

Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia

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List of Abbreviations

CBRHA:	Community-Based Reproductive Health Agent
CHA:	Community Health Agent
DACA:	Drug Administration and Control Authority
FDRE:	Federal Democratic Republic of Ethiopia
FMOH:	Federal Ministry of Health
FP:	Family Planning
GBV:	Gender-Based Violence
GMP:	General Medical Practitioner
ICPD:	International Conference on Population and Development
IPPF:	International Planned Parenthood Federation
IUCD:	Intrauterine Contraceptive Device
LNMP:	Last Normal Menstrual Period
MVA:	Manual Vacuum Aspiration
PHCU:	Primary Health-Care Unit
PO:	Per Os
RH:	Reproductive Health
SMC:	Sharp Metallic Curettage
STDs:	Sexually Transmitted Diseases
TBA:	Traditional Birth Attendant
VCT:	Voluntary Counseling and Testing
VIA:	Visual Inspection of Cervix Using Aceto-Acetic Acid



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Members of the Task Force that developed this guideline under the leadership of the FMOH, whose names and affiliations appear on the last page of this document, deserve special thanks for their contributions.

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Foreword

Ethiopian women carry a disproportionately high morbidity and mortality as compared to their counterparts in other parts of the world. Evidences show that women in developing countries like Ethiopia have one-two hundred fold increased lifetime risk of death from causes related to pregnancy and childbirth. Although we are witnessing a slow but steady change in the reproductive health status of women as indicated with the results of the recent DHS, improvement in the status of women desires much more focused attention investments, political commitment, and intersectoral collaborations

Pursuant to its national and global commitments to improve the well being of its citizens and changing social and gender dynamics, the Government of Ethiopia had taken several policy and legal measures over the last decade. The revision of the Criminal Code of the Ethiopia that came after more than five decades is among such notable measures. As an instrument for change and a tool for the security of the individual and the society, the Criminal Code would undoubtedly contribute to the overall development intentions of the nation.

The Criminal Code of 2005 addresses a variety of issues that negatively affect the reproductive lives of women including harmful traditional practices such as early marriage and female genital cutting, rape, abortion, gender-based violence. The 1955 Law that restricted abortion to women whose lives are at risk had been reformed to include women with particular risks whose continuation of the pregnancy might endanger their well being and lives. This Guideline translates the Law into actionable measures and envisages to inform women, health

professionals, law enforcement agencies and all sectors of the society who care for well-being of women and their families. It is worthy of note here that this Guideline follows the launch of the National Reproductive Health Strategy that provides the framework for all our RH services and programs.

Health care providers at all levels are expected to not only have a good grasp of this Guideline, but also prepared to discharge their professional responsibilities as outlined in the document. The FMOH provides unreserved support and guidance to the implementation of the Guideline as an essential component of the strategy to reduce maternal morbidity and mortality.

It goes without saying that we have to act in synergy with key stakeholders in the UN family, bilateral agencies, professional associations, international and local NGOs to ensure access to safe abortion services to Ethiopian women. I would therefore call upon all concerned parties to work in unison to meet this end.



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I. Introduction

Abortion is more than a medical issue, or an ethical issue, or a legal issue. It is, above all, a human issue, involving women and men as individuals, as couples, and as members of societies (Tietze, 1978).

Statistical returns from health facilities across the country and from hospital-based studies show that unsafe abortion is one of the top 10 causes of hospital admissions among women. Unsafe abortion accounts for nearly 60% of all gynecologic admissions and almost 30% of all obstetric and gynecologic admissions. Due to the clandestine nature of unsafe abortion services, however, these figures represent only the tip of the iceberg and not the full magnitude of the problem.

It is estimated that there are 3.27 million pregnancies in Ethiopia every year, of which approximately 500,000 end in either spontaneous or unsafely induced abortion. The maternal mortality rate in Ethiopia is 1.68 per 1,000 women aged 15 to 49 years. According to the REDUCE model, unsafe abortion is the most common cause of maternal mortality, accounting for up to 32% of all maternal deaths in the country. For each woman that dies from complications of unsafe abortion, many more sustain short- and long-term morbidities, including infertility.

Institution-based studies have shown that the cost of care to the health system for abortion complications is enormous. In addition, the loss of productivity due to absence from work by

the patient and her attending family members can affect the overall economy.

Ethiopia has ratified international human rights conventions and treaties that are legally binding and that form international law. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which provides the foundation for reproductive rights, is one such notable convention. The Tehran Proclamation, the International Conference on Population and Development (ICPD), the Fourth World Congress on Women, and the 2000 United Nations (UN) Summit are some of the major forums at which national governments have expressed their commitment to improve the status of women in the society. These and other international initiatives have yielded wider recognition of individuals' rights to lead safe and responsible reproductive lives and have underscored the responsibility of governments to not only respect those rights but also to create the legal and policy environment for their realization.

In reference to abortion, the international community has pledged commitment to reducing the need for abortion through expanding and improving family planning (FP) services and, where the laws of the land allow, providing women with high-quality abortion care. Furthermore, at the five-year review of the ICPD, there were calls for governments to consider reviewing laws that contain punitive measures against women who undergo illegal abortions. Governments have also agreed that, in circumstances where abortion is not against the law, health systems should train and equip providers and take measures to ensure that abortion services are safe and accessible. Additional measures to safeguard women's health are also required.

