Guidelines for Implementing National Standards for Comprehensive Abortion Care
Table of contents

INTRODUCTION ................................................................................................................................. 2

LEGISLATION AND LICENSING REGULATIONS ................................................................. ERROR! BOOKMARK NOT DEFINED.

INDICATIONS FOR LEGAL ABORTION ....................................................................................... 6

ORGANIZATION OF THE PREGNANCY TERMINATION SERVICES ...................................... 9

WHO MAY PERFORM PREGNANCY TERMINATION OPERATIONS .................................. 9

WHEN AND WHERE CAN PREGNANCY TERMINATION BE PERFORMED ...................... 10

ORGANIZATION OF THE PREGNANCY TERMINATION SERVICES .................................. 11

FACILITIES OF THE PREGNANCY TERMINATION SERVICES ........................................ 12

REGISTRATION AND REPORTING OF PREGNANCY TERMINATION OPERATIONS ........... 13

AUTHORIZATION AND AUDIT OF PREGNANCY TERMINATION SERVICES .................. 15

COUNSELING AND INFORMED CHOICE .................................................................................. 16

PREGNANCY TERMINATION-RELATED PROCEDURES ..................................................... 18

BLOOD TESTS ............................................................................................................................... 18

RH TESTING AND ANTI-RH IMMUNE GLOBULIN ADMINISTRATION .................................. 18

BACTERIOLOGICAL TESTS ......................................................................................................... 18

CERVIX CYTOLOGY ...................................................................................................................... 19

ULTRASONOGRAPHY .................................................................................................................... 19

OTHER PROCEDURES ............................................................................................................... 19

USE OF PERI-OPERATIVE ANTIBIOTICS .............................................................................. 20

PRE-OPERATIVE ENDOCARDITIS PROPHYLAXIS .................................................................. 22

PREGNANCY TERMINATION PROCEDURES ...................................................................... 23

GENERAL ASPECTS .................................................................................................................... 23

PREGNANCY TERMINATION BY SURGICAL PROCEDURE .............................................. 25

Pre-operative procedure ............................................................................................................. 25

Operative procedure (vacuum aspiration or uterine curettage) ............................................... 25

Post-operation procedure ......................................................................................................... 26

PREGNANCY TERMINATION BY MEDICAL PROCEDURE ............................................... 27

ANESTHESIA ............................................................................................................................... 29

Definitions .................................................................................................................................. 29

Personnel and Monitoring ........................................................................................................ 29

Facilities and Equipment .......................................................................................................... 30

EVALUATION OF EVACUATED UTERINE CONTENTS ...................................................... 32

COMPLICATIONS ........................................................................................................................ 33

EMERGENCY PROCEDURES ...................................................................................................... 33

BLEEDING ................................................................................................................................... 34

Pre-operative bleeding ............................................................................................................... 34

Intra-operative bleeding ............................................................................................................ 34

Delayed bleeding ....................................................................................................................... 34

PERFORATION ............................................................................................................................ 36

POSTOPERATIVE CARE ............................................................................................................. 38

POST ABORTION CONTRACEPTION ...................................................................................... 39

FETAL TISSUE DISPOSAL .......................................................................................................... 40

INSTRUMENT PROCESSING ....................................................................................................... 41

REFERENCES ................................................................................................................................. 42
Technical Working Group Members

S. Khishgee  Team Leader (MCHRC)
D. Uranchimeg  Project Coordinator (PHI)
Y. Buyanjargal  (DMS)
B. Yanjinsuren  (HSUM)
B. Tsedmaa  (MCHRC)
B. Lhagvasuren  (MCHRC)
J. Demberelsuren  (PHI)

Steering Committee Members

Ts. Sodnompil  (MOH)
I. Davaadorj  (MOH)
R. Gansukh  (DMS)
B. Jav  (HSUM)
L. Narantuya  (PHI)
G. Choijamts  (MCHRC)
S. Tsedenbal  (MFE)
Regzen  (MSW)
R. Baymbaa  (Mongol Em Impex)
D. Ariunruya  (MJHA)
B. Tserenhand  (NSO)
B. Mashbadrach  (MFOS)
S. Govind  (WHO)
W. Wagner  (GTZ)
I. Narula  (JICWELS)
Acknowledgements

As follow-up to a national strategic assessment, members of the technical working group for the Comprehensive Abortion Care Project developed national standards and guidelines for safe termination of pregnancy.

This work was funded by MFOS and the WHO. We express special thanks to our colleagues Mashbadrah (MFOS), Peter Fajans (WHO), Ronnie Johnson (Ipas), and B. Jav (Consultant). We also thank members of the project steering committee who provided review and valuable comments, including Ts. Sodnompil, I. Davaadorj, Wolf Wagner, Mohan Narula, and Wivat. We also thank the director of the MCHRC, G. Choijamts.
Introduction

Mongolia legalized abortion in 1989. This allowed women to have safe services and to choose when and how many children to bear and dramatically reduced the rate of abortion-related morbidity and mortality. The early 1990s was a time of socioeconomic transformation from a state controlled to a market-based economy. Economic hardships in combination with expanded abortion services, especially within the private sector, resulted in a dramatic increase in the number of legal abortions.

In response to the increasing number of abortions and related concerns about quality of care in abortion service delivery, the Ministry of Health implemented a strategic assessment of abortion and contraception in Mongolia in 2003. The assessment demonstrated the need to increase the availability and accessibility of contraception as well as the need for better information about government benefits available to women bearing children.

For women who choose to terminate their pregnancy, they should have access to safe, high-quality, comprehensive abortion-care services, including choice of procedures, pain-medications, pre- and post-abortion counseling, contraception, and screening and referral for other health needs. Comprehensive abortion care can reduce unwanted pregnancy and the subsequent need for repeat abortion while improving the quality of services and reducing the number of procedural complications and deaths.

Key recommendations of the Strategic Assessment include:
- Development of national standards and guidelines;
- Establishing and testing a model comprehensive abortion-care intervention within the MCHRC; and
- Preparation and training of trainers in comprehensive abortion care.

Definitions

Standards for abortion care are norms that must be applied for all uncomplicated cases with exceptions being rare and difficult to justify.

Guidelines provide evidence-based information regarding how to best implement the standards.

Comprehensive abortion care includes all aspects of the abortion process including the procedure to terminate pregnancy and information and options for preventing repeat unwanted pregnancies and abortion.
Legislation and Licensing Regulations

[Get English translation from MOH documents.]

Classification

Termination of pregnancy is classified as either “early” or “late” abortion.

An early procedure is the termination of pregnancy performed up to 12 weeks from the last menstrual period.

A late procedure is the termination of pregnancy between 12 and 23 weeks from the last menstrual period.
Organization of the pregnancy termination services

The facility which provides early abortion care must meet the following requirements:

- They should have a specialist to provide obstetric and gynecological care.
- They should meet hygienic and infection prevention requirements according to Order 336 (1997) of the Ministry of Health and Social Welfare.
- They should have the ability to provide necessary emergency care, especially cardiopulmonary resuscitation in case of complications.
- Pregnancy termination is performed by accredited hospitals providing obstetrics and gynecology care at the inter-soum and above levels. This includes all delivery departments in central hospitals, maternity hospitals, regional health centers, MCHRC, and licensed private clinics and international NGOs (e.g., Mongolian Family Welfare Association and Marie Stopes, International).

Abortions can be performed by any specialist obstetrician-gynecologist working in a licensed center.

Abortion facilities should be clearly marked, easy to find, and accessible to all women.

The document includes medical practice norms having a different flexibility degree, depending on the extent to which the interventions' results are known. Thus, standards are the most rigid in order for the recommendations not to be very flexible, while options give the patient the opportunity to adjust policies to specific cases.

- **Standards** are norms that must be rigidly applied and followed in almost every case, exceptions being rare and difficult to justify.
- **Recommendations** are not very flexible, they don't have the same force as standards, and when they are not applied, their justification must be rational, logical and documented.
- **Options** are neutral from the point of view of choosing a conduct, indicating the fact that several types of interventions are possible and that different physicians can make different decisions. They may contribute to the training process and and they don't need any justification.

The document includes discussions on controversial issues and it enumerates the most important references concerning the discussed issue.

