.*
24/3/10	*11259*	*19*	*9*	*Nurse-midwife*	*Hijklmno*		*600mcg*		*X*		*Yes: IUD*	*Yes*	*None*	*Yes- For IUD at local hospital*	*Two weeks since successful treatment with misoprostol.*
24/3/10	*14798*	*35*	*9*	*Physician*	*Pqrstuv*	*X*					*Yes: injectable*	*Yes*	*None*	*N/A*	*Two weeks since successful treatment with MVA.*

Tool 6C.

Monthly service report

As part of the monitoring plan, a small number of key indicators should be assessed on a monthly basis, namely resources needed (supplies) and service utilization (including the number of patients, method of treatment used for incomplete abortion, and post-treatment contraceptive provision). Collect this information from the relevant and available registries, records (such as ***Tool 6B: Service delivery logbook****), and supply logs (such as supply ledgers).*

Name of health institution: _____

District: _____

Year and month: _____

Completed by: _____

Service utilization

Method for treatment of incomplete abortion	Total number treated	Number discharged with a contraceptive method	Number returned for a follow-up visit	Number with complications	Number referred
Misoprostol					
MVA					
Expectant management					

Notes: _____

_____

Tool 6D.

Supervisory and performance quality improvement checklist

Supportive supervision visits should be scheduled on an ongoing basis (for example, quarterly).[24] *Adapt this checklist to meet the needs of your supervision and monitoring plan.*

Name of health institution: _____

Location: _____

Period under review: _____ to _____ Date of visit: _____

Completed by: _____

Recommended steps:

- ❑ Conduct a review of 10 patient records chosen at random. By reviewing individual patient records, you can gather information on adherence to medical protocol, proper documentation of services, rate of follow-up attendance, and other issues. Confirm that clinicians provided the correct dose and route to each patient receiving misoprostol as well as appropriate pain management.
- ❑ Observe 10 clinician-patient interactions, from the initial contact until the patient is discharged. This will allow you to assess client flow, informed consent procedures, patient privacy, as well as patient-provider communication and staff attitudes and perceptions. Discuss results of observations with clinicians.
- ❑ Examine and discuss with clinicians the quality of counseling and information given to women about the misoprostol treatment procedure and postabortion contraception, the systems for post-treatment contraception and referral for other services. Discuss provision of care with clinicians and other staff. Here are some issues to explore with staff:
  - › Do they feel comfortable providing misoprostol for treatment of incomplete abortion?
  - › Is there additional information, training, or support they need to feel more comfortable?
  - › How do they feel about the women they are treating?
  - › Do they have any negative attitudes about women, or particular groups of women (such as HIV-positive, young, or unmarried women), coming for treatment?
  - › Do they have any negative attitudes toward providing the service?
  - › What would enable them to provide better quality services?
  - › Do they feel supported by other staff and supervisors to provide quality services?
  - › Are they able to make suggestions and positive changes?
- ❑ If possible, assess patients' views of service quality by asking them to participate in a quick survey. (See **Tool 6E: Patient satisfaction rapid assessment** at the end of this module for an example.)
- ❑ Complete the supervisory checklist and discuss the results with your health-care team and managers.

24. For more information consult Ipas and Gynuity Health Projects' forthcoming training manual on misoprostol for incomplete abortion at www.ipas.org or www.gynuity.org.

SUPERVISORY CHECKLIST					
	Yes	**No**	**Don't know**	**N/A**	**Additional comments**
Recordkeeping and management of services					
Staff are using the recordkeeping and reporting systems correctly, including: • Patient forms filled out correctly					
• Logbook filled out consistently					
• Supply ledger filled out consistently					
Internal supervision system exists and is functioning					
Efficient patient flow (minimal waiting time before and after treatment)					
Average amount of time from arrival to procedure: _____					
Hours services are available: _____					
Resources *(Indicate if items are available and/or stocked. If they are not, state the reason and exactly what product or item is missing.)*					
Infrastructure, furniture and equipment • Counseling and examination room(s)					
• Toilet facilities					
• Clean water supply					
Equipment and supplies • Supplies for pelvic and bimanual exam, including speculum, gloves, etc.					
• Disinfection supplies for instruments and gloves					
Drugs and contraceptive supplies • Misoprostol					
• Analgesics (ibuprofen, paracetamol) and antipyretics					
• Contraceptive supplies					