At the UN summit in 2000, governments of the world ratified the Millennium Development Goals (MDGs) as an international tool for reducing poverty and improving the standard of living in the developing world. One of the eight MDGs is to reduce the maternal mortality rate by 75% (from 1990 levels) by the year 2015. Preventing unsafe abortion is one of the five strategies for reducing maternal mortality that was endorsed by the World Health Organization (WHO) in 2004.

In response to these developments at the global level and changes in social and gender relations within the country, the government of the Federal Democratic Republic of Ethiopia (FDRE) has reviewed its laws and policies within the last decade.

Articles 14, 15, and 16 under Section I (Human Rights) of the Constitution refer to the rights to life, liberty, and security of the person. Article 35 refers to women's equality with men and their rights to information and the capacity to be protected from the dangers of pregnancy and childbirth.

The Women's Policy recognizes the low status accorded to women in Ethiopia and elaborates on the unacceptably high level of maternal mortality, high fertility rates, low use of contraceptives, harmful traditional practices such as female genital cutting and early marriage, and disproportionately high illiteracy rates. It also describes how the laws of the land negatively affect women's status in the society. The strategies for improving women's status outlined in the policy include informing and educating the community on harmful traditional practices and ensuring women's access to basic health care and information on FP methods. The policy also states that

“...conditions whereby women can have effective legal protection of their rights shall be facilitated.”

The Health Policy of the Transitional Government of Ethiopia (1993) states that the health needs of women and children require particular attention. The policy recommends decentralizing services and “enriching the concept and intensifying the practice of family planning for optimal family health and planned population dynamics.” The policy also discusses the need for “adequate maternal health care including care for high-risk pregnancies” and, in reference to health-related laws, recommends “developing new rules and regulations to help in the implementation of the current policy and addressing new health issues.”

Cognizant of the extent of the problem of unsafe abortion, and with due recognition of the need for an integrated approach to reducing maternal morbidity and mortality, the FMOH has issued this guideline for health workers across the country. The guideline was developed by the FMOH on the basis of the authority vested in it by the House of Representatives of the FDRE per Article 552 sub-article 1 of the Penal Code of Ethiopia (promulgated in May 2005).

Aim of the guideline

This guideline is a working document on the techniques and procedures that must be observed in providing safe termination of pregnancy services as permitted by the recently revised law (May 9, 2005). In developing the guideline, members of the Working Group reviewed and analyzed relevant knowledge, evidence, and experience. New, locally applicable, and appropriate procedures had been included based on national, regional, and international studies. Clinical guidelines are defined as systematically developed statements that assist

clinicians in making decisions about appropriate treatment for specific conditions.

In the process of developing this guideline, due consideration has been given to the knowledge and skills acquired in basic education by all cadres of health providers. This guideline is for health managers, program coordinators, and all categories of health-care providers practicing in Ethiopia. Instructors from teaching institutions and reproductive health care trainers may also find the guideline useful.

This guideline will be implemented in all health institutions recognized by the FMOH as specified under "Section X: Abortion Services by Level of Care". The guideline is meant to ensure that all women obtain standard, consistent, and safe termination of pregnancy services as permitted by law.

II. TYPES OF ABORTION SERVICES

Abortion is the termination of pregnancy before fetal viability, which is conventionally taken to be less than 28 weeks from the last normal menstrual period (LNMP). If the LNMP is not known, a birth weight of less than 1000gm is considered as abortion.

There are two types of care related to termination of pregnancy: woman-centered abortion care and postabortion care.

Woman-centered abortion care is a comprehensive approach to providing abortion services that takes into account the various factors that influence a woman’s individual mental and physical health needs, her personal circumstances, and her ability to access services. This care includes a range of medical

and related health services that support women in exercising their sexual and reproductive rights.

Woman-centered abortion services have three key elements. These are:

- **Choice:** which includes the right to determine if and when to become pregnant, to continue or terminate a pregnancy, to select between options, and to have complete and accurate information.
- **Access:** which includes having access to termination of pregnancy services that are provided by trained and competent providers with up-to-date clinical technologies and that are easy-to-reach, affordable, and non-discriminatory.
- **Quality:** which refers to respectful, confidential services that are tailored to each woman's needs using accepted standards and appropriate referral procedures.

Postabortion care is a comprehensive service for treating women that present to health-care facilities after abortion has occurred spontaneously or after an attempted termination. Postabortion care has five essential elements, which are:

- **Community-service provider partnerships** involving the local community and informal health workers (CHAs, CBRHAs, TBAs) in addition to formal health personnel. These partnerships are designed to increase recognition of the signs and symptoms of pregnancy complications, to mobilize resources, and to address social and economic issues at the community level.
- **Counseling**, whereby women are provided with accurate and complete information on reproductive

health issues including FP, voluntary counseling and testing (VCT), and gender-based violence (GBV).

- **Emergency treatment** of incomplete abortion and its complications.
- **FP services** based on free and informed choice and the availability of methods.
- **Linkage** of the above services with other reproductive health services including the diagnosis and treatment of sexually transmitted diseases (STDs); information on breast feeding, child nutrition, and immunization; screening of reproductive tract cancers; and so on.

Several methods of termination of pregnancy are available. The best method for a woman depends on the duration of pregnancy, the general health status of the woman, the availability of each method, the distance from a referral center, the knowledge and skill of the provider, and the level of care.

III. LEGAