SERVICE DELIVERY STANDARDS AND GUIDELINES
FOR HIGH-QUALITY SAFE UTERINE EVACUATION
AND POSTABORTION CARE

Department of Health
Government of Punjab, Pakistan

April 2015
Cover Inside
NOTIFICATION

Pursuant to the recommendations of Punjab Reproductive Health Technology Assessment Committee (PRHTAC), the Competent Authority has been pleased to approve the Service Delivery Standards and Guidelines for High Quality Safe Uterine Evacuation and Post-Abortion Care, for implementation and further dissemination to the relevant stakeholders, with immediate effect.

2. The approved Standards and Guidelines for High Quality Safe Uterine Evacuation and Post-Abortion Care are attached herewith.

SECRETARY
TO GOVERNMENT OF THE PUNJAB
HEALTH DEPARTMENT

NO EVEN, Dated Lahore, the 15th April, 2015.

Copy of the above is forwarded for information & necessary action to the:-

1. Advisor to Chief Minister, Punjab on Health.
2. Vice Chancellor, University of Health Sciences, Lahore.
3. Vice Chancellor, King Edward Medical University, Lahore.
4. Additional Secretary (Staff)/ PSO to Chief Secretary, Punjab.
5. Director General, Health Services, Punjab, Lahore.
6. Director General Public Relations, Punjab, Lahore.
7. Programme Director, Policy & Strategic Planning Unit (PSPU), Lahore.
8. All the Principals of Autonomous Medical Institutions in Punjab.
9. All the Heads of Special Health Institutions in Punjab.
10. All the Executive District Officers (Health) in Punjab.
11. All the Medical Superintendents of Teaching and DHQW Hospitals in Punjab.
12. Additional Secretary / P.S.O. to Secretary to Government of the Punjab, Health Department.
13. P.S.O. to Additional Chief Secretary, Punjab.
15. P.S. to Special Secretary to Government of the Punjab, Health Department.
16. P.A. to Additional Secretary (Establishment), (Administration) and (Technical), Health Department.

[Signature]

(DR. NASIR MAHMOOD SHAKIR)
DEPUTY SECRETARY (ME)
FOREWORD

Health is one of the most important social sectors, and healthy performance indicators in the health sector are among the major positive contributing factors in the overall economy of the country. Since devolution of Ministry of Health in 2011, the Government of Punjab, through the Department of Health and under its umbrella the Policy and Strategic Planning Unit has vigorously intensified its efforts to systematically improve the effectiveness of the health care delivery system especially the maternal health care at primary and secondary levels and practiced a comprehensive approach to all components of reproductive health (RH). The efforts are bearing results and we have seen a gradual decline in maternal mortality, but a lot more is to be done in this regard.

It is unfortunate that six percent of maternal mortality in our country is associated with unsafe abortions which are one of the most easily preventable among all the causes of maternal mortality. Therefore, providing high-quality, safe uterine evacuation/postabortion care is one of the key elements of our reproductive health strategy.

While guidelines pertaining to different components of maternal health care are in existence, there is a strong felt need among service providers and health managers for updated and comprehensive guidelines on safe uterine evacuation/postabortion care. Recognizing this need, Department of Health, Punjab tasked Ipas and partners for technical assistance and developing Provincial Service Delivery Standards and Guidelines for WHO recommended methods for Safe Uterine Evacuation/Postabortion Care. The guidelines have been developed to provide health workers with prerequisites and guidance for reference during service delivery, improving service quality as well as to provide health administrators/managers with standards to evaluate quality of care as well as checklists for monitoring and supervision.

We, at the Department of Health, Punjab, consider these Service Delivery Guidelines for the provision of high-quality safe uterine evacuation/postabortion care as a dynamic document that needs continuous updating and improvement to keep pace with changes in medical technology and global best practices. We envision that these guidelines would be a resource for not only the healthcare providers but will also be useful for policymakers & program managers in implementing effective and high quality services for safe uterine evacuation/postabortion care at every level of health care service delivery.

Secretary
Government of Punjab
Health Department
Lahore

Date: April 15, 2015
ACKNOWLEDGMENTS

Department of Health, Government of Punjab would like to express its gratitude to the members of Punjab Reproductive Health Technology Assessment Committee (PRHTAC) and Pakistan Alliance for Postabortion Care (PAPAC) for their invaluable support throughout the development of this document.

We are grateful to Ipas staff- both in Pakistan and the United States- for their technical assistance in drafting this document.