SUPERVISORY CHECKLIST					
	Yes	**No**	**Don't know**	**N/A**	**Additional comments**
Emergency treatment supplies (for referral health facilities) • Emergency resuscitation materials and drugs (including IV lines and fluids, blood transfusion/ blood)					
• Manual vacuum aspiration (MVA) equipment					
• Other evacuation equipment if MVA is not available					
There is an adequate supply of misoprostol pills throughout the month.					
Staffing					
All staff are trained on misoprostol medical and programmatic protocols.					
Number of clinicians trained to provide misoprostol for treatment of incomplete abortion:_____ Is this number adequate to meet the patient load? Yes ☐ No ☐					
Patient satisfaction					
Patients seem satisfied with services. (see ⚙ **Tool 6E: Patient satisfaction rapid assessment**)					
Patients have complaints.					*Describe in additional comments section at the end*
Contraceptive service provision					
What types of contraceptive methods are available? (✓ all that apply)					
☐ Oral pills ☐ Male condoms ☐ Female condoms ☐ Spermicides	☐ Implants ☐ Injectables ☐ IUDs ☐ Male sterilization	☐ Female sterilization ☐ Other: _____			
Most popular method: _____ Next most popular: _____					

SUPERVISORY CHECKLIST					
	Yes	**No**	**Don't know**	**N/A**	**Additional comments**
Adequate supply of contraceptives, including all methods that should be available at this clinic					

Obstacles to providing contraceptive services: (✓ all that apply)

- ☐ Staff not adequately trained in contraceptive services.
- ☐ Staff do not have time to counsel.
- ☐ Contraceptive methods are not available at all times.
- ☐ Contraceptive counseling and stock of methods are in different locations [for resupply methods, not for IUD and/or sterilization].
- ☐ Method(s) not available where services are provided. (list) _____
- ☐ Contraceptive board not displayed.
- ☐ Patients not interested in discussing contraceptive services.
- ☐ Method(s) ordered but not received. (list) _____
- ☐ Method(s) not approved for use by facility. (list) _____

Major observations and additional comments: _____

_____

_____

_____

_____

_____

Tool 6E.

Patient satisfaction rapid assessment

This tool can be used to help you determine patient satisfaction with misoprostol for postabortion care services, as well as provide insights into how services are being provided in your facility. Make sure you explain to the woman: the purpose of the assessment; that all responses to the assessment are confidential; and that participation will have no effect on care received now or in the future. In addition, make sure the woman understands that she does not have to participate. Allow the woman to complete the form in a private space, either by herself or with the assistance of someone who did not provide her services.

Name of health facility: _____	Date: _____ / _____ / _____ DD MM YY

Please read each of the ten items below, and place a check mark (✓) in the appropriate column.

		Yes	No	Not sure	N/A
1	Was your clinician able to attend to you quickly?				
2	Did the clinician explain what to expect?				
3	Did you get enough information to meet your needs?				
4	Did you feel comfortable discussing your health needs with your clinician?				
5	Do you feel you had enough time with your clinician to discuss everything you needed?				
6	Do you feel your clinician treated you with respect?				
7	If MVA and misoprostol were both available at the facility, were you able to choose the method you wanted for your treatment?				
8	If there was a cost involved in your treatment, did you feel that the cost was appropriate (not too expensive)?				
9	Would you recommend services to a friend who needed care?				
10	Overall, are you satisfied with the services you received today?				

Comments and additional recommendations for service improvement

Thank you for your participation.

