MEDICAL ABORTION GUIDELINE

LESS THAN 9 WEEKS

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WomanCare GLOBAL academy

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CREDITS

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MEDICAL ABORTION GUIDELINES

INTRODUCTION

This guideline provides evidence-based recommendations for provision of medical abortion services up to 9 weeks (63 days) gestation .

Abortion should be available on the request of woman or girl. Dkt WomanCare Global is committed to the principles of right's based, person-centred care delivered in an enabling environment where there is respect for human rights, a supportive framework of law and policy, availability and accessibility of information within a supportive health system.

Box 1:
General Principles of Right's based Abortion

Provision WHO, Abortion Care Guidelines 2022

- Sexual and reproductive health and rights are grounded in a range of human rights recognized and guaranteed in national and international law.
- States have a duty under international human rights law to ensure that the regulation of abortion does not cause women and girls to resort to unsafe abortions.
- States must provide essential medicines listed under WHO's Action Programme on Essential Drugs.
- Treaty monitoring bodies have called for the decriminalization of abortion in all circumstances.
- Regardless of whether abortion is legal or restricted, States are required to ensure access to post-abortion care.

Purpose and Scope

The purpose of this guideline is to provide evidence-based information for:

Developing Dkt WomanCare Global medical abortion training packages

Dkt WomanCare Global clinical and non-clinical staff members to ensure services provided are safe, effective and patient-centred care of the highest quality as per organisational mission and vision

Health care providers including mid-level providers, nurses, midwives, and pharmacists.

Sources

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- Best Practice in Post Abortion Contraception Royal College of Obstetricians and Gynaecologists, September 2022 https://www.rcog.org.uk/media/53fhrbz2/post-abortion-contraception-best-practice-paper-2022.pdf
- Ectopic pregnancy and miscarriage: diagnosis and initial management NICE guideline [NG126} November 2021 https://www.nice.org.uk/guidance/ng126

Definition of Terms

Partly derived from Abortion Care Guidelines, WHO 2022

Medical abortion is the use of pharmacological agents to terminate pregnancy - most commonly mifepristone and misoprostol in combination, or misoprostol alone. These medications can be used for management of induced, spontaneous or incomplete abortion.

Mifepristone blocks the effects of progesterone which is essential for the pregnancy to continue. It also as cervical ripening effects and increases sensitivity of the uterus to contractions.

Misoprostol is a synthetic prostaglandin E1 analogue which has a cervical ripening effect and induces uterine contractions.

Induced abortion is the termination of an ongoing pregnancy using drugs or uterine aspiration.

Spontaneous abortion is the non induced loss of a pregnancy before 24 weeks gestation. The term miscarriage is used interchangeably with abortion.

Missed abortion: The demise of a pregnancy where the fetus/embryo remain in the uterus and the cervical os remains closed. Symptoms may include pain and/or bleeding, or there may be no symptoms at all.

Incomplete abortion occurs when uterine contents not fully expelled or removed after spontaneous abortion or induced abortion by clinical presence of an open cervical os.

"Unsafe abortion" refers to abortion when it is carried out by a person lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

Post-abortion care is defined as the provision of services after an abortion, such as contraceptive services and linkage to other needed services in the community or beyond. It includes optional follow up as requested by the woman. It can also include management of complications after any type of abortion. It should always be provided regardless of whether abortion is restricted in a particular setting.

Telemedicine: A mode of health service delivery where providers and clients, or providers and consultants, are separated by distance. This can include real time on line or phone interactions and follow up of message left by phone/email/SMS. This service delivery approach should be an option offered as alternative to person to person interactions.

Self-management of abortion: Self-management of the entire process of medical abortion or one or more of its component steps, such as self-assessment of eligibility for medical abortion, self administration of medicines without the direct supervision of a health worker, and self-assessment of the success of the abortion process.

Surgical aspiration. This involves evacuation of the contents of the uterus through a cannula, attached to a vacuum source. Electronic vacuum aspiration (EVA) requires a power supply and manual vacuum aspiration (MVA) in the form of a hand held syringe.

Gestational age: The number of days or weeks since the first day of the woman's last menstrual period in women with regular cycle. For women with irregular cycles or when last menstrual period (LMP) is unknown, gestational age is the size of the uterus, estimated in weeks, based on clinical examination or ultrasound, that corresponds to a pregnant uterus of the same gestational age dated by LMP.

Principles of MA service provision

Any method of abortion should be initiated with no delay to reduce risks as pregnancy gestation increases and also to increase patient satisfaction. This means that services should be accessible, available and affordable.

Care should be focused on the patient and her needs in a welcoming demedicalised environment which respect auditory and visual privacy.

Providers should be trained in counselling and be able to provide information in a non judgmental manner. There must be complete assurance of patient confidentiality.

Counselling should ensure that the patient is able to make an informed choice without coercion. It should include information on the choice of abortion method, possible complications and need for follow-up especially if complications arise.

There should be well established referral networks to other sexual health services if these are not provided on site.

All aspects of service provision should be documented.

Providers should achieve basic competencies during training and be aware aware of the limits of their training especially with respect to gestation of pregnancy and refer to other providers where appropriate.

Principles of quality of care in abortion services

Quality is defined as a service that is ***safe, effective, and patient centred.*** Some examples are outlined in Table 1. Other essential dimensions of quality include weather services are accessible and equitable discussion of which is out of scope of this document.

TABLE 1: Quality of care for abortion services

Principles of quality care*	Examples	Implications of poor quality care	Steps to reduce risks of poor quality care
SAFE:			
Are service users, staff and visitors protected from abuse and avoidable harm?	• Poor clinical techniques can increase chance of complications such as infection. • Lack of knowledge and skill to avoid complications and to recognise and treat then when they occur. • Incorrect assessment of gestational age.	• Infection, bleeding, genital tract trauma. • Minor or major morbidity, death.	• Competency based training. • Post training follow up and support. • Procurement of quality supplies and equipment.
EFFECTIVE:			
Is people's care, treatment and support achieving good out-comes, promotes a good quality of life and is evidence-based where possible?	• Poor techniques in uterine evacuation. • Lack of knowledge of appropriate MA methods for gestation. • Incorrect assessment of gestational age.	• Incomplete procedures requiring follow up treatment.	• Competency based training. • Post training follow up and support. • Procurement of quality supplies and equipment.
PATIENT CENTRED:			
Do staff involve and treat people with compassion, kindness, dignity and respect? Is care shaped to fit the individual. Is it flexible to those preferences and needs? Does it adapt to fit if those needs or preferences change?	• Lack of visual or auditory privacy. • Lack of confidentiality. • Lack of information and informed consent. • Inadequate pain relief Judgemental staff.	• Patient may not return for follow up or be put off from seeking further care. • She may not recommend to friends and family. • Psychological effects on woman and her partner	• Training in counselling and patient centred care. • Patient surveys to assess quality of care.

* Care Quality Commission Key Lines of Enquiry, July 2022
https://www.theaccessgroup.com/en-gb/blog/key-lines-enquiry-kloe-explained/

Pre Procedure Care

ROLES AND RESPONSIBILITIES

Healthcare workers providing medical abortion services should have training in how to assess the woman who requests medical abortion, administering the medications with full instructions, and providing information on what happens after the abortion process including how to determine whether it has been successful. Healthcare workers are eligible to provide medical abortion services or part of the service range from community health workers, pharmacists, auxiliary nurses, nurses midwives and doctors depending on local regulations.

In some settings, women may be able to administer their own medications at home and manage the process themselves – 'self management'. This requires provision of the highest quality information on what to expect and where follow up may be required. Remote support can be provided via telemedicine as well as with healthcare workers in person. Self management of the medical abortion process should be offered wherever possible for women who would prefer to be at home rather than be treated in a healthcare facility.

Medical abortion >14 weeks gestational age should only be done by an appropriately qualified generalist doctor or specialist. Before the medical abortion procedure it is essential to assess eligibility for treatment.
The key components are:

Diagnosing the pregnancy and performing a test if required.

Determining gestational age

- This is essential to ensure that the gestation is accurate so that the woman receives the correct doses of medication. Medical abortion at later gestations should be performed in a healthcare facility because of increase risk of bleeding.
- This can be reasonably estimated in most cases as the number of weeks and days from the first day of the last menstrual period (LMP).
- Routine ultrasound examination is not necessary unless there is uncertainty about gestational age. request for an ultrasound can also delay the procedure. An ultrasound should be performed however if there is suspicion as an ectopic pregnancy.
- Gestational age can also be estimated with a physical examination with a trained provider where there is further doubt about duration of pregnancy and/or ultrasound is not available.

Excluding medical conditions which may be contraindications for treatment.

- These include a known or suspected ectopic pregnancy* and a previous allergic reaction to Mifepristone and Misoprostol.
- Women who have severe uncontrolled asthma, adrenal failure or an inherited porphyria should not use Mifepristone.
- Women who have bleeding disorders or take blood thinning agents will need careful assessment about the location of procedure and whether medications should be stopped.

The following are *not* routinely required before medical abortion:

- Estimation of haemoglobin unless the woman has symptomatic anaemia.
- Physical examinations including breast examination or cervical cancer screening.
- Blood pressure measurement.
- STI screening.
- Prophylactic antibiotics.
- Anti D for women <12 weeks gestation.

* An ectopic pregnancy is where the embryo develops outside the womb. This will typically be in a fallopian tube or, less commonly, in the abdominal cavity, ovary or cervix.

Counselling and informed consent

Any information provided to the patient either written or verbal must comply with human rights principles of counselling set out in Box 2

BOX 2: Key considerations relevant to the provision of information

- Informed consent requires the provision of complete and accurate, evidence-based information.
- Accurate information on abortion must be available to individuals in a way that respects privacy and confidentiality.
- The right to refuse such information when offered must be respected.
- Abortion information should be available to all persons without the consent or authorization of a third party. This includes abortion information being available to adolescents without the consent or authorization of a parent, guardian or other authority.
- Information must be non-discriminatory and non-biased and presented in a respectful manner. It should not fuel stigma or discrimination and bed and in a manner understandable to/tailored to the individual.
- Dissemination of misinformation, withholding of information and censorship should be prohibited.
- Information should be acceptable to the person receiving it and of high quality; it should be presented in a way that can be understood. Throughout the process there should be an ongoing assessment of the woman's understanding of the information provided, openness to answer any questions and to confirm whether her decision is being taken voluntarily.

Developed from WHO Abortion Care guidelines 2022

Key facts about medical abortion

All methods of abortion that are available should be discussed so that the woman can make an informed choice. Table 2 presents the key counselling points for MA and provides a comparison for surgical abortion for reference.

TABLE 2: Key facts about medical and surgical abortion for gestations of less than 9 weeks (Adapted from)

Medical abortion before 9 weeks	Surgical abortion before 9 weeks
Avoid surgery.	Short procedure.
Mimics the process of miscarriage.	Takes place in a health facility.
In some settings and gestations it can take place at home.	Timing of the abortion is controlled by the provider and the clinic.
Process usually completed in 1-2 days but may take longer s to complete the abortion which can be unpredictable. women will experience bleeding and cramping during this time especially in the few hours when the pregnancy is being expelled.	Requires instrumentation of the uterus.
Misoprostol may cause other side effects such as vomiting, shivering and nausea. (1 in 10)	Can take place under local anaesthetic or sedation.
May require more than one visit to the clinic if bleeding and pain require treatment and to ensure that the pregnancy has passed.	Small risk of uterine or cervical injury.
There is a chance that women may see the products of conception.	Pain and bleeding may occur for 1-2 weeks after the procedure addition reduce over-time.
All contraceptive methods can be started at the time of the medical abortion, except intrauterine devices (IUDs), which can be inserted immediately after the pregnancy is expelled.	Complete abortion easily verified by evaluation of aspirated product of conception.
	All contraceptive methods can be started at the time of the procedure, including the IUD.