Since the Guidelines would not have been possible without the dedicated and painstaking work of the reviewers, apart from the authors and contributors, we are grateful to the several experts in the field with extensive experience in reproductive health especially in Postabortion Care for providing their valuable inputs particularly acknowledging the valuable technical contributions of Dr. Zahid Pervez Director General Health Services, Punjab; Dr. Tanveer Ahmad Ex-Director General Health Services; Dr. Zafar Ikram, Provincial Coordinator MNCH program; Dr. Javed Umar Provincial Coordinator National Program for Family Planning and Primary Health Care; Dr. Syeda Zahida Sarwar Additional Director (Technical) Policy and Strategic Planning Unit, Professor Rubina Sarmad Institute of Public Health, Dr. Naila Akhtar Director Technical Population Welfare Department, Dr. Babar Alam Provincial MNCH officer WHO Punjab (now provincial coordinator UNFPA Punjab); Dr. Jameel Ahmad Provincial Coordinator UNFPA Punjab; Dr. Tahir Manzoor Health specialist UNICEF; Dr. Noreen Zafar Obgyn Consultant/Provincial Representative National Committee for Maternal and Neonatal Health, Professor Rubina Sohail Obgyn Consultant/Head of Department Services Hospital Lahore and Dr. Ghulam Shabbir Awan Country Manager Ipas Pakistan.

We owe special thanks to the Ipas Pakistan, World Health Organization and UNFPA, Punjab for their facilitation and cooperation during the endorsement process of the document from the stakeholders.
LIST OF ACRONYMS

D&C - Dilatation and Curettage
HIV - Human Immunodeficiency Virus
IUD - Intrauterine Device
IV - Intravenous
LMP - Last Menstrual Period
MVA - Manual Vacuum Aspirator
PAC - Postabortion Care
STIs - Sexually Transmitted Infections
UE - Uterine Evacuation
UNFPA - United Nations Population Fund
WHO - World Health Organization
INTRODUCTION:

Each year, according to the World Health Organization (WHO), 42 million women have unsafe abortions. The failure to meet women’s needs for safe abortion services results in nearly 47,000 deaths and disabilities for an additional five million women annually. These deaths and disabilities are almost entirely avoidable: contraception can greatly reduce the need for abortion, and when properly performed, abortion is extremely safe. As such these preventable deaths represent enormous shortcomings in the delivery of essential health and contraceptive services and the failure of laws, policies and societies to respond to women’s needs. Vulnerable women are most affected by unsafe abortion – poor rural women, women in refugee and displaced settings, women who have experienced violence, and women with low levels of education. Unsafe abortion constitutes a global public health crisis, a social injustice and a violation of women’s human rights and dignity.

Effectively addressing the provision of high-quality, safe, accessible uterine evacuation care is essential to ensuring fewer maternal deaths and better reproductive health outcomes for women and girls in Pakistan. High levels of unmet need for contraception and low levels of contraceptive use put women at particular risk for unintended pregnancies. Given high levels of stigma, service cost barriers and the lack of clarity in interpreting law by both women and healthcare providers, many women experiencing an unintended pregnancy in Pakistan resort to clandestine and unsafe abortion procedures. A national study released by the Population Council in 2013 found that an estimated 696,000 women were treated for postabortion complications in healthcare facilities across the country. The primary reason for abortion is poor socio economic status.

Following a 1989 decision of the Pakistan Supreme Court, which held that part of the Penal Code of 1860 dealing with offences against the human body was invalid because it was repugnant to the injunctions of Islam Pakistan, revised its abortion law. The revised law, now in conjunction with Islamic principles came into effect provisionally in 1990 and became permanent law in 1997. Abortion is legal in Pakistan for expanded indications in early pregnancy, generally accepted by Islamic legal scholars as up to 120 days of pregnancy, when the abortion is caused in good faith to save the woman’s life and to provide “necessary treatment”. After 120 days of pregnancy, abortion is legal only to save a woman’s life.

Clearly, serious complications and morbidity from unsafe abortion have a substantial impact on women’s health, on their families, on the communities to which they belong, and on the healthcare system. Governments at every level must strive to prevent unintended pregnancies and to mainstream and institutionalize safe uterine evacuation care in the health systems within a supportive policy environment, so that women can safely exercise their sexual and reproductive rights.

The service delivery standards and guidelines in this document aim to set the standard of care and provide guidance to healthcare workers on the provision of high-quality, comprehensive uterine evacuation care. There are other important documents supporting healthcare delivery, include
clinical protocols and training curricula. The standards and guidelines in this document should be individualized to each woman, with emphasis on her clinical status and the specific method of uterine evacuation to be used, while considering each woman's preferences for care. The target audience for this guidance is policymakers, program managers and healthcare providers in the province of Punjab.

SERVICE DELIVERY STANDARDS AND GUIDELINES:

1. Uterine Evacuation Care Methods

Standard 1: WHO-recommended methods to be used for first trimester uterine evacuation care are vacuum aspiration (electric or manual) and medical methods (misoprostol).

Guidelines:
1. Healthcare providers need to take the following factors into considering which uterine evacuation method to use:
   - women’s personal preferences
   - clinical condition
   - uterine size/gestational age
   - availability of equipment, supplies and skilled staff and
   - Currently available scientific and medical evidence.
2. Sharp curettage is not recommended because it is less safe than other methods.
3. The use of medical methods of uterine evacuation requires the back-up of vacuum aspiration, either on-site or through referral to another healthcare facility in case of failed or incomplete abortion.
4. Providers should explain the difference between all available options and help the woman explore which option is best for her.
5. Providers should discuss the possible benefits, risks and what to expect with each method.

2. Healthcare Providers (See Appendix C)

Standard 2: Uterine evacuation care can be safely provided by any properly trained health care provider, including a range of non-physician, midlevel providers who are trained to provide basic clinical procedures related to reproductive health, including bimanual pelvic examination to determine the age of pregnancy and positioning of the uterus, uterine sounding and other transcervical procedures.

3. Provider Skills and Performance

Standard 3: Healthcare workers must be trained, technically competent and use appropriate clinical technologies in order to provide high-quality uterine evacuation care.
Standard 4: Uterine evacuation care training programs (both pre- and in-service) must be competency based (a minimum of 5 supervised cases is suggested), and conducted in facilities that have sufficient patient flow to provide all trainees with the requisite supervised practice, including practice in managing abortion complications. Sites with low case flow may want to use other facilities for clinical practice to ensure adequate practice for trainees.

Guidelines:
1. Training programs should use a variety of teaching methodologies and should address both technical and clinical skills. All staff should receive periodic updating in these skills.
2. Training should address healthcare provider attitudes and beliefs about sexual and reproductive health, including abortion, safeguarding privacy and confidentiality, treating all women with dignity and respect, and attending the special needs of the rape survivors and those who may be vulnerable for other health or socioeconomic reasons.
3. In addition to skills training, participating in values clarification exercises can help providers differentiate their own personal beliefs and attitudes from the needs of women seeking uterine evacuation care.
4. Training curricula may vary in content, as well as length of training depending on the skills the healthcare provider has on entry into the training program.
5. Trained providers need support following training to put skills into practice, and need to work in an environment that ensures adequate drugs, equipment, infrastructure, remuneration and professional development to support the provision of safe uterine evacuation care services.

Standard 5: The service system must ensure that trained providers receive supportive and facilitative supervision and oversight to ensure that service delivery meets norms and standards, satisfies clients’ needs and respects their rights. An important tool for supervision can be a checklist of items that supervisors are to monitor regularly.

Standard 6: Where certification of uterine evacuation care providers is required, the purpose must be to ensure that providers are clinically competent and meet the essential criteria for safe provision of care. Certification and licensing requirements must not be used to exclude categories of health professionals, or impose excessive requirements for sophisticated equipment, infrastructure or staff that are not essential to the provision of safe uterine evacuation care and would unnecessarily restrict access.

4. Healthcare Levels (see Appendix A)

Standard 7: Properly trained community-based healthcare providers (including skilled birth attendants and all midlevel cadres) play an important role in helping women avoid unintended pregnancy, through providing contraceptive information, counseling and methods, and informing women and men about the risks of unsafe abortion. They can also provide women with misoprostol for uterine evacuation care; inform women about how and where to obtain safe, vacuum aspiration; and can refer women with complications from unsafe abortion to emergency care. Lady Health Workers have a key role in providing counseling and family planning services, and making referrals to the health facilities when required.
Standard 8: Both vacuum aspiration and medical methods may be considered at the primary-care level, but where capacity to provide high-quality uterine evacuation care services does not exist, referral to services at higher levels is essential.

Standard 9: District hospitals should offer all primary-care level uterine evacuation care services on an outpatient basis, and be equipped and prepared to manage the complications of abortion; they should therefore be prepared to accept abortion-related referrals from healthcare facilities throughout the catchment area.

Standard 10: Secondary and tertiary-care level hospitals should have staff and facility capacity to perform uterine evacuation care in all circumstances permitted by law and to manage all complications of unsafe abortion.

Standard 11: The provision of uterine evacuation care at teaching hospitals is particularly important to ensure that relevant cadres of health professionals develop competence in safe uterine evacuation service delivery; MVA during clinical training rotations.

Standard 12: Most of the supplies, equipment and infrastructure needed for uterine evacuation care are same as those needed for gynecological care and for clinical contraception. A detailed list of equipment and supplies for the provision of MVA and medical methods is included in Appendix B. These instruments and medications must be routinely included in the planning, budget procurement, and distribution and management systems.

Standard 13: Health facility budgets must include sufficient funds for the following types of costs (equipment, medications and supplies required to provide safe uterine evacuation care; staff time; training programs and supervisions; infrastructure upgrades; record-keeping; monitoring and evaluation).

Standard 14: A well-functioning referral system must be in place for the provision of safe uterine evacuation care services. All health centers, clinics or hospital staff must be able to direct women to appropriate services if they are not available on site.

Guidelines:
1. Referral and transport arrangements among various levels of the healthcare system are necessary to ensure that:
   a. Women who need services can obtain them in a timely manner and;
   b. Women who need care for complications of unsafe abortion receive treatment promptly and properly.

5. Infection Prevention

Standard 15: All clinical and support staff that provide uterine evacuation care services must understand and apply standard precautions (also known as universal precautions) for infection prevention and control, for both their own protection and that of their clients.
**Guidelines:**

1. Standard precautions should be applied in all situations where healthcare workers anticipate contact with blood, secretions, excretions and other body fluids, non-intact skin, and mucous membranes.
2. The essential elements of infection prevention are hand washing, use of personal protective barriers, proper handling and processing of sharp instruments and items, proper handling and processing of instruments and materials, use of aseptic technique, environmental cleanliness and proper disposal of infectious waste.
3. During surgical procedures and when handling sterile instruments, it is essential to use a no-touch technique.
4. All infectious waste should be incinerated, or at the least, secured, contained and disposed of properly.
5. If a healthcare worker is exposed to blood or other body fluids, follow appropriate procedures for the management of occupational exposures as indicated in hospital waste management and infection prevention guidelines being implemented in Punjab.

**6. Community Linkages**

**Standard 16:** Health systems will make safe uterine evacuation care available in communities where women live and work.

**Standard 17:** Healthcare providers should be aware of their role in the community as role models and leaders, while working in partnership with community members to advance women’s health. Lady Health Workers in areas where they are appointed or working or where the services of Lady Health workers are utilized should play important role for building linkages between communities and providers. Partnerships between health facility staff and communities play a key role in reducing maternal mortality and morbidity from unsafe abortion.

**Standard 18:** Health systems should partner closely with communities to help ensure that all women with abortion-related emergencies can recognize signs and symptoms and access care in a timely manner.

**7. Respect for Women’s Informed and Voluntary Decision-Making, Autonomy, Confidentiality and Privacy**

**Standard 19:** All women have the right to high-quality, safe, comprehensive uterine evacuation care. Healthcare providers must provide high-quality care while protecting the human rights of their clients, including clients’ rights to privacy and confidentiality, information, dignity and autonomy. Care must be provided without discrimination, with special attention to equal treatment for marginalized groups such as young girls, poor women, and women with disabilities. Healthcare providers must be prepared to offer effective and compassionate interaction, communication, emotional support and, if desired, counseling that focuses on the woman’s needs.
Standard 20: Healthcare providers must explain the woman’s condition and options to her in non-technical language and obtain her voluntary, informed consent prior to initiating care. She needs to be treated with respect and understanding and to be provided with information in a way that she can understand so that she can make a decision free of inducement, coercion or discrimination. In cases of shock or other life-threatening conditions, a complete clinical assessment and voluntary, informed consent may be deferred until after the woman is stabilized. If a woman is in extreme pain or emotional distress, counseling should be offered when she is stable and able to comprehend and communicate.

Standard 21: Healthcare providers must be trained to inform, counsel and treat all women regarding the treatment and care options being offered.

Standard 22: Healthcare workers must support minors to identify what is in their best interests, including consulting parents or other trusted adults about their pregnancy, without bias, discrimination or coercion.

Standard 23: Confidentiality is a key principle of medical ethics and the right to privacy, and must be guaranteed.

Guidelines:
1. Healthcare providers have a duty to protect medical information against unauthorized disclosures.
2. Health service managers should ensure that facilities provide auditory and visual privacy for conversation between women and providers, as well as for actual services.

Standard 24: Informed consent should be taken and documented

Standard 25: Women who are pregnant as a result of rape are in need of particularly sensitive treatment, and all levels of the health system should be able to offer appropriate care and support without requiring involvement of administrative or judicial procedures.

8. Conscientious Objection

Standard 26: Healthcare providers have a right to conscientious objection to providing abortion, but that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women, putting their health and life at risk. Where a healthcare provider refuses to provide uterine evacuation they must refer the woman to a willing and trained provider in their facility, or another easily accessible healthcare facility. Where referral is not possible, the healthcare provider who objects must provide safe abortion to save the woman’s life and to prevent serious injury to her health.

Standard 27: All women who present with complications from an unsafe abortion must be treated urgently and respectfully, as any other emergency patient, without punitive, prejudiced or biased behaviors.
9. Contraceptive Services

**Standard 28:** All women receiving uterine evacuation care, must be offered contraceptive information and counseling, and if they desire, a contraceptive method, including emergency contraception, before leaving the healthcare facility.

*Guidelines:*
1. It is important for healthcare providers to discuss contraceptive and uterine evacuation options together because the uterine evacuation method selected has implications for whether and how certain contraceptive methods can be provided, for example: at the time of service versus at a return visit. For example, for women who want an IUD, a vacuum aspiration procedure would allow her to have the IUD inserted immediately, ensuring that she can leave the facility with her method of choice. However, women who choose medical abortion and desire an IUD must return to a provider to have it inserted. Women who choose an implant can have it inserted immediately, whether they have a vacuum aspiration procedure or medical abortion.

**Standard 29:** Contraceptive services support the basic human right to decide whether and when to have children. Women receiving contraceptive services have a right to privacy, confidentiality and informed choice.

**Standard 30:** Healthcare providers must establish trust, strive to understand a woman’s contraceptive preferences and needs, and tailor the counseling session to meet those needs.

**Standard 31:** Healthcare providers must ensure women know they may ovulate within 10 days after uterine evacuation care and can become pregnant if they resume sexual intercourse without a modern contraceptive method.

**Standard 32:** Providers must be knowledgeable about the range of contraceptive methods and consider each woman’s medical eligibility for various methods, including emergency contraception.

10. Clinical Assessment

**Standard 33:** Clinical assessment for uterine evacuation care must include taking a client history including LMP, H/O IUD usage, previous history of ectopic pregnancy, a general physical exam Gynecological exam; speculum and bimanual exam, and if needed collection of specimens and ordering of any lab tests.

**Standard 34:** Laboratory testing and ultrasound are not required for routine uterine evacuation care services, but may be helpful if a woman’s pregnancy status and dating are unclear.

**Standard 35:** An assessment of the uterine size and position and gestational age must be completed before performing a uterine evacuation care procedure. In addition to estimating the duration of pregnancy, clinical history taking should serve to identify contraindications to vacuum aspiration or medical methods and to identify risk factors for complications.
Standard 36: Women presenting for postabortion care need to be stabilized and then clinical assessment can focus on determining abortion-related complications and eligibility for vacuum aspiration or misoprostol. It may be necessary to refer to another facility if life-threatening complications or pre-existing conditions require additional resources.

Standard 37: Prophylactic antibiotics should be administered prior to vacuum aspiration to help reduce the risk of post-procedure infection. Prophylactic antibiotics are not needed for medical methods. Lack of access to prophylactic antibiotics should not be a barrier to uterine evacuation care.

11. Uterine Evacuation Care with Manual Vacuum Aspirator (MVA)

Standard 38: All women who present for uterine evacuation care should routinely be offered pain management (e.g. non-steroidal anti-inflammatory drugs) and provided these services without delay.

Guidelines:
1. Providers should offer gentle, respectful care and provide appropriate information which can help women stay calm and reduce anxiety.
2. Pain and discomfort during an MVA procedure can be reduced using a combination of verbal support, oral medications, paracervical block, gentle clinical technique and calming environment.
3. General anesthesia is not routinely recommended for MVA.

Standard 39: Evacuated tissue must be inspected for quantity and the presence of products of conception and signs of complete evacuation or molar pregnancy.

Guidelines:
1. If visual inspection is not conclusive, the material should be strained, immersed in water or vinegar, and viewed with light from beneath. If indicated, tissue specimen may also be sent to a pathology laboratory.

Standard 40: Post-procedure monitoring is conducted to ensure that the woman is recovering well, to detect and manage any complications, to offer counseling and referrals and to provide the woman with discharge instructions and information.

12. Uterine Evacuation Care with Misoprostol

Standard 41: Counseling includes the discussion of: basic information about uterine evacuation care with misoprostol, risks and benefits, expected effects and possible side effects, the warning signs for potential complications and when and where to seek medical help.

Standard 42: Preparation prior to administering misoprostol includes: counseling and obtaining informed consent; performing a client assessment, including physical, speculum and bimanual exam;
confirming that the woman knows what to do, if there is an emergency; and discussing her contraceptive needs.

Guidelines:
1. Whenever possible, women should be offered a choice of taking the misoprostol at home or in the healthcare facility, as different women have different needs and desires. For some women, home may be a more private place but for others, the healthcare facility may afford a greater degree of privacy.
2. It is of great importance that only those women are given the medicine to use at home, who can and will return at the time of emergency e.g., heavy bleeding. The distance from the health facility, support at home, transport and support, all should be carefully evaluated.
3. Healthcare providers should provide the following things to all women taking misoprostol at home:
   - Misoprostol pills or a prescription for them;
   - Detailed information on number of tablets to be taken
   - Details on the route of taking misoprostol
   - Pain medicine, such as ibuprofen and/or mild narcotics with instructions about how to take it;
   - Written and pictorial information on the uterine evacuation with misoprostol process, side effects and warning signs, what signs indicate that the evacuation is complete, and information for follow-up contact, if desired;
   - Information on whom to contact, including a telephone number where possible, in case of questions, problems or complications, or the possibility of an unsuccessful evacuation, and where to go in the case of an emergency;
   - Other optional items: sanitary pads, cotton wool, contraceptive information and supplies.

Standard 43: Thoroughly and accurately confirming the uterine size and gestational age and ruling out ectopic pregnancy is key to safe, effective uterine evacuation care with misoprostol.

Standard 44: Both non-narcotic and narcotic analgesics can be used to treat pain associated with uterine evacuation with misoprostol.

Standard 45: Since different misoprostol products have varying quality and can degrade over time, healthcare providers should track medical abortion success rates to ensure that they are using an effective product. Misoprostol should be stored in a cool, dry place.

13. Discharge and Follow-up

Standard 46: Healthcare providers must provide clear oral and written discharge instructions.

Standard 47: Healthcare providers must provide emotional support, if needed and refer to other services as determined by assessment of each women’s individual needs, such as STI/HIV counseling.

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1 To ensure the adequate drug efficacy, quality of purchased misoprostol should be in line with the recommended protocols.
Standard 48: Routine follow-up is not necessary but may be offered following an uncomplicated vacuum aspiration procedure. A routine follow-up visit is recommended in the case of medical methods with misoprostol to assess uterine evacuation success and serve as an additional opportunity to follow-up regarding contraceptive options e.g., IUD may be inserted then.

14. Complications

Standard 49: Healthcare staff must recognize and be able to treat or make the appropriate referral for complications that might occur during postabortion care, during a uterine evacuation procedure, in the recovery period or later. Complications may be presenting, procedural or pregnancy-related.

Standard 50: Women with abortion complications must be closely monitored, informed about necessary follow-up care and counseled on any medical and emotional consequences.

Standard 51: Adverse events should be documented, reported and analyzed so that information learned can be used to improve care and client safety.

15. Monitoring, Quality Improvement and Evaluation

Standard 52: The accurate collection of service statistics and routine monitoring and evaluation at the healthcare facility level must be a key component of program management, and feedback based on analysis of these data must provide necessary information for improving access and maintaining and improving the quality of uterine evacuation care services delivered. The facilities may have their own data reporting system but we should have a built in system for data entry about UE/MPAC services, commodity supply (Misoprostol, and MVA), follow up as well as the contraceptive advise. (e.g., by adding an extra page to the registers)

Guidelines:
1. Monitoring should fit into the routine work of the facility, use simple indicators, be open and participatory, and be performed ethically.
2. When possible, monitoring should include input and participation of community members or clients who have received services, including all women.
3. Monitoring should be a simple, inclusive and rewarding (not punitive) process.
4. At the facility level, mechanisms for monitoring services may include analysis of routine service statistics, logbook reviews, case reviews, observation using checklists, facility assessments, maternal death and near-miss audits, and obtaining feedback from service users to improve the quality of care.
5. Routine uterine evacuation care service delivery information to be recorded in site logbooks may include:
   - Case number
   - Day/month/year of services
   - Age of client
   - Gestational age (# of weeks since LMP)
   - Uterine size (in # of weeks)
• Diagnosis (induced abortion, incomplete abortion, other)
• Pain management (includes medical abortion): pain management given; prescription, information given; none given
• Primary procedure method: MVA/EVA, misoprostol, sharp curettage/ dilatation and curettage (D&C), other
• Contraceptive methods received: implant/IUD/injectables/oral contraceptive pills/condoms/sterilization (indicating if no method desired/method desired but no method received)
• Adverse events
• Was the woman referred elsewhere?
• How the woman learned about services?
• provider name, initial or identification

**Standard 53:** Quality assurance and improvement for uterine evacuation care must include planned and systematic processes for identifying measurable outcomes based on these standards and guidelines and the perspectives of health service users and healthcare providers, collecting data that reflect the extent to which the outcomes are achieved, and providing feedback to program managers and service providers.

*Guidelines:*

1. Quality improvement processes should attempt to identify and address both individual and organizational barriers to the achievement of good quality of care.
2. Quality improvement involves ongoing monitoring of routine service delivery, provider performance and patient outcomes, as well as period assessments conducted at the facility level.

**Standard 54:** Evaluation must include a systematic assessment of service delivery processes and outcomes.

*Guidelines:*

1. Comprehensive evaluation requires multiple data sources, including service statistics, feedback from healthcare providers and from women and communities served, and financial records.
2. Program evaluators may focus their attention on three key areas related to policies, programs and services: access, availability, and quality of care.
REFERENCES:


APPENDICES:

APPENDIX A

TYPES OF UTERINE EVACUATION CARE SUITABLE TO EACH LEVEL OF THE HEALTH SYSTEM

<table>
<thead>
<tr>
<th>Community Level (Community Midwives/Lady Health Workers):</th>
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<tbody>
<tr>
<td>• Public health education/information on reproductive health, including contraception and uterine evacuation care</td>
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<tr>
<td>• Community-based distribution of appropriate methods of contraception (condoms, pills, injectables and emergency contraception)</td>
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<tr>
<td>• All healthcare workers providing reproductive health services trained to provide counseling on contraception, unintended pregnancy and uterine evacuation care</td>
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<tr>
<td>• Lady Health Workers trained to provide information on, and referral to, pregnancy-detection and safe uterine evacuation services</td>
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<tr>
<td>• Community Midwives trained to provide uterine evacuation with misoprostol</td>
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<tr>
<td>• All healthcare workers trained to recognize abortion complications and promptly refer women for treatment</td>
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<td>• Transportation to services for management of complications of abortion</td>
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<tr>
<td>• All healthcare workers (and other key professionals such as police or teachers) trained to recognize signs of rape and to provide referral to healthcare or other social services</td>
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<thead>
<tr>
<th>Primary Care Level (Basic Health Units/Rural Health Centers)</th>
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<tbody>
<tr>
<td>• All elements of care mentioned for the community level</td>
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<tr>
<td>• All healthcare workers providing reproductive health services trained to provide counseling on contraception, unintended pregnancy and uterine evacuation</td>
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<tr>
<td>• A broad range of contraceptive methods, including IUDs, injectables and emergency contraceptive pills.</td>
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<tr>
<td>• Vacuum aspiration (manual) for pregnancies of gestational age up to 13 weeks</td>
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<tr>
<td>• Medical methods of abortion for pregnancies of gestational age up to 12 weeks</td>
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<tr>
<td>• Clinical stabilization, provision of antibiotics, and uterine evacuation for women with complications of abortion</td>
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<tr>
<td>• Vacuum aspiration or treatment with misoprostol for incomplete and missed abortion</td>
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<tr>
<td>• Prompt referral for women needing services for abortion or for management of abortion complications that cannot be provided on-site</td>
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<tr>
<th>Referral Hospitals (Tehsil, District Headquarter and Tertiary Hospitals)</th>
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<tr>
<td>• All elements of uterine evacuation care mentioned for the primary-care level</td>
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<tr>
<td>• Provision of implants and sterilization in addition to other contraceptive methods</td>
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<tr>
<td>• Uterine evacuation services for all circumstances and stages of pregnancy, as permitted by law</td>
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<tr>
<td>• Management of all abortion complications</td>
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<tr>
<td>• Information and outreach programs covering the full catchment area</td>
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<tr>
<td>• Training of all relevant cadres of healthcare professionals in uterine evacuation provision</td>
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APPENDIX B