As presented in this document, standards and recommendations are hierarchically organized. Therefore, in practice it is the highest level in a certain field's hierarchy that takes precedence over the others. A recommendation or an option that is hierarchically subordinated to a standard is indented to the right as opposed to the superior hierarchical level. A recommendation or an option that is independent from a superior hierarchical level is aligned to the left just like the standards.

These standards and recommendations need to be permanently adjusted in keeping with the progress of the medical technologies and of the health systems and they will be periodically revised depending on the new information that may appear.

**REFERENCES**


Legislation and regulations

According to the legal provisions in force elective pregnancy termination (requested by pregnant women) may be performed up to a 3 month gestation (12 weeks from conception date or 14 weeks from the first day of the last menstruation). According to the Criminal Code (article 185) pregnancy termination is illegal if performed in one of the following circumstances:

- outside the medical institutions or the medical practices authorized for this purpose
- by a person who doesn’t qualify as a specialist physician
- if the pregnancy age has exceeded 14 weeks.

Pregnancy termination can be performed later by a specialist physician only if this is necessary for therapeutic reasons.

Although not specifically mentioned, the term specialist physician can be assimilated to physician of obstetrics and gynecology specialty and the gestational age of 14 weeks can be assimilated to 14 weeks of amenorrhea (or 12 weeks of gestation).

Pregnancy termination performed in any conditions without consent of the pregnant woman is punishable, in if the deed results in serious injuries or the woman’s decease it is considered to be even more serious.

Pregnancy termination performed by a specialist physician is not punishable if

- it is necessary in order to save the life, health or physical integrity of the pregnant woman from a serious and imminent danger and which cannot be otherwise removed
- if the pregnant woman was unable to express her will, and pregnancy termination is necessary for therapeutic reasons.

The conditions in which elective pregnancy termination is performed, the fees that are charged and the categories that are exempt from paying these fees were repeatedly regulated in time by Order of the Minister of Health Nr. 605 from December 12th 1989, Order of the Minister of Health Nr. 619 from May 10th 1991, Order of the Minister of Health Nr. 206 from February 17th 1997.

The criteria for issuing the free practice authorization, the methodological norms for issuing the health permit as well as the performance and minimal facilities of the public and private medical units are specified in the Order of the Minister of Health Nr. 84 from February 6th 1998, completed by the Order of the Minister of Health Nr. 915 from December 23rd 1999. Annex 2 of Order Nr. 84/1998 was abolished through Order of the Minister of Health and Family Nr. 153 from February 26th 2003 completed with Order of the Minister of Health and Family Nr. 560 from June 9th 2003.
Organization of the pregnancy termination services

<table>
<thead>
<tr>
<th>WHO MAY PERFORM PREGNANCY TERMINATION OPERATIONS</th>
</tr>
</thead>
</table>

**Principle:** Abortion is a safe procedure when performed by licensed practitioners.

**Standard 1.** According to the legislation in force, pregnancy termination is performed only by ObGyn licensed physicians who are certified by order of the Minister of Health and Family.

**Standard 2.** All personnel performing abortions must receive training in the performance of abortions, in the provision of procedure-related care and in the prevention, recognition and management of complications as well as in the cardio-pulmonary resuscitation.

**Standard 3.** In order for the ObGyn residents to have the right to perform pregnancy termination, there must be a document certifying that they are licensed and they must be supervised by a licensed physician who is responsible for the procedure. The document is issued by the medical unit where the resident physician receives his specialized training.
**WHEN AND WHERE CAN PREGNANCY TERMINATION BE PERFORMED**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td>Elective pregnancy termination can only be performed in public or private medical units that are authorized for this purpose, provided that the current standards are adhered to.</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td>Elective pregnancy termination is allowed only during the first 14 weeks from the last menstrual period.</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>Pregnancy termination for pregnancies ranging from 12 to 14 weeks from the last menstrual period may be performed only in the structures for day hospitalization of the hospitals which have departments of gynecology or obstetrics and gynecology, and provided that the current standards are adhered to.</td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td>Elective pregnancy termination for pregnancies with an associated pathology that poses a major risk for the patient may be performed only in the ObGyn sections of the hospital units and provided that the current standards are adhered to.</td>
</tr>
<tr>
<td><strong>Recommendation 1.</strong></td>
<td>If a patient who requests pregnancy termination in a medical unit cannot undergo the procedure, she must be duly informed about the existing alternatives and this information must be documented.</td>
</tr>
<tr>
<td><strong>5.</strong></td>
<td>All units performing elective pregnancy termination in public or private settings will develop their own protocols for pregnancy termination based on the current standards.</td>
</tr>
</tbody>
</table>
ORGANIZATION OF THE PREGNANCY TERMINATION SERVICES

**Standard 1.** Elective pregnancy termination without complications in public medical units is considered to be an ambulatory medical service carried out at hospital level, and does not require hospitalization.

**Standard 2.** If the physician performing the elective termination of pregnancy considers that the patient needs supervision or treatment for over 12 hours, she will be admitted to the gynecology or obstetrics and gynecology department of the hospital.

**Standard 3.** Patients undergoing elective pregnancy termination without complications in structures for day hospitalization of the hospitals are not considered to be hospitalized and released patients and no hospitalization day shall be accounted for them.

**Standard 4.** Beds that are approved in the structures for day hospitalization of the hospitals for the elective pregnancy termination activity according to Standard 1 shall be accounted separately in the structure of the hospital and will not be included in the number of beds reported and financed for the hospital in-patient services.

**Standard 5.** Private medical units performing elective pregnancy termination activities must have beds for the post-intervention recovery of the patient in keeping with the current standards.

**Standard 6.** All medical units performing termination must display the tariffs for the procedure/procedures in a visible manner.
### Facilities of the Pregnancy Termination Services

**Standard 1.** In order for a medical unit to be authorized to provide pregnancy termination services, it must have the following specialized licensed personnel:

- a) ObGyn licensed physician
- b) Anaesthesiology/Intensive Care licensed physician
- c) Nurse

**Option 1:** A medical unit providing pregnancy termination services must have personnel that is licensed to provide the respective counseling.

**Standard 2.** In order for a medical unit to be authorized to perform pregnancy termination procedures, it must have a Health Permit allowing its functioning.

**Standard 3.** In order for a medical unit to be authorized to perform pregnancy termination procedures, it must have separate circuits allowing women to have easier, confidential access.

**Standard 4.** In order for a medical unit to be authorized to provide pregnancy termination services, it must have the facilities demanded by the regulations in force, and these facilities must include:

- a) its own sink
- b) separate toilet for patients
- c) bed/beds for post-abortion recovery
- d) pyjamas, slippers and changeable or disposable sheets for each patient

**Standard 2.** In order for a medical unit to be authorized to provide pregnancy termination services, it must have the facilities demanded by the regulations in force, and these facilities must include:

- a) electric or manual uterine aspiration equipment
- b) typical intensive care facilities, including oxygen sources
- c) a minimum of specific medication for emergency or intensive care, including IV fluids according to the specific regulations in force
REGISTRATION AND REPORTING OF PREGNANCY TERMINATION OPERATIONS

Standard 1. Registration of data regarding the patients for elective pregnancy termination procedures without complications, performed in structures of day hospitalization according to Standard 1 in the chapter on the Organization of the pregnancy termination services is done on a the Day Hospitalization Record (according to the Order of the Minister of Health and Family Nr. 440 from May 12th 2003) and on the Annex for Elective Termination of Pregnancy.

Standard 2. The record and annex must be filled in with all data, including the following information:
   a) personal data of the patient
   b) anamnesis and findings of the physical examination
   c) full diagnosis, including gestational age
   d) results of the mandatory and optional investigations that were performed
   e) detailed description of the procedure and anaesthesia that were used
   f) patient’s signed refusal to allow sending a medical letter to the family physician

Standard 3. Registration of data regarding the patients of elective pregnancy termination procedures without complications, performed in private ob/gyn outpatient clinics is done on the Record for Elective Termination of Pregnancy.

Standard 4. Daily recording of patients for elective termination of pregnancy, including data on contraceptives given and patient signature for receiving them is kept in a Daily Activity Register.

Standard 5. Reporting of the pregnancy termination procedures performed in the structures for day hospitalization and whose data were introduced in the Day Hospitalization Record, reporting is done separately from that of reporting of the patients discharged from the hospital and from the beds for continuous hospitalization.

Standard 6. Centralization of statistical data regarding the pregnancy termination procedures performed in the structures for day hospitalization is made on a monthly basis on the Monthly Centralizer.

Standard 7. Reporting of the pregnancy termination procedures performed in the structures for day hospitalization is made on a trimestrial basis to the Service of Statistics and Informatics of the District Health Authorities not later than the 5th of the month following the trimester reported.

Standard 8. Registration of data regarding the patients of elective pregnancy termination procedures performed for patients who are hospitalized in an ObGyn department according to Standard 2 in the chapter on the Organization of the pregnancy termination services is done on the Clinical General Observation Card.

Standard 9. Reporting of data regarding the patients of elective pregnancy termination procedures performed for patients who are hospitalized in an ObGyn department is done as together with the hospital activity (according to the Order of the Minister of Health and Family Nr. 29 of January 20th 2002).

Standard 10. Elective pregnancy termination is codified and reported according to WHO ICD 10 classification with the Z30.3 code.

Standard 11. Reporting and registration principles and regulations of the pregnancy termination activity are valid both for the public and for the private medical units.

Standard 12. The physician performing a pregnancy termination procedure must send a medical letter to the patient’s family physician if the patient does not oppose it. The opposition must be documented under the patient’s signature.

DISCUSSIONS

The Order of the Minister of Health and Family Nr. 440 from May 12th 2003 regulates the recording and statistical reporting of the patients receiving day care medical services and the content of the Day Hospitalization Record. In view of the specifics of the pregnancy termination procedure, which is a surgical procedure, specific details of the procedure are recorded on the Annex for Elective Pregnancy Termination. The forms shall be implemented in all public or private medical units performing pregnancy termination.
The Order of the Minister of Health and Family Nr. 29 of January 20\textsuperscript{th} 2002 regulates electronic collection as well as reporting of the Minimum Set of Patient-related data for those patients who were released of Romanian hospitals. Patient-related data are collected in the Clinical General Observation Card which is used for hospitalized patients and approved by order of the Minister of Health and Family Nr. 798 of January 15\textsuperscript{th} 2002.
Authorization and audit of pregnancy termination services

Standard 1. In order for a public or private medical unit to provide pregnancy termination services, it must have a specific authorization for this purpose in keeping with the existing norms and regulations as well as with the current standards and recommendations. The authorisation is issued by the Ministry of Health and the Romanian College of Physicians through the Judet Public Health Directorate and of the Judet College of Physicians.

Standard 2. Public or private medical units providing pregnancy termination services are audited every two years by a commission made up of representatives of the Judet Public Health Directorate and of the Judet College of Physicians.

Standard 3. The audit plan shall mandatorily include elements for checking whether the requirements included in this document were met, including the existence of local protocols for pregnancy termination.

Standard 4. Units that fail to meet the requirements will be withdrawn the authorisation to perform pregnancy terminations until the causes will be fixed. The acknowledgement of that situation will be made by a commission made up of representatives of the Judet Public Health Directorate and of the Judet College of Physicians.
Counseling and informed choice

**Principle:** A patient’s informed and free choice is essential for performing a quality pregnancy termination procedure.

**Standard 1.** All women undergoing pregnancy termination must be appropriately informed in order to be able to make a decision.

**Standard 2** Information on the risks and benefits of the pregnancy termination which is provided to the patient must be accurate and they must include:

a) alternatives to pregnancy termination  

b) support that pregnant women are entitled to get by the law  

c) institutions that may provide this support  

d) pregnancy termination techniques and potential risks of each procedure, including those related to anaesthesia used  

e) potential complications and long term sequellae

**Recommendation 1.** Information on complications and trauma must include the following aspects: bleeding, uterine perforation, trauma, persistent pregnancy, postabortion infection, later reproductive capacity, psychological trauma.

**Option 1.** Both the group and the individual information method are acceptable.

**Standard 3.** Information on contraception must be provided to all patients undergoing a pregnancy termination procedure.

**Standard 4.** Women must be informed in a clear, polite language and using a minimum of specialized terminology.

**Recommendation 2.** Information must be accompanied by offering written, correct and impartial information materials that the patient is able to understand and take with her to read.

**Standard 5** All women undergoing pregnancy termination in public or private medical units must sign an Informed Consent before undergoing the procedure, including her statement that she understands the procedure and the existing alternatives, potential risks, benefits and complications, that the decision is uncoerced and that she is ready for pregnancy termination.

**Standard 6.** If the patient’s age is below that of legal consent (18) the parent’s or the legal guardian's approval to terminate pregnancy must be documented.

**Standard 7.** The Informed Consent form signed by the patient/legal guardian must be attached to the Day Hospitalization Record (for public units) or to the Record for Elective Termination of Pregnancy (for private units).

**Recommendation 3.** Physicians who are in charge of women requesting an elective abortion, must try to identify the patients who need support in making the decision and they must give additional support to these women, including access to social services if necessary.

**Recommendation 4.** All women undergoing pregnancy termination must be given the opportunity to receive voluntary counseling (if she accepts it) concerning the decision to terminate pregnancy and the feelings that are associated with it.

**Recommendation 5.** Voluntary counseling must be private and confidential.

**Recommendation 6.** The personnel providing voluntary counseling must be trained to do that.

**Standard 8.** All service providers involved in providing abortion services, taking all reasonable precautions, must keep the information confidential.

**Standard 9.** All medical units performing pregnancy termination must display the patient’s rights in a visible manner.

**Discussion**

Law Nr. 46 of January 21st 2003 regulates patients’ rights including for the area of reproductive health.
Providing information to the patient with a view to make an informed choice and providing pregnancy termination counseling are two distinct processes. The purpose of the informed choice is to ensure that women’s decisions are voluntary and informed and to get legal permission to terminate pregnancy. Abortion service providers must have accurate knowledge about the complications and traumas that might occur following the abortion. This allows them to give women the information they need in order to give their informed consent.

Bleeding at the time of the abortion is rare (1.5 cases per 1000 abortions). Its incidence is lower for abortions performed at early gestational ages (1.2 cases per 1000 abortions under 13 weeks).

Uterine perforation at the time of the abortion is rare. Its incidence is of approximately 1-4 cases per 1000 abortions. Its incidence is lower for abortions performed at early gestational ages and for abortions performed by experienced physicians.

Cervical trauma: incidence of lesions at cervix level at the time of the abortion is no bigger than 1%. This rate is lower for abortions performed at early gestational ages and for those performed by experienced physicians.

Persistent pregnancy: all first trimester abortion methods may fail in terminating pregnancy. In this case, a new procedure is needed. The incidence is of 2.3/1 000 while for medical abortion it is of approximately 6/1.000.

Post-abortion infection: infections of the genital tract having different degrees of severity, including inflammatory pelvic disease, occur in up to 10% of the cases. Risks are low in case of prophylactic administration of antibiotics or when infections of the genital tract were excluded by bacteriological screening.

Later reproductive capacity: the association between pregnancy termination and infertility or premature delivery has not been proved.

Psychological trauma: long term psychological traumas following pregnancy termination occur only in a minority of women. Early discomfort, although frequent, is usually a continuation of the pre-abortion condition. If a woman is denied performance of an abortion, negative effects both on mother and the child are said to appear.

Counseling is discussing the feelings and concerns of a woman who is in a crisis situation. There are plenty of personal styles of counselling, and no style fits all situations perfectly. Counseling is not therapy and, consequently, it is not intended to last for a long period of time. Guidance by the specialised counseling services should exist if necessary or if women’s needs exceed the counsellor’s training area. Counseling may include exploring women’s feelings, helping them in making a decision, choosing contraceptives, clarifying values, or guidance towards other services. Counseling before pregnancy termination has the same purpose of preparing women for the procedure by diminishing the anxiety level. Counseling should not be a barrier to the service, consequently it should be voluntary.

REFERENCES

Pregnancy termination-related procedures

**Blood Tests**

**Recommendation 1.** Evaluation before pregnancy termination should include the following blood tests:

a) measurement of haemoglobin.

**Rh Testing and Anti-Rh Immune Globulin Administration**

**Principle:** Rh alloimmunization is a significant health risk to Rh (-) women undergoing abortion.

**Recommendation 1.** Rh status must be documented in all women undergoing abortion.

a) This documentation may be obtained by on-site testing or outside medical source;

b) Du testing is not required.

**Option 1.** If the Rh is negative the level of antibodies may be determined.

**Recommendation 2.** Rh immune globulin administration should be offered to non immunized Rh (-) women and documented.

**Recommendation 3.** If Rh immune globulin is not administered in the facility, one of the following is required:

a) informed waiver signed by a patient who refuses Rh immune globulin;

b) documentation of other arrangements for administration.

**References**


**Bacteriological Tests**

**Principle.** Infections of the genital tract may lead to pregnancy termination related morbidity.

**Recommendation 1.** Evaluation before pregnancy termination should include the bacteriological testing of the vaginal content.

**Option 1.** Evaluation before pregnancy termination may include testing for Chlamydia.
CERVIX CYTOLOGY

**Principle.** The time of pregnancy termination may be the right time for evaluating a possible cervical pathology.

**Recommendation 1.** Women who did not have any cervical cytological test during the last year should undergo such a test.

**Standard.1** If a cytological test is performed at the time of the pregnancy termination procedure, women should be told of the results and there should be the right reaction mechanism for that particular test.

ULTRASONOGRAPHY

**Principle:** Ultrasonography is not essential to pregnancy termination performance.

**Recommendation 1:** Units performing pregnancy termination should have access to the ultrasound-computer if necessary, especially when or when there are reasons to believe that there is an ectopic pregnancy.

a) pregnancy diagnosis is uncertain;
b) there is a difference between the chronological and clinical gestational age;
c) there are reasons to believe that there is an ectopic pregnancy;
d) there is a gynecological pathology associated (like uterine fibromatosis, malformations, etc.);
e) there is a IUD in place
f) there is a suspicion of not fully emptying the uterus.

OTHER PROCEDURES

**Recommendation 1.** When women come to the doctor for undergoing pregnancy termination the latter must try to identify other health needs that remain uncovered and which are mainly related to reproductive health and to give these women recommendations in order for these needs to be solved.
USE OF PERI-OPERATIVE ANTIBIOTICS

**Principle:** Prevention and treatment of infection will reduce post-abortion morbidity. Pregnancy termination care given to the patient should also include a strategy for minimizing the post-abortion infection risk. The strategy may include antibiotic prophylaxis or screening for lower genital tract infections and for treating potential cases.

**Recommendation 1:** During the pregnancy termination procedure through aspiration or curettage, patients should be given prophylactic antibiotics. The recommended regimens for antibiotic prophylaxis are:

a) Metronidazole 1g, rectally at abortion time.

b) Doxycycline 100mg, orally 2 times daily for 7 days, starting immediately after the abortion.

**Recommendation 2:** Therapeutic doses of antibiotics should be considered for high-risk patients.

**Recommendation 3:** For documented infections the following treatment regimens were published:

- **Chlamydia:**
  - Doxycycline 2 x 100mg, 7 days
  - Azithromycin 1 mg, stat
  - Erythromycin 7 days
  - Ofloxacin 2 x 300mg, 7 days
- **Bacterial vaginosis:**
  - Metronidazole 2 x 500mg, 7 days or 2mg stat

**Option 1.** Antibiotics may be initiated at the time of insertion of osmotic dilators.

**Option 2.** Patients with non-cardiac prostheses may be given peri-operative antibiotics.

**DISCUSSION**

Our review of the literature supports universal antibiotic treatment of all women undergoing surgical abortion and administration of antibiotic to all patients regardless of their risk level. Several antibiotic types and doses are effective.

High-risk patients are defined as those at increased risk of Chlamydial cervicitis:

a) age under 21
b) new or multiple sexual partners;
c) mucopurulent discharge;
d) presence of another STD;
e) previous history of pelvic inflammatory disease.

The opinion of the American Academy of Oral Medicine is that there is insufficient scientific evidence to support routine antibiotic prophylaxis for patients with prosthetic joints who are receiving dental (see reference 4)

**REFERENCES**

**PRE-OPERATIVE ENDOCARDITIS PROPHYLAXIS**

**Principle:** Endocarditis is a potential risk of surgical procedures.

**Option 1.** Patients with a prosthetic heart valve, previous bacterial endocarditis or surgically constructed pulmonary shunt may be given pre-operative prophylactic antibiotics.

**Option 2.** Patients with mitral valve prolapse with a murmur may be given oral antibiotics prior to the procedure.

**DISCUSSION**

A review of endocarditis prophylaxis literature summarizes the indications for antibiotic prophylaxis as follows: “Prophylaxis against endocarditis, therefore, should be reserved for higher-risk procedures in patients with higher-risk cardiac disorders. Otherwise, prophylaxis should be considered either optional or unnecessary. Prophylaxis is advised when both the underlying cardiac condition and the procedure seem to pose substantial risk (see ref 2).

The American Heart Association specifically does not recommend prophylaxis in the absence of infection for the following procedures: urethral catheterization, dilation and curettage, uncomplicated vaginal delivery, abortion, insertion or removal of intrauterine device, sterilization procedures, and laparoscopy. The AHA does not define “absence of infection”. Notwithstanding the ATIA recommendations, it is reasonable medical practice to follow the advice of consultants and/or referring cardiologist, about prophylaxis.

"Because no adequate, controlled clinical trials of antibiotic regimens for the prevention of bacterial endocarditis in humans have been done, recommendations are based on in vitro studies, clinical experience, data from experimental animal models, and assessment of both the bacteria most likely to produce bacteremia from a given site and those most likely to result in endocarditis. The substantial morbidity and mortality in patients who have endocarditis and the paucity of controlled clinical studies emphasize the need for continuing research into the epidemiology, pathology, prevention, and therapy of endocarditis" (see ref. 1)

**REFERENCES**

Pregnancy termination procedures

**GENERAL ASPECTS**

**Principle:** Pregnancy termination is one of the safest surgical procedures. The following standards and recommendations increase the level of its safety.

Optimal methods for pregnancy termination procedures at different gestational ages depend on several factors. For instance, most gynaecologists can perform optimal pregnancy termination procedures until the gestational age of 10 weeks (12 weeks from the last menstrual period LMP). Performance of pregnancy termination procedures after this age requires special training, enough experience and access to adequate equipment.

Currently, the availability of medical abortion is limited in Romania, but the rapid development of techniques and regimens inducing medical abortion will lead to their being included among the other services that are provided. Therefore, these methods are also detailed in this document, in order to prepare physicians and programme managers for their potential inclusion among these services.

The pregnancy termination methods recommended by WHO for different intervals of gestational age are presented below.

<table>
<thead>
<tr>
<th>Completed weeks since the last menstrual period</th>
<th>Preferred methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22</td>
<td></td>
</tr>
<tr>
<td>Vacuum aspiration (manual/electric)</td>
<td>By specially trained physicians</td>
</tr>
<tr>
<td>Mifepristone and misoprostol (or gemeprost)</td>
<td>Under study</td>
</tr>
<tr>
<td>Mifepristone and repeated doses of misoprostol or gemeprost</td>
<td></td>
</tr>
<tr>
<td>Vaginal prostaglandins</td>
<td></td>
</tr>
<tr>
<td>Dilatation and evacuation</td>
<td></td>
</tr>
<tr>
<td>Alte metode</td>
<td></td>
</tr>
<tr>
<td>Dilatation and curettage</td>
<td></td>
</tr>
<tr>
<td>Hipertonic solutions</td>
<td></td>
</tr>
<tr>
<td>Intraextra-amniotic prostaglandins</td>
<td></td>
</tr>
</tbody>
</table>

**Recommendation 1.** The earlier abortion is performed the lower the risk of complications is.

**Recommendation 2.** All pregnancy termination services should provide at least one of the methods recommended for each interval of gestational age.

**Recommendation 3.** Ideally, services should provide the opportunity to choose one of the several methods recommended for that particular gestational age interval.

**Recommendation 4.** Medical abortion using mifepristone and a prostaglandin is the election method for pregnancies under 7 weeks LMP.
Recommendation 5. Vacuum aspiration should be avoided for pregnancies under 7 weeks LMP if medical abortion is available.

Recommendation 6. Dilation and curettage using a strict protocol may also be adequate for pregnancies under 7 weeks LMP.

Standard 1. The medical method using mifepristone and a prostaglandin continues to be an adequate method for 7-9 week LMP pregnancies.

Recommendation 7. Vacuum aspiration is an adequate method for 7-12 weeks LMP pregnancies.

Standard 2. The duration of the pregnancy termination procedure should be minimal, and the quality of the procedure as high as possible.

DISCUSSIONS

Pregnancy termination procedures performed by aspiration for pregnancies under 7 weeks are three times more likely to fail in emptying the uterine cavity as opposed to those performed between 7 to 12 weeks.

REFERENCES

**Pregnancy termination by surgical procedure**

**Principle:** Manual or electric vacuum aspiration is the recommended surgical method for pregnancy termination. Dilation and uterine curettage is also an effective method, although less recommendable. Adequate counseling and later care contribute to increasing even more these methods’ safety and acceptability.

### Pre-operative procedure

| Standard 1 | Pertinent medical history must be obtained and documented. |
| Standard 2 | Confirmation of pregnancy must be documented. |
| Standard 3 | Gestational age must be verified and documented. **Option 1.** Ultrasonography can be of clinical value in verifying intra-uterine pregnancy and gestational age. |
| Standard 4 | The patient must be evaluated for ectopic pregnancy if: |
| | a) transvaginal ultrasonography shows an image suggestive for ectopic pregnancy |
| | b) transvaginal ultrasonography shows no intra-uterine pregnancy and serum quantitative hCG exceeds 2000 mIU/ml, or |
| | c) abdominal ultrasonography shows no intra-uterine pregnancy and serum quantitative hCG exceeds 3600 mIU/ml. |
| Standard 5 | When a patient with a positive pregnancy test presents with vaginal bleeding and/or pelvic pain, ectopic pregnancy must be considered. **Option 2.** Evaluation may include: |
| | a) sonography; |
| | b) uterine aspiration; |
| | c) serial quantitative hCG. |

**Recommendation 1.** Determination of hematocrit and of hemoglobin must be performed in women with a history or with symptoms of significant anemia.

**Recommendation 2.** Vital signs (e.g. blood pressure, pulse and temperature) and physical exam should be done as indicated by medical history and patient symptoms.

### Discussion

By determining the relations between risks, costs and results, it was found that pre-operative determination of hematocrit is not the most reliable in preventing morbidity and mortality caused by first trimester pregnancy termination in the case of a healthy woman that has no history of anemia or other major diseases.

### Operative procedure (Vacuum aspiration or uterine curettage)

| Standard 1 | Patient comfort level during the procedure must be considered. **Option 1.** Analgesic or other comfort agents may be used as needed unless there are contraindications. |
| Standard 2 | All instruments entering the uterine cavity must be sterile. |
| Standard 3 | The vagina should be cleansed with a bactericidal agent. **Recommendation 1.** Anesthesia should be used unless there are contraindications (see chapter on anesthesia). |
Recommendation 2. Pre-aspiration preparation of the cervix is beneficial and should be routinely done for patients whose age is under 18 or for pregnancies over 12 weeks LMP. Published regimens for the cervix preparation are:
   a) gemeprost 1mg intravaginal administration 3 hours before the intervention.
   b) misoprostol 400µg intravaginal administration 3 hours before the intervention
   c) misoprostol according to the brochure.

Recommendation 3. The cervix should be dilated gently and gradually.
   Option 2. Adequate dilation may be achieved by osmotic dilators or misoprostol.
   Option 3. At very early gestational age, cervical dilation may be facilitated by delaying the procedure.
   Option 4. Intra-operative ultrasonography can be of value to locate fetal parts and aid in their extraction, to verify an empty uterus, and to verify an intact uterus.

Standard 4. Aspiration and curettage procedure must include the following steps:
   a) analgesic provision
   b) bimanual examination in order to determine the size and the position of the uterus after emptying the bladder and rectum.
   c) putting on the sterile gloves
   d) disinfection of the vulvar region with a bactericidal solution
   e) placing a clean sheet under the patient
   f) placing the speculum or the valves
   g) disinfection of the vagina and the cervix
   h) local anaesthesia in he cervix at the position where the tenaculum will be placed.
   i) placing the tenaculum
   j) administration of the anaesthesia (according to the decision of the operating physician)
   k) measuring the uterine cavity (histerometry)
   l) gradual and gentle dilation of the cervix
   m) use of the forceps to evacuate the conception product
   n) introducing the curette or the aspiration cannula and emptying the uterus
   o) removing the forceps
   p) disinfection of the cervix, vagina and of the vulva with a bactericidal solution
   q) removing the speculum or the valves

Option 5. In case vacuum aspiration is used, a slight limited uterine instrumental control may be performed to check an empty uterine cavity.

Post-operation procedure

Standard 1. Completion of the procedure must be verified and documented (see chapter on the evaluation of the evacuated uterine content).

Recommendation 1. Anti-D immunoglobulin must be administered in keeping with the standards and recommendations concerning Rh (see chapter on Rh testing and anti-D immunoglobulin administration)
   Option 1. Anti-D immunoglobulin may be injected into the cervix for Rh(−) patients.

Standard 2. All standards and recommendations should be followed for post-operative care.
**Pregnancy Termination by Medical Procedure**

**Principle:** Medical induction is an effective pregnancy termination method. Adequate counseling and follow-up care will further enhance its safety and acceptability.

The standards and recommendations laid down in the subchapters on surgical abortion pre and post operative procedures also apply for medical abortion, except for the administration of Rh immunoglobulin, where recommendations for the two methods differ.

**Standard 1.** The patient must be informed about the number of follow-up consultations the medical method requires (3 visits) and her consent must be documented:
- a) first visit to administer mifepristone
- b) second visit to administer prostaglandin, 36-48 hours after the first visit
- c) third visit to evaluate completion of the abortion, 14 days after the first visit

**Standard 2.** The patient must be informed about the efficacy, side effects and risks the method involves, especially excessive bleeding and teratogenicity associated with the medication to be used and about the fact that surgical abortion will have to be performed if the medical method fails.

**Standard 3.** The patient must be informed on how to use the medication and on possible complication symptoms.

**Recommendation 1:** Written instructions should be given to all patients.

**Standard 4.** The patient’s willingness to consent to surgical abortion if medical abortion fails must be documented.

**Standard 5.** The patient’s medical history must be documented, to rule out any conditions or ailments that might act as medical contraindications for medical abortion.

**Standard 6.** The facility must provide an emergency contact service on a 24-hour basis and must offer or assure referral for uterine aspiration if indicated.

**Standard 7.** Gestational age must be documented.

**Recommendation 2.** Ultrasoundography should be used to confirm and document gestational age when physical exam and LMP are substantially discordant.

**Option 1.** Ultrasoundography may be used routinely.

**Recommendation 3.** When mifepristone and oral misoprostol is used, the patient’s gestation should be no greater than 49 days since the last day of the latest menstruation.

**Recommendation 4.** When mifepristone and vaginal misoprostol is used, the patient’s gestation should be no greater than 63 days since the last day of the latest menstruation.

**Standard 8.** For medical termination of pregnancy under 9 weeks LMP, a 200mg dose of mifepristone combined with prostaglandin is recommended.

**Standard 9.** Vaginal misoprostol is a cost-efficient alternative to gemeprost termination of pregnancy.

**Standard 10.** The following regimens for medical termination of pregnancy are published:
- a) 200 mg oral mifepristone, followed 36-48 hours later by
  - 1 mg vaginal gemeprost
  - 800 µg vaginal misoprostol
  - 400 µg oral misoprostol up to 7 completed weeks.

**Standard 11.** Patient comfort level during the abortion procedure must be considered.

**Option 2.** Analgesic or other comfort agents may be used as needed unless there are contraindications.

**Standard 12.** Completion of the abortion must be documented by clinical means, by ultrasonography, or by hCG testing.

**Recommendation 5.** Ultrasoundography should be used to evaluate completion of the abortion when expected bleeding does not occur after medications.
Option 2. Ultrasonography may be used routinely.

Recommendation 6. Rh immune globulin must be offered when the prostaglandin is administered, in accordance with Rh Guidelines (see chapter on Rh testing and Rh immune globulin administration).

Standard 13. Ectopic pregnancy must be considered when:
   a) ultrasonography shows no intrauterine pregnancy or shows a suspicious adnexal mass;
   b) no preabortion ultrasonography has been performed, and there is no or minimal bleeding in response to medications.

DISCUSSION

Many patients in countries where this method is available (more than 30 countries, among which France, Sweden, Great Britain, and many other European countries, Israel, the United States, China, and others) prefer pharmacological methods of terminating early pregnancies rather than suction or curettage. Medical abortion has several advantages: it avoids surgery and anesthesia and offers women more active participation and control over the abortion process. The method also has certain disadvantages, since it is less effective than the surgical method (90-98% versus 99% or greater). It also takes longer and may require more office visits.

Extensive research has established the safety and efficacy of mifepristone combined with misoprostol for early pregnancy termination. However, medical methods are still evolving, and Investigators continue to explore various pharmacologic agents and dosing regimens, the length of gestation during which they can be used, and the ideal protocols for their use.

Mifepristone is administered orally. Original trials involved a 600 mg dose, but further research indicates that 200 mg provides comparable overall efficacy. Information is also evolving on the types, doses, and routes of administration of the prostaglandin agents used in medical abortion regimens. Highly effective agents used in early European regimens included gemeprost and sulprostone, although the latter was discontinued due to adverse cardiovascular effects. Recently, misoprostol has been defined as the favored agent because it is efficacious, cheap, and stable without refrigeration, and already FDA-approved for other indications. Data suggest that vaginal misoprostol is more effective and associated with fewer gastrointestinal side effects, than oral misoprostol, although efficacy using either route appears comparable at very early gestational ages.

The effectiveness of mifepristone declines with increasing gestational age. Whereas the major U.S. medical abortion trials used transvaginal ultrasonography routinely for gestational age assessment and follow-up, the extensive French experience relied more on clinical evaluation and hCG monitoring, reserving ultrasonography for cases of uncertain dating or outcome. Ultrasonography avoids underestimation of gestational age, helps confirm complete abortion, and assists in the diagnosis of ectopic pregnancy. However, no randomized trials have been performed to assess the effects of ultrasonography or clinical evaluation on medical abortion outcomes.

These standards and recommendations include remarks on gestational age limits because efficacy rates have been shown to drop significantly beyond those limits.

Pharmacological induction of abortion provides an important alternative to surgical abortion in some circumstances. For example, medical methods may succeed when congenital uterine anomalies or fibroids limit surgical access to the gestational sac. Use of prostaglandin agents such as misoprostol may also avoid surgery in cases of incomplete spontaneous abortion.

REFERENCES

**ANESTHESIA**

**Principle:** The use of anesthesia and/or analgesia can minimize pain and anxiety in abortion procedures but has certain risks in addition to its benefits.

**Definitions**

The following degrees of anesthesia will be defined:

1. **Local Anesthesia.** Elimination or reduction of sensation, especially pain, in one part of the body by topical application or local injection of a drug. In the context of abortion practice, this almost always signifies paracervical block.

2. ** Conscious Sedation.** A minimally depressed level of consciousness that retains the patient’s ability to maintain a patent airway independently and continuously, to be easily aroused, and to respond appropriately to physical stimuli and verbal commands.

3. **Deep Sedation.** A controlled state of depressed consciousness from which the patient is not easily aroused. This may be accompanied by a partial or complete loss of protective reflexes, including inability to maintain a patent airway independently and/or to respond purposefully to physical stimulation or verbal command. Deep sedation can result from sedative and analgesic administration intended to produce only conscious sedation.

4. **General Anesthesia.** A controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to maintain an airway independently and to respond purposefully to physical stimulation or verbal command.

The official American Society of Anesthesiologists classification of the physical status of patients is as follows:

- **P-1** – A patient with normal health.
- **P-2** – A patient with mild systemic disease.
- **P-3** – A patient with severe systemic disease.
- **P-4** – A patient with severe systemic disease that is a constant threat to life.
- **P-5** – A moribund patient who is not expected to survive without the operation.
- **P-6** – A declared brain-dead patient whose organs are being removed for donor purposes.

**Personnel and Monitoring**

**Standard 1.** Aspiration is safer when performed under local anesthesia than when performed under general anesthesia.

**Recommendation 1.** General anesthesia should be available at the patient’s request.

**Standard 2.** Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthesia, paracervical anesthesia and monitored anesthesia care.

**Standard 3.** The practitioner administering general anesthesia or deep sedation must be accredited in accordance with legal requirements in force.

**Standard 4.** The practitioner administering general anesthesia or deep sedation must not be the practitioner performing the abortion.

**Standard 5.** For general anesthesia and deep sedation, the patient’s oxygenation, ventilation, circulation and temperature must be continually monitored.

**Recommendation 1.** When deep sedation and/or general anesthesia are used, IV access should be maintained.

**Standard 6.** When conscious sedation, deep sedation, or general anesthesia are used, monitoring of the patient’s level of consciousness must be documented.

**Standard 7.** When conscious sedation or local anesthesia is used, the practitioner responsible for the treatment of the patient and/or the administration of drugs for sedation must be appropriately trained.

**Standard 8.** When conscious sedation is used, a person other than the physician performing the termination of pregnancy procedure, trained to monitor appropriate physiological parameters, must be present.
Recommendation 1. During conscious sedation the patient should be checked frequently for verbal responses.

Standard 9. The personnel administering conscious sedation must recognize that conscious sedation may lead to deep sedation with hypoventilation and be prepared to provide respiratory support (see chapter on Emergency Procedures).

Standard 10. The supervising practitioner must be immediately available when conscious sedation is administered.

Standard 11. When conscious sedation is used, monitoring must be of a degree which can be expected to detect the respiratory, cardiovascular, or neurological effects of the drugs being used.

Option 1. Pulse oximetry may be used to enhance this monitoring.

Recommendation 1. During conscious sedation or local anesthesia, IV access should be maintained for patients in ASA P-3, P-4 and P-5.

Standard 12. The use of nitrogen protoxide/oxygen must follow guidelines for at least conscious sedation.

Standard 13. Equipment for the delivery of N₂O/O₂ must:
  g) provide a concentration of N₂O of no more than 70% inspired;
  h) provide a maximum of 100% and minimum of 30% O₂ concentrations;
  i) be outfitted with an O₂ analyzer;
  j) be checked and calibrated regularly.

Standard 14. When conscious sedation, deep sedation, or general anesthesia is used, there must be documentation that the patient has been warned of possible transient mental impairment.

**Facilities and Equipment**

See chapter on Emergency Procedures.

**Discussion**

On the use of anesthesia in general. All medication used in anesthesia have the potential for serious risk. This risk may be reduced to a minimum by adherence to established practice guidelines. Standards developed by other organizations concern themselves with anesthesia delivered primarily in hospital settings and to patients varying widely in age and general health. Abortion patients, however, are younger and rarely have significant health problems. Nonetheless, anesthesia complications are an increasing proportion of total abortion morbidity and mortality (see ref. 10).

The promulgation of guidelines for the delivery and monitoring of anesthesia care issued by organizations such as the American Society of Anesthesiologists (ASA), the American Dental Society of Anesthesiologists (ADSA), American Society of Gastrointestinal Endoscopists and others have clarified many of the issues related to anesthesia care. Whether it be local anesthesia, intravenous sedation, or general inhalation analgesia/anesthesia, it is the degree of CNS depression rather than any type of modality per se that is the basis for establishment of NAF guidelines. Levels of sedation are not completely distinct, but merge one with the next - each level of deeper sedation requires an increased level of care and monitoring. These levels of sedation are defined elsewhere.

These standards specifically address the use of conventional anesthesia. It is recognized that patient comfort and reduced anxiety are not dependent only on pharmacologic measures, but are significantly affected by patient counseling and by a supportive staff. It is also recognized that there is a wide range of alternative modalities (such as acupuncture, yoga, hypnosis) that are helpful for many patients. The focus of these standards, however, is on the monitoring necessary for the safe and effective use of pharmacologic methods generally used in outpatient abortion facilities.