Risks and compications of medical abortion

Risks and complications of abortion procedures are rare. High quality information provided to the patient will result in timely management of any problems when they occur. Management of complications is discussed on page 13.

TABLE 3 : Risks and complications of abortion (from RCOG 2022)

Complication/risk	Medical abortion	Surgical abortion
Continuing pregnancy	1 - 2 in 100	1 in 1000 Higher in pregnancies <7 weeks
Need for further intervention to complete the procedure	<14 weeks: 70 in 1000	<14 weeks: 35 in 1000
Infection*	Less than 1 in 100	Less than 1 in 100
Severe bleeding requiring transfusion	<20 weeks: less than 1 in 1000	<20 weeks: less than 1 in 1000
Cervical injury from dilation and manipulation	–	1 in 100
Uterine perforation	–	1 - 4 in 1000

*Upper genital tract infection is most commonly associated with pre existing lower genital tract infection at time of procedure

Medical abortion drugs: doses and routes of administration

A combination of mifepristone and misoprostol should be used if available as it is more effective than misoprostol alone. Combination also reduces side effects, decreases the likelihood of failure of the procedure and shortens the time taken to complete the abortion. There is no lower gestational age limit for medical abortion.

WHO 2022 Recommend the use of 200 mg mifepristone administered orally, followed 1–2 days later by 800 µg misoprostol administered vaginally, sublingually or buccally. The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.*

When using misoprostol alone: Recommend the use of 800 µg misoprostol administered buccally, sublingually or vaginally.*

*repeat doses of misoprostol may be required as gestation increases for expulsion to occur.

It is important to understand the differences between different routes of administration of medications (Table 4). Not adhering to the instructions may lead to a procedure which is less effective.

TABLE 4 : Routes of administration for mifepristone and misoprostol (from BJOG IOL)

Route	Instructions for Use
Oral	Pills are swallowed
Buccal	Pills are placed between the cheek and gums and swallowed after 20- 30 minutes
Sublingual	Pills are placed under the tongue and swallowed after 30 minutes
Vaginal	Pills are placed in the vaginal fornices (deepest portions of the vaginal) and the woman is instructed to lie down for 30 minutes

Alternate regime : The use of combination regime of Letrozole plus Misoprostol.
(Letrozole 10mg orally each day for 3 days followed by Misoprostol 800 µg sublingually on the fourth day as a safe and effective option).

Pain relief should be offered routinely, either non steroidal anti inflammatory drugs (or paracetamol (acetaminophen) where these are not an option). Stronger analgesics such as codeine may also be offered depending on the clinical picture. Conservative measures such as hot water bottles, heat pads may also provide some relief.

Post procedure care

All women should be given written and verbal information after the procedure or when medications are dispensed. It should be remembered that women may require emotional support as well as physical.

Administrative information

- How and where to access follow up services and their opening times and emergency contact numbers. There should be an open door policy for any follow up questions.
- How to access other services that have been discussed such as STI/HIV counselling, gender based violence support services.

Self care guidance

- Thick sanitary pads are recommended when the bleeding is heavy rather than tampons.
- No douching should be performed.
- Regular pain relief in the form of NSAIDs +/- paracetamol, heat pads, hot water bottles and maintain hydration, +/- antiemetic may be required to manage the side effect of misoprostol.
- She can resume sexual intercourse when she feels ready. There is no evidence that sex when bleeding post abortion leads to a risk of infection.
- The next period may take 4-8 weeks to return.

Identifying when to come back

- The woman should seek advice if she experiences the following:
  - Excessive bleeding (e.g. soaking more than two pads in one hour for more than two hours).
  - Pain that is not controlled with medication.
  - Any fever greater than 38°C.
  - Offensive vaginal discharge, severe pain or abdominal distention.

- Women should also be aware of the signs of an ongoing pregnancy:
  - No bleeding after taking misoprostol.
  - Pregnancy symptoms persisting after a few days (sore breasts, nausea).
  - If next menstrual period has not returned by 4 weeks.