EQUIPMENT AND SUPPLIES FOR UTERINE EVACUATION CARE WITH MVA

- Personal protective barriers such as gloves, face protection
- Examination table with stirrups
- Strong light
- MVA aspirator
- Lubricant for aspirator
- Selection of cannulae
- Speculum
- Tenaculum
- Small cup with sponge clamp and gauze
- Tapered mechanical dilators (Pratt or Denniston) or cannulae of increasing sizes
- 10 - 20cc syringe
- #20 - 23 gauge spinal or hypodermic needle or needle from IV insertion set
- Sponge stick with gauze
- Medium basin
- Smooth forceps
- Strainer
- Clear basin
- Betadine® or other non-alcohol based antiseptic
- Xylocaine 0.5% without epinephrine (for paracervical block)

MINIMUM REQUIREMENTS FOR UTERINE EVACUATION CARE WITH MISOPROSTOL

- **Infrastructure and furniture**
  - Counseling and examination room(s)
  - Light (electricity not required, can be a flashlight)
  - Toilet facilities
  - Clean water supply
- **Equipment and supplies**
  - Supplies for pelvic and bimanual exam, including speculum and gloves
  - Disinfection supplies for instruments and gloves
- **Drugs and contraceptive supplies**
  - Misoprostol
  - Analgesics and antipyretics (non-steroidal anti-inflammatory drugs)
  - Contraceptive supplies

*Additional requirement for referral facilities:*
- **Emergency treatment supplies**
  - Emergency resuscitation materials and drugs (including IV lines and fluids, IV antibiotics, blood transfusion and other surgical supplies)
  - MVA equipment
  - Other evacuation equipment if MVA is not available
## APPENDIX C

**Matrix Showing Role of Community and Facility Level Healthcare Providers in Safe Uterine Evacuation and Postabortion Care**

<table>
<thead>
<tr>
<th>S. No</th>
<th>Services</th>
<th>Cadres*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Health Care Providers’ skills for clinical assessment of client</td>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
</tr>
<tr>
<td>2.</td>
<td>Provide Confidentiality and Privacy to the clients</td>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
</tr>
<tr>
<td>3.</td>
<td>Respect and provide support to Women’s Informed and Voluntary Decision-Making and Autonomy</td>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
</tr>
<tr>
<td>4.</td>
<td>Community Linkages for Referral and Support</td>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
</tr>
<tr>
<td>5.</td>
<td>Conscientious Objection</td>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
</tr>
<tr>
<td>6.</td>
<td>Uterine Evacuation Care with Misoprostol</td>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
</tr>
<tr>
<td>7.</td>
<td>Uterine Evacuation Care with Manual Vacuum Aspiration</td>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
</tr>
<tr>
<td>8.</td>
<td>Postabortion contraceptive counseling and service provision**</td>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
</tr>
<tr>
<td>9.</td>
<td>Client Follow-up</td>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
</tr>
<tr>
<td>10.</td>
<td>Complications Referral</td>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
</tr>
<tr>
<td>11.</td>
<td>Complications Pre-referral Treatment</td>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
</tr>
<tr>
<td>12.</td>
<td>Complications Treatment</td>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
</tr>
<tr>
<td>13.</td>
<td>Follow necessary Infection Prevention protocol for instruments cleaning and disinfecting</td>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
</tr>
<tr>
<td>14.</td>
<td>Maintain environmental Hygiene of UE services provision area and Health facility</td>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
</tr>
<tr>
<td>15.</td>
<td>Monitoring, Quality Improvement and Evaluation</td>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
</tr>
</tbody>
</table>

* LHW = Lady Health Worker; FWA = Family Welfare Assistant; FWW = Family Welfare Worker; CMW = Community Midwife; MW = Midwife; LHV = Lady Health Visitor; NM = Nurse Midwife; WMO = Woman Medical Officer

** WMO provides counseling and all FP methods including implant and Tubal ligation; MW/LHV/NM/FFW counseling and method provision including condoms, pills, injections and IUDs, and referral for implant and tubal ligation; CMW/ LHW/FFWA counseling and method provision including condoms, pills, injections, and referral for rest of the services
Back Cover Inside
Back Cover