6.6 Compiling and synthesizing monitoring data

The objective of data monitoring activities is to identify the service areas that are most in need of attention so that you can study them more thoroughly and take action. Compiling and reviewing the findings of the monitoring process presents an opportunity to openly discuss the strengths and weaknesses of the facility, conceive and implement a plan of action for improvement, and assess progress in improving care.

You should compile and synthesize the data collected during the information-gathering process so that each member of the monitoring team can review them. The team should then identify problem areas and issues of concern, as well as areas of strength and competency, so as to identify potential solutions. For example, the underlying causes of deficient counseling services might be identified as a lack of staff training in counseling and a patient intake process that leaves insufficient time for counseling. The group might also identify causes that are more pervasive, for instance, an underlying belief that counseling is not an important part of the service delivery process.

Often, a team may find that surface problems and their underlying causes are interrelated. This is important because the monitoring team may be able to develop solutions aimed at correcting several problems at once. The team must decide which problems are high priority and will be included in the improvement plan.

6.7 Developing a workplan for continuous quality improvement

After identifying and assessing problem areas, the monitoring team can develop an action plan to try to resolve the problems and improve the quality of PAC services. An action plan can help improve service provision, especially if the plan prioritizes issues, develops solutions, and matches solutions to available resources.

The team should carefully discuss a range of approaches to each problem before reaching a decision about which solution is most feasible. It is helpful to list alternate solutions as potential future options, in case the initial solution does not meet expectations.

After implementation of the action plan, it is important to carry out continuous monitoring to determine: 1) if the action plan was implemented correctly, and 2) whether the corrective action actually improved the problem area. If the problem persists (assuming the corrective action was implemented), this means that the team did not correctly identify the root cause of the problem, or that the corrective action was not on target to solve the problem. In this case, the root

POSSIBLE SERVICE DELIVERY IMPROVEMENT SOLUTIONS

- On-the-job training for staff
- Reorganization of clinic services
- Changes to clinic hours of operation
- Changes to supplies procurement and storage systems
- Strengthening referral systems

cause must be reassessed and a new action plan developed and monitored. This process is called continuous quality improvement.

For example, if only 50 percent of women completing **Tool 6E: Patient satisfaction rapid assessment** at a given facility answer "yes" to eight or more questions, the monitoring team can develop a strategy to improve the overall quality of care that is being provided. As another example, if the findings of **Tool 6D: Supervisory and performance quality improvement checklist** reveal that patient forms are not being filled out correctly, the monitoring team can discuss this with the health-care team and work on finding a solution.

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Contact information

Thank you for using *Misoprostol use in postabortion care: A service delivery toolkit*. If you need additional information, technical assistance in implementing these services, or would like to provide our team with feedback, please contact us at the following email addresses: misoforpac@ipas.org or info@vsinnovations.org.

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ANNEX 1: Clinical assessment reference guide: Overview of misoprostol for the management of incomplete abortion[1]

A. Introduction

Incomplete abortion occurs when a pregnant woman presents with vaginal bleeding, cramping, and an open cervix. She may also be passing products of conception (POC). Misoprostol provides a safe and effective way to treat women experiencing incomplete abortion (Chung et al. 1995, Clark et al. 2007, Diop et al. 2009, Gynuity Health Projects 2009, Rizzi 2007, Shwekerela et al. 2007). Studies have reported high satisfaction with misoprostol among women (Bique et al. 2007, Dao et al. 2007, Shwekerela et al. 2007, Weeks et al. 2005), and a preference for medical versus surgical treatment (Dabash et al. 2010, Diop et al. 2009). Misoprostol has several notable advantages, including ease of use and low cost (WHO 2003, You and Chung 2005). Regarding ease of use, the drug can be administered by clinicians with minimal training via several routes, can be used in remote areas without need of specialized equipment, can be self-administered, avoids iatrogenic injury, and reduces risk of pelvic infection. Misoprostol requires no refrigeration or special transport or storage conditions, though some manufacturers recommend protecting the product from heat and humidity (POPPHI 2008).

B. Misoprostol uses, administration and mode of action

Misoprostol is a prostaglandin E1 analogue. When taken during pregnancy, it causes the cervix to soften and the uterus to contract. Misoprostol has several uses in obstetrics and gynecology, which include treatment of incomplete abortion and miscarriage; treatment of missed abortion (including intrauterine fetal death); labor induction; prevention and treatment of postpartum hemorrhage; cervical priming; and pregnancy termination (FLASOG 2007, Goldberg et al. 2001, Weeks and Faundes 2007, WHO 2003).[2] Because the uterus becomes much more sensitive to the effects of misoprostol as pregnancy advances, doses of misoprostol for labor induction are *much* lower than doses for first-trimester postabortion care treatment.

Routes of misoprostol administration include oral, sublingual, buccal, vaginal and rectal. Sublingual and oral routes have the quickest onset of action (Tang et al. 2007). For the treatment of incomplete abortion, misoprostol 400mcg sublingually and misoprostol 600mcg orally have similar safety and effectiveness profiles when used with uterine size less than or equal to 12 weeks LMP (last menstrual period) (Diop et al. 2009, Gynuity Health Projects 2009).

1 This has been adapted from: Bixby Center for Population, Health and Sustainability and Venture Strategies Innovations. 2010. Misoprostol in obstetrics and gynecology: Clinical guidelines, protocol for physicians and midwives; and Osur, J., J. Karanja, C. Kiggundu, M. Ogutu and E. Nakirija. 2009. Misoprostol for the management of incomplete and missed abortions: A clinical protocol for service delivery. Ipas Africa Alliance. Unpublished.

2 Please see International Federation of Gynecology and Obstetrics website for dosage guidelines: http://www.figo.org/news/misoprostol-safe-dosage-guidelines.

Misoprostol for the treatment of missed abortion and anembryonic gestation

Although this toolkit focuses on the indication of misoprostol for the treatment of incomplete abortion, misoprostol, as noted, can also be used for the treatment of missed abortion and anembryonic gestation. Because both types of early pregnancy loss involve little to no bleeding and a closed cervix, misoprostol treatment is not as effective for these indications as it is for incomplete abortion. The dosage for missed abortion and anembryonic gestation is misoprostol 800mcg vaginally or misoprostol 600mcg sublingually every three hours for a maximum of three doses. Treatment of missed abortion with sublingual misoprostol has not been widely studied. A single sublingual dose of misoprostol 600mcg may also be effective. Reported success rates for misoprostol treatment of missed abortion vary widely. For more detailed information about the reported use of misoprostol treatment for missed abortion, see Gynuity Health Projects' introductory guidebook, *Misoprostol for treatment of incomplete abortion*.

MISSED ABORTION:

In some cases of first-trimester pregnancy failure, arrest of embryonic or fetal development occurs before the expulsion (miscarriage). The term "missed abortion" is used when the embryo or fetus has died but is retained in the uterus. Anembryonic gestation (formerly called blighted ovum) is when a gestational sac develops but there is no embryo within it. In both conditions, the cervix is closed, and there is no or only slight bleeding. Ultrasound examination shows an embryo or fetus without cardiac activity or a gestational sac without an embryo by six weeks LMP. Other terms used are: silent or missed miscarriage, embryonic or fetal demise, and fetal or embryonic death.

C. Regimens and efficacy of misoprostol treatment for incomplete abortion

For the purposes of standardization and to avoid confusion, it is advisable that local experts and authorities select **one misoprostol regimen** to use in their country. For more detailed information on misoprostol administration and dosing, see **Tool 5E: Dosage card.**

Uterine Size	Misoprostol dose	Route	Timing	Success[3]	References
Up to 12 weeks	600mcg	Oral	Three 200mcg tablets taken at once.	91-99 percent	(Bique et al. 2007, Dao et al. 2007, Diop et al. 2009, Shwekerela et al. 2007, Taylor et al. 2011, Weeks et al. 2005)
	400mcg	Sublingual	Two 200mcg tablets under the tongue for 30 minutes, then swallow the remaining pill fragments.	95-98 percent	(Dabash et al. 2010, Diop et al. 2009)

3 Success is defined here as complete uterine evacuation without further intervention with vacuum aspiration or curettage.

D. Eligibility

Misoprostol may be used to treat incomplete abortion for eligible women.

Conditions for eligibility:

Women with any of the following conditions are eligible for misoprostol:

- Open cervical os
- Vaginal bleeding or history of vaginal bleeding during this pregnancy
- Uterine size at or under 12 weeks LMP

Conditions for ineligibility

Women with any of the following conditions are not eligible for misoprostol:

- Known allergy to misoprostol or to other prostaglandins
- Confirmed or suspected ectopic pregnancy
- Signs of sepsis or active pelvic inflammatory disease[4]
    - › Women with sepsis may need postabortion care but their care should be managed if possible in an acute-level facility with ability to perform blood and cervical cultures and administer IV antibiotics if possible.
- Hemodynamic instability or shock
    - › Women who are hemodynamically unstable need uterine evacuation as soon as their condition permits, with supportive care such as fluid replacement and/or blood transfusion.

Precautions

Women with the following conditions can use misoprostol, but they may require additional treatment and further care. Whether to administer misoprostol to women with these conditions will depend on the available options for safe postabortion care, referrals, and clinical judgment.

- IUD in place — remove before beginning the regimen
- Hemorrhagic disorder or concurrent anticoagulant therapy
    - › In general, it may be safer for women with hemorrhagic disorder or who are taking anticoagulants to receive care in a health facility where they can be observed and monitored; vacuum aspiration (if available) may be the safer treatment choice.
- Severe anemia
- Uterine size larger than 12 weeks LMP
    - › Uterine size larger than 12 weeks LMP may be due to presence of fibroids and, in this case, the woman would still be eligible for misoprostol for postabortion care.

4 This does not include infections limited to the vagina, such as yeast infections or bacterial vaginosis.

Women who are breastfeeding may take misoprostol. There is no evidence to suggest that misoprostol is harmful to infants, though it enters breast milk soon after taken. Misoprostol is undetectable in breast milk 4-5 hours after ingestion, so the woman can breastfeed, take misoprostol, and wait 4-5 hours for the next feed (Abdel-Aleem et al. 2003, Tang et al. 2007, Vogel et al. 2004).

E. Clinical assessment

It is important to note that diagnosis of incomplete abortion can be done with a targeted medical and obstetric history, symptoms and physical and pelvic exam. Pregnancy testing and ultrasonography are not routinely needed to diagnose incomplete abortion (Bique et al. 2007, Dabash et al. 2010, Ngoc et al. 2005, Shwekerela et al. 2007, Weeks et al. 2005).

The first step is to evaluate whether the woman is in a state of emergency or whether her condition is stable enough to provide misoprostol treatment for postabortion care. Clinical assessment is therefore divided into two sections: care of the woman who is stable and assessment of the woman who is unstable.

I. If the woman is in stable condition…

A. The woman is ambulatory and is not in acute distress.

B. Prepare the woman for what to expect — a series of questions followed by an exam. Clinicians should recognize the needs of special populations. For example, an adolescent may never have had a physical examination before and may be experiencing stress and concerns about the exam.

1. **Targeted medical and obstetric history**

- Medical history
  - › Is the woman taking any medicines now?
  - › Is the woman allergic to any medicines or agents (i.e., iodine)?
  - › Does the woman have a current acute medical illness, or does she have a chronic medical illness?
- Obtain targeted medical history as it relates to misoprostol eligibility and precautions.
- Get a brief obstetric and contraceptive history.
- History of current pregnancy: LMP, when pregnancy symptoms began, when bleeding began, amount and duration of bleeding. Cramping or pain woman has experienced, severity of pain, nature of pain, whether intermittent (contractions) or constant.

2. **Ancillary testing (if indicated and available)**

- Hemoglobin or hematocrit
- Pregnancy testing is not routinely needed to diagnose incomplete abortion.
- Ultrasonography is not routinely needed to diagnose incomplete abortion.