On the use of pulse-oximetry. There have been no trials on young women undergoing abortion who only rarely have respiratory or hemodynamic impairment. Given the low risk of morbidity and mortality associated with this procedure it is unlikely that there will be studies large enough to assess pulse oximetry on the basis of outcomes. The major correlation with prolonged oxygen desaturation is advancing age and cardiovascular function deficits.

On the need for qualified anesthesia personnel to be present in the room. Because of the rapid changes in patient status during anesthesia, qualified anesthesia personnel shall be continuously present to monitor the patient and provide anesthesia care. In the event there is a direct known hazard, or in the event that an emergency requires the temporary absence of the person primarily
responsible for the anesthetic, the best judgment of the anesthesiologist will be exercised in comparing the emergency with the anesthetized patient’s condition and in the selection of the person left responsible for the anesthetic during the temporary absence.

REFERENCES

Evaluation of evacuated uterine contents

**Principle:** Complete removal and identification of products of conception help prevent complications of abortion.

**Standard 1.** Evacuated uterine contents must be examined before the woman leaves the facility.

- **Option 1.** In first trimester terminations, flotation of tissue with backlighting should be used to identify products of conception, including gestational sac.
- **Option 2.** Pathological examination of evacuated uterine contents may be performed.

**Standard 2.** When insufficient tissue or incomplete products of conception are obtained, the patient must be reevaluated.

- **Recommendation 1.** When insufficient tissue or incomplete products of conception are obtained, follow-up pelvic ultrasonographic examination should be considered.
- **Recommendation 2.** When insufficient tissue or incomplete products of conception are obtained, resuctioning should be considered.

**Standard 3.** If insufficient tissue is present after complete uterine evacuation, a protocol to rule out ectopic pregnancy must be followed, and the patient must be informed of symptoms and dangers of ectopic pregnancy.

- **Recommendation 3.** If the uterine cavity is determined to be empty, serial quantitative hCG or a pregnancy test should be measured. The pregnancy test is positive at 50 mIU of β-hCG.

**Standard 4.** The patient must not be released from follow-up care until the diagnosis of ectopic pregnancy has been excluded or an appropriate referral has been documented.

- **Recommendation 4.** A 48-hour post-procedure serum quantitative hCG test should be done. If there is a decrease of 50% or more, no further ectopic follow up is necessary.
- **Recommendation 5.** If 48-hour post-procedure serum quantitative hCG testing shows no change, or a subnormal increase in value, ectopic pregnancy evaluation and definitive treatment should be instituted and documented, or a referral made and documented.
- **Recommendation 6.** If the above are not identified, the following should be considered: ultrasonographic evaluation, intravenous oxytocin administration, repeat uterine exploration.
- **Recommendation 7.** The clinician should continue care of the patient until completion of the abortion has been determined.

- **Option 4.** Intraoperative ultrasonographic guidance may be used to facilitate uterine exploration.
Complications

EMERGENCY PROCEDURES

**Principle:** Optimal management of abortion emergencies reduces morbidity.

**Standard 1.** Functioning equipment and current medication must be available on site to handle medical emergencies and must include: an \( \text{O}_2 \) delivery system, oral airways, uterotonics and adrenaline.

**Recommendation 1.** Facilities should have a specified area for emergency equipment to include oxygen, medications, and supplies.

**Recommendation 2.** Protocols should be in place to ensure ongoing training of staff in the use of emergency equipment, the management of emergencies and the indications for emergency transport.

**Recommendation 3.** Medications should include iv crystalloids, and, in clinics using iv sedation, narcotic antagonists.

**Standard 2.** When abortion procedures are being performed, a current CPR-certified staff member must be available on-site for emergency care.

**Recommendation 4.** All medical staff should have CPR training.

**Option 1.** The following treatment may be used:

<table>
<thead>
<tr>
<th>Type of Emergency</th>
<th>Prevention, Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaphylaxis</td>
<td>Corticosteroids, adrenaline</td>
</tr>
<tr>
<td>Allergic reactions</td>
<td>Hemisuccinate hydrocortisone, adrenaline, Romergan, calcium</td>
</tr>
<tr>
<td>Hemorrhage, shock</td>
<td>IV crystalloid (normal saline or Ringer’s Lactate), uterotonics</td>
</tr>
<tr>
<td>Respiratory arrest</td>
<td>Oxygen, suction, Ruben ambu bag, Guedel pipe, intubation</td>
</tr>
<tr>
<td>Cardiac arrest</td>
<td>CPR</td>
</tr>
<tr>
<td>Seizure</td>
<td>Diazepam, midazolam</td>
</tr>
<tr>
<td>Respiratory depression</td>
<td>Pulse oximeter</td>
</tr>
</tbody>
</table>
**BLEEDING**

**Principle:** One of the most serious complications of an abortion procedure is hemorrhage. Early recognition of the source of bleeding can reduce morbidity and mortality.

**Pre-operative bleeding**

Recommendation 1. An ectopic pregnancy or spontaneous abortion should be considered.

**Intra-operative bleeding**

Standard 1. When there is excessive bleeding, the surgeon must institute measures to identify the etiology of the bleeding and control it.

Recommendation 2. The surgeon should consider incomplete procedure, atony, fibroids, lacerations, perforations, placenta accreta, cervical or cornual pregnancy, coagulopathy.

Option 1. Ultrasonography may be useful to determine whether the uterus is empty and to detect occult bleeding.

Option 2. When a cervical bleeding source is suspected, hemostasis may be achieved by compressing the cervix at the lateral fornices with ring forceps or placing a suture.

Option 3. When atony is suspected, uterine massage and uterotonics may be useful (ergometrine intracervical or im, oxytocin intracervical, im or iv); prostaglandins (intracervical or im).

Option 4. When coagulopathy is suspected, blood products or integral fresh blood may be administered with close monitoring of the coagulation—fluid balance.

Recommendation 3. Uterotones and vasoconstrictors administered during the operation may work as a prevention method to reduce the loss of blood during the procedure.

Recommendation 4. Oxytocics are effective in reducing the loss of blood during the procedure.

Standard 2. When excessive bleeding continues, the following measures should be instituted:

- a) monitor and document blood pressure, pulse, clinical status uterotonics;
- b) establish IV access;
- c) initiate appropriate volume replacement;
- d) prepare for transfer to a hospital facility if necessary.

Standard 3. The patient must be transferred to a hospital facility when the bleeding does not respond to therapeutic measures or when the patient is hemodynamically unstable.

**Delayed bleeding**

Standard 4. When a patient reports excessive bleeding (saturation of more than one pad per hour for more than 3 hours) after discharge from the abortion facility, she must be evaluated by that facility or an emergency contact service.

**Discussion**

Excessive bleeding in the pre-operative and in the post-operative period is almost always due to uterine atony, often complicated by incomplete emptying of the uterus. Therefore, the most important initial efforts should be directed at assuring complete evacuation of the uterus and at increasing uterine tone through uterotonics.

Problems arise when bleeding is ignored or its severity underestimated. Clinicians must always remember to do the simple things when confronted with a developing bleeding problem: continue assessment of the blood loss, measure and record blood pressure and pulse frequently, assure intravenous access.
When bleeding continues after assurance of complete uterine emptying and when there are no visible cervical or vaginal lacerations, the clinician must consider other complications such as perforation, coagulopathy, or placenta accreta.