There is no need for routine follow up after medical abortion

Complications

Be prepared with clear well developed referral pathways to surgical abortion or higher level facilities

TABLE 5 : Complications

Complication	Symptoms	Treatment after Clinical assessment
Incomplete abortion	• Bleeding • Abdominal pain	• Expectant management ('wait and see') if patient is stable • Repeat pills • MVA
Infection	• Fever or chills • Foul smelling vaginal discharge • Abdominal pain • Vaginal bleeding	• Admit to hospital • Under antibiotic coverage check for retained products, re- evacuate uterus • **Severe infections may need hospitalisation**

Post abortion family planning

Ovulation can occur 8-10 days after an abortion so it is important to discuss this during counselling and ascertain if the woman would like to start a particular method immediately. The following contraceptive methods may be started immediately if there are no restrictions to medical eligibility after surgical or medical abortion

Combined hormonal contraceptives

- Given the option of starting hormonal contraception immediately after the first pill of the medical abortion regimen.

Progesterone-only contraceptives (POCs) including implants, injections.

Diaphragm, cap.

Intrauterine devices (IUDs) may be started.

- IUD placement at the time that success of the abortion procedure is determined but not started immediately after septic abortion.

Management of other types of abortion

Women with a diagnosis of **missed abortion** can be counselled on whether would prefer expectant management ('wait and see' approach), surgical aspiration or medical management.

The choice method is entirely dependent on the women's preference and assessment of her clinical situation.

For those choosing medication, pre and post procedure advice is the same as for women having medical abortion for induced abortion.

In these cases combination of mifepristone and plus misoprostol is recommended over using misoprostol alone.

WHO 2022

Recommended regimen 200 mg mifepristone administered orally, followed 24 hours later by 800 µg misoprostol administered by any route (buccal, sublingual, vaginal).*
Alternative regimen: 800 µg misoprostol administered by any route (buccal, sublingual, vaginal).

*Repeat dosing may be required for higher gestations.

Incomplete abortion can present with vaginal bleeding and abdominal pain and can be the result of induced abortion (safe or unsafe) or spontaneous abortion.

Management options include expectant management, surgical aspiration or medical management. As for missed abortion, the choice method is entirely dependent on the women's preference and assessment of her clinical situation with respect to bleeding, pain and any signs of infection.

Healthcare professionals should be alert to the risk of an unsafe abortion having taken place signs of which include genital tract injury, presence of foreign objects in the vagina.

WHO 2022

For the medical management of incomplete abortion at ***< 14 weeks uterine size***: **Suggest** the use of 600 µg misoprostol administered orally or 400 µg misoprostol administered sublingually.
For the medical management of incomplete abortion at ***≥ 14 weeks uterine size***: **Suggest** the use of repeat doses of 400 µg misoprostol administered sublingually, vaginally or buccally every 3 hours.

It should be noted that management of incomplete abortion is a signal function of basic emergency obstetric care BEmONC services.

Other uses of medical abortion drugs

1

Intrauterine fetal demise (IUFD) over 14 weeks of pregnancy occurs when the fetus or embryo is not viable. Confirmatory diagnosis is on ultrasound.

- *The suggested regimen* uses combination mifepristone plus misoprostol over misoprostol alone: 200 mg mifepristone administered orally, followed 1–2 days later by repeat doses of 400 µg misoprostol administered sublingually or vaginally every 4–6 hours. The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.
- *Alternative regimens:* repeat doses of 400 µg misoprostol administered sublingually or vaginally every 4–6 hours.

2

Induction of labour. 25mcg misoprostol orally every 2 hours is as effective as other prostaglandins such as dinoprostone to artificially initiate labour.

3

Postpartum haemorrhage (PPH). FIGO 2022 This is defined as blood loss of greater than 500ml within 24 hours of delivery. It affects 5% of all women giving birth and is associated with around 25% of all maternal deaths. Misoprostol 400 mcg or 600mcg given orally after delivery of the baby and before deliver of the placenta can be used as to prevent PPH related to uterine atony as an alternative to oxytocin where this is not available. This can be self administered where skilled birth attendants are not available. PPH due to uterine atony can be treated with 800mcg misoprostol sublingually where intravenous oxytocin is not available.

Additional sources of information

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