3. **Physical exam**

- Vital signs: blood pressure, temperature, pulse

- General appearance (for example, indication of severe anemia, level of energy and alertness, is the woman able to walk into the exam room unaided or is she doubled over in pain, does she appear in general good health or does she appear very fatigued and pale).
- Pelvic exam
  - › Uterine size, tenderness
  - › Cervical motion tenderness
  - › Adnexal mass suggestive of ectopic pregnancy
  - › Speculum exam: cervical os open or closed, POC protruding from external os, purulent discharge from os, color and amount of blood in vaginal vault
  - › Signs of pelvic infection (foul-smelling discharge, abdominal tenderness)

4. **Treatment**

- Discuss treatment options: misoprostol, manual vacuum aspiration (MVA), expectant management, or other. Medical eligibility, women's preferences, and local circumstances (such as transport conditions and an assessment of women's ability to manage the medical versus surgical options) should be considered in choosing the treatment method.
- Provide treatment.
- Describe to woman when she should come for follow-up and explain the warning signs of treatment complications (see F3: Warning signs).
- Women may take misoprostol in the clinic or at home. It is not necessary to observe women in the clinic following misoprostol administration, unless facility space permits and this is the woman's preference.
- When using misoprostol to treat incomplete abortion, infection rates are very low (Shwekerela et al. 2007, Trinder et al. 2006, Weeks et al. 2005). Antibiotics should be used if history and physical exam are suggestive of infection or risk of infection (Blum et al. 2007).

II. If the woman is in emergency/unstable condition
(including if the woman appears syncopal, is short of breath, is in extreme pain, or is experiencing frank, profuse hemorrhage)…

1. **Rapid initial assessment for shock**

- Fast, weak pulse (rate ≥ 110 per minute)
- Low blood pressure (diastolic <60)
- Pallor (extremely pale, pallor of palms or around the mouth)
- Sweatiness
- Rapid breathing (respiration ≥30 per minute)
- Anxiousness, confusion or unconsciousness

- Frank, profuse hemorrhage

2. **If woman is in shock or clinically unstable, determine the etiology of the condition and treat or refer accordingly**
   - If woman is conscious or a family member is present, find out:
     - › If woman is on current medications
     - › If woman has a serious health condition
     - › If woman has known allergies
   - **Proceed immediately to stabilize the woman:**
     - › IV fluid volume or, after cross-match, whole blood replacement with large-bore IV catheter
     - › Oxygen by mask if available
   - If sepsis is suspected, blood and cervical cultures if possible
   - Broad-spectrum IV antibiotics if indicated
   - Uterine evacuation ASAP (as soon as possible) if indicated
   - Determine underlying etiology of shock (for example, a ruptured ectopic pregnancy would require emergency surgery).
   - If woman will be transported, she may need stabilization and volume replacement with IV fluids before/during transport.
     - › Notify referral facility that woman is being transported and give report on her diagnosis and condition.

F. Treatment effects, side effects and complications

Most women will experience *treatment effects* after taking misoprostol. There are also possible *side effects* that a minority of women may experience. In a small number of cases, a woman may experience *complications* that will require her to seek immediate help from a clinician. Women should be counseled on what to expect after taking misoprostol and clinicians should ensure that women understand the warning signs that are indicative of a complication and require immediate assessment. For more information, see **Tool 5G: Managing expected effects, side effects and complications**.

1. Treatment effects

Expected effects of misoprostol for treatment of incomplete abortion include cramping, bleeding and expulsion of products of conception (POC). Generally, symptoms may occur within the first few hours after the medication is taken. Expulsion occurs over several hours to several weeks; bleeding will most likely be heavy for about three to four days, followed by light bleeding or spotting for several weeks (Blum et al. 2007). A recent study in Egypt, which compared vaginal bleeding after misoprostol and MVA treatment, concluded that the likelihood of a clinically significant decrease in hemoglobin (at least 2 g/dL) following either treatment was extremely low (less than 1 percent) (Dabash et al. 2010).