REFERENCES

**Principle:** Uterine perforation is a complication of abortion that can lead to significant morbidity.

| Standard 1. | If, in the clinician’s judgment, an instrument passes farther than expected, then uterine perforation must be considered. |
| Recommendation 1. | If uterine perforation is suspected, laparoscopy is the recommended method of investigation for diagnosis. |
| Standard 2. | If a perforation occurs, even if the patient is asymptomatic, close observation and follow-up must be done. |
| Option 1. | The patient may be transferred to a hospital or held under surveillance for 24-48 hours in in-patient care. |
| Option 2. | Antibiotic coverage may be instituted. |
| Option 3. | Uterotonics may be administered. |
| Option 4. | If a perforation occurs and the pregnancy has not been disrupted, the completion of the procedure may occur immediately, after a delay, or by referral to another provider that can deal with complications. |
| Recommendation 2. | If a perforation occurs and the pregnancy has been disrupted, the abortion should be completed as soon as feasible. |
| Option 5. | The uterine evacuation may be completed under direct ultrasonography. |
| Option 6. | The abortion may be completed under laparoscopic visualization. |
| Option 7. | Re-identification of the uterine cavity may be performed and the abortion completed. |
| Standard 3. | The patient must be hospitalized for definitive care if: |
| a) | intra-abdominal viscera are detected in the uterine cavity, cervix, vagina, suction tubing, or on tissue examination; |
| b) | fetal parts are detected in the abdominal cavity; |
| c) | expanding intra-abdominal hematoma is detected; or |
| d) | hemodynamic instability is present. |
| Standard 4. | When uterine perforation is suspected and the cannula has been inserted into the uterine cavity, suction must be released immediately before the cannula is withdrawn. |

**DISCUSSION**

Perforations may be difficult to identify correctly. When a perforation is suspected, it is safest to proceed as if there has been a perforation until that possibility has been excluded. Most perforations are midline and/or fundal in location, especially in the first trimester. Perforations are often occult and usually do not present early symptoms. Lateral perforations are more likely to damage uterine vascularity. Perforations are more likely to occur in the following situations:

a) marked uterine anteflexion or retroflexion;

b) cervical internal os stenosis requiring more force to dilate;

c) uterine abnormalities;

d) difficult and prolonged uterine evacuation.

Uterine perforation is likely if:

a) an instrument extends without resistance further into the uterine cavity than expected;

b) the patient experiences more than the expected amount of pain during the procedure;

c) the patient experiences unusual and persistent pain in the immediate recovery period.
Several factors may help prevent perforations:

a) straightening the axis of the uterus;
b) cervical pharmacological preparation
c) using laminaria;
d) lubrication of dilators;
e) accurate assessment of gestational age; and
f) accurate assessment of uterine position.

REFERENCES

Postoperative Care

**Principle:** Most serious abortion complications are detectable in the immediate postoperative period. Appropriate and accessible follow-up care is essential to patients’ well being.

---

**Standard 1.** Completion of the abortion must be verified and documented, in accordance with guidelines on the evaluation of evacuated uterine contents.

**Recommendation** Rh immune globulin must be offered to all non-immunized Rh negative women after pregnancy termination, irrespective of the abortion method and gestational age, in accordance with Rh guidelines.

**Standard 3.** All patients must be observed for at least one hour after the procedure is completed, if there are no complications.

**Standard 4.** Until medically stable, all patients must be observed during the recovery period by a physician or a nurse trained in postoperative care.

**Standard 5.** The following criteria must be documented prior to discharge: the patient must be ambulatory with a stable blood pressure and pulse, and bleeding and pain must be controlled.

**Standard 6.** The patient must be given instructions outlining the signs and symptoms of postoperative complications.

**Recommendation 1.** After an abortion, all patients should receive a written document on possible symptoms and a list of facilities she can go to in case of emergency.

**Standard 7.** When leaving the facility, all patients must be given a medical document providing the needed information on the procedure for any other physician to be able to treat any complications.

**Standard 8.** The healthcare facility must provide an emergency contact service on a 24-hour basis and must assure physician referral if indicated.

**Option 1.** A feedback form may be sent home with the patient to help gather medical, psychological, and social information that may have affected her post-operative evolution.

**Standard 9.** All patients must be called in for a follow up visit 2 weeks after the procedure.
## Post Abortion Contraception

**Principle:** Contraceptive counseling and provision after an abortion helps reduce significantly the incidence of repeat abortion.

<table>
<thead>
<tr>
<th>Standard 1.</th>
<th>Before leaving the facility, all patients must be informed on existing birth control options and offered the selected method.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation 1.</strong></td>
<td>The selected method should be used right after the abortion.</td>
</tr>
<tr>
<td>Standard 2.</td>
<td>If there are no contra indications, IUD insertion right after the pregnancy is terminated is can safe and effective.</td>
</tr>
<tr>
<td>Standard 3.</td>
<td>If there are no contra indications, surgical sterilization can be performed safely during the pregnancy termination. However, such a procedure performed at this time is often associated with high rates of failure, as well as the patient’s regret.</td>
</tr>
</tbody>
</table>
Fetal Tissue Disposal

**Principle:** The improper disposal of tissue can lead to spread of infectious disease. Because of the possible infectious nature of tissue removed during the abortion procedure, guidelines for proper fetal tissue disposal are established.

**Standard 1.** All surgically removed tissue must be considered biohazardous and be disposed of in accordance with applicable regulations. A proper protocol for tissue disposal must be in place.

**Recommendation 1.** There should be medically adequate protection of personnel during all moments of possible contact with biological fluids.

**Recommendation 2.** There should be proper handling and storage of tissue using either:

a) biohazard disposal service;
b) licensed pathology laboratory.

**DISCUSSION**

Tissues extracted during the termination of pregnancy are considered anatomical pathology waste and anatomical parts. Norms regarding the definition, classification, collection at the site, packaging, temporary storage, transport and final disposal of these waste are regulated by the Order of the Minister of Health and Family No. 219 of 1.04.2002. This Order regulates also the modalities of evidence keeping and recording of data regarding medical waste, staff training and responsibilities regarding waste management.

In addition to the above, fetal tissues extracted during the termination of pregnancy must be treated with respect due to their lost potential of development into a human being. Therefore, possible wishes from the parents should be taken into consideration, especially at later gestational ages when distinct fetal parts may be identified.
Instrument Processing

Standard 1. All instruments must be processed in accordance with healthcare regulations in force, to include the following steps:
   a) mechanic removal of tissue residues
   b) decontamination
   c) high-level disinfection or
   d) sterilization

Standard 2. Metal instruments must be properly sterilized in the autoclave, in accordance with the specific regulations in force.

Standard 3. The manual vacuum aspiration syringe need not be sterile, since it does not come in direct contact with the patient.

Recommendation 1. High-level sterilization of the syringe may however be considered:
   a) sterilization by 10-hour submergence in glutaraldehyde solution or in another solution having similar properties, to be prepared according to the instructions of the producer; the syringe is then rinsed with sterile water.
   b) High-level disinfection by 20-minute submergence in glutaraldehyde solution or in 0.1% chloramine solution (or in another solution having similar properties, to be prepared according to the instructions of the producer). The syringe is then rinsed with sterile water and left to dry on a towel or in the open air.

Standard 4. Uterine aspiration cannulae sterilized with ethylene oxide stay sterilized if the package is intact.

Recommendation 2. Uterine aspiration cannulae are single-use: they must be treated and disposed of as any other infectious waste.

Standard 5. Sterilization equipment must be kept to optimum functioning parameters and checked regularly in accordance with the specific regulations in force.

Standard 6. The effectiveness of sterilization must be regularly assessed and documented, in accordance with specific regulations in force.

Discussion

These remarks are based on the “best practices” regarding the repeated use of manual uterine vacuum aspiration syringe and can be used as a starting point for laying down local protocols on the maintenance of vacuum aspiration syringes. Other chemical substances apart from those mentioned above might deteriorate the instruments.
References

Besides the references mentioned under various chapters, concerning the discussions specific of those chapters, the following sources provide information and scientific evidence to validate the standards and recommendations included in this document.


35. Dixon M. Assertions about patient information are not supported [letter; comment]. BMJ. 1995;311:946-


111. RCGP & RCOG. Induced abortion operations and their early sequelae. Joint study of the Royal College of General Practitioners and the Royal College of Obstetricians and Gynaecologists. Journal of the Royal College of General Practitioners. 1 985:35:1 75-80.


116. Rookus MA and van Leeuwen FE. Induced abortion and risk of breast cancer: reporting (recall) bias in a Dutch case-control study. Journal of the National Cancer Institute 1 996;88: 1759-1784.


128. Thong K J and Baird DT. An open study comparing two regimens of gemeprost for the termination of pregnancy in the second trimester. Acta Obstetrician et Gynecologica Scandinavica 1998;77