Management of treatment effects

Pain

Uterine contractions, which the woman experiences as cramping, are necessary to expel the products of conception and residual tissue. Ibuprofen or other non-steroidal anti-inflammatory drugs (NSAIDs) should be provided around the time of misoprostol administration or shortly thereafter (for example, ibuprofen 400-600mg orally every six hours). Good counseling and emotional support may also alleviate anxiety and reduce perceptions of pain.

Bleeding

Amount and duration of bleeding will vary from woman to woman, ranging from bleeding lighter than a menstrual period to bleeding much heavier than a menstrual period. Passage of clots and/or tissue is expected. In one randomized clinical trial of 300 women receiving misoprostol for postabortion care treatment, 24 percent of women using oral misoprostol and 26 percent of women using sublingual misoprostol experienced heavy bleeding in the two hours after taking misoprostol (Diop et al. 2009). Women should be prepared with full-thickness sanitary pads or similar cloths used locally. Provide information about the normal range of bleeding and warning signs that should prompt the woman to call her clinician or seek urgent medical care.

2. Possible side effects

Clinicians should discuss the side effects women may experience after taking misoprostol, including: chills/fever, nausea/vomiting, and diarrhea. Side effects are usually mild and self-limited, lasting less than 24 hours (Clark et al. 2007). Prolonged or serious side effects with misoprostol treatment are rare (Blum et al. 2007, Gemzell-Danielsson et al. 2007).

Management of side effects

All women should be counseled that chills/fever, nausea/vomiting and diarrhea are possible side effects of misoprostol treatment. Symptomatic treatment (such as administration of an antiemetic) is not routinely necessary, but may be helpful in select cases (for example, in a woman who is already vomiting or who has prior experience with misoprostol causing vomiting). If needed, antipyretics can be provided for the treatment of chills/fever. An example is ibuprofen 400-800mg every six hours.

3. Warning signs

Most women will not experience serious complications as a result of taking misoprostol for the treatment of incomplete abortion. However, women should be counseled on the warning signs that would indicate that they have a complication. *If women experience one of the listed warning signs, they should immediately seek help from a health center clinician.*

- **Heavy bleeding**
  - Soaking two full-thickness sanitary pads per hour for two consecutive hours
  - Heavy bleeding that occurs after bleeding had slowed down or stopped
  - Feeling light-headed or dizzy as bleeding continues
- **Fever which lasts more than a day or starts any day after the day misoprostol is taken**

- **Severe pain, even on the day of misoprostol, that does not get better with medication, rest, or a heating pad**
- **Feels very sick**

Management of heavy bleeding

Uterine evacuation (vacuum aspiration) is necessary if there are retained products of conception and heavy bleeding. Hemorrhagic disorders should be treated accordingly if they are the cause. Anemia resulting from heavy bleeding requiring treatment is rare (Dabash et al. 2010), but anemia can coexist as a condition in many reproductive age women. In those cases, anemia should be treated as necessary in addition to the vacuum aspiration for acute bleeding.

If persistent bleeding or intermittent mild (not severe) cramping does not improve by the time of the follow-up visit, a repeat dose of misoprostol or vacuum aspiration should be considered. If the woman is treated with a repeat dose of misoprostol, it is advisable to re-evaluate the woman again in one to two weeks. (See H: Follow-up).

If bleeding is profuse or prolonged and heavy, the woman should have vacuum aspiration.

If bleeding has been hemorrhagic or profuse/prolonged, blood transfusion may be necessary in rare cases to restore hemodynamic stability.

Management of infection

Signs of infection include:

- Fever that lasts more than a day or starts any day after the day the woman takes misoprostol
- Persistent abdominal pain
- Foul-smelling or purulent vaginal discharge

Where infection is confirmed, appropriate treatment with antibiotics should be given; in serious cases, hospitalization and IV antibiotics should be considered.

Management of constant cramping and pain

Persistent, unrelieved cramping or severe pain warrants evaluation prior to the follow-up visit (see F3: Warning signs).

Constant cramping and pain can result from treatment failure or to other complications, such as infection, unrecognized ectopic pregnancy, unrecognized tears, foreign bodies as a result of unsafe abortion practices, or some other health problem. Women should be reassessed carefully, and treated based on the root cause of the problem, along with symptomatic management of pain.

When treating incomplete abortion, clinicians may face complicated cases due to unsafe abortion practices to which women were exposed before they sought treatment of incomplete abortion. These could include uterine perforation, cervical tears, foreign objects in the vagina, infection or sepsis, or even shock due to excessive blood loss.

It is important to note that side effects and possible complications from *surgical treatment* of incomplete abortion may be different from those of medical management. Complications resulting from surgical treatment can include uterine perforation or infection caused by unhygienic surgical procedures.

G. Postabortion contraceptive counseling

Contraceptive counseling should be a routine part of postabortion care. Clinicians should provide information on the rapid return to fertility and offer appropriate contraceptive counseling and a method of the woman's choice.

- Most contraceptive methods should be provided as soon as possible — usually the same day as misoprostol. Highly effective contraception, such as injectables, contraceptive implants and oral contraceptives can be administered on the same day that misoprostol is given.
- The intrauterine device (IUD) may be inserted at follow-up if the misoprostol treatment was successful.
- If there will be more than a 10-day delay before a woman can start a chosen method, another method, such as condoms, should be provided in the interim.

CONTRACEPTIVE COUNSELING FOR POSTABORTION CARE PATIENTS

Effective postabortion contraception is the best way to prevent future unwanted pregnancies. Unfortunately, it is usually one of the weakest links in postabortion care, and the proportion of women who receive a contraceptive method after postabortion care remains low. Therefore, contraceptive counseling and provision of a method should be priorities in all PAC services. In addition, some women may have experienced an unwanted pregnancy while already using a method; it is very important to address the reasons for failure, and counsel women accordingly.

- Emergency contraception can also be provided to women to take in the event of unprotected intercourse.
- Women should be counseled to delay intercourse until contraception is in place if they want to prevent another pregnancy.

H. Follow-up

A follow-up visit should be scheduled one to two weeks following misoprostol administration if feasible; depending on the local circumstances, clinicians also may suggest alternatives to follow-up.

Follow-up visits should cover the following:

Treatment outcome: To determine if treatment was successful, the clinician should ask the woman about her experience and then conduct a physical exam. *Treatment success is defined as complete uterine evacuation and resolution of all symptoms.*

- **History** suggestive of successful treatment:
  - The woman experienced bleeding. (Bleeding can range from lighter than a normal menstrual period to much heavier than a menstrual period, with large clots.) The woman also experienced cramping and passage of clots or tissue, but bleeding and cramping have now subsided or are minimal.
  - Pregnancy symptoms have lessened or disappeared and the woman does not feel pregnant.
- **Physical exam** suggestive of successful treatment:
  - Minimal or absent bleeding

- Normal uterine size (small, firm)
- Nontender uterus and adnexae and no cervical motion tenderness
- Closed cervical os

Continued incomplete abortion: If the evacuation process is not yet finished at the follow-up visit and the woman is clinically stable, she may be offered close observation with expectant management and be re-evaluated in one to two weeks. Alternatively, a repeat dose of misoprostol may be offered (Blum et al. 2007). If the woman is treated with a repeat dose of misoprostol, it is advisable to re-evaluate her in one to two weeks. In the event of infection or clinically significant bleeding, completion with vacuum aspiration should be considered.

Contraception: If the woman wishes to avoid a subsequent pregnancy, ensure that she is comfortable with her contraceptive method, or offer counseling and a method if these have not yet been provided.

Reproductive health: Link the woman with other reproductive health services as needed, such as cervical cancer screening, HIV testing or care, referral to a fertility clinic or fertility services, care for sexual violence, and others.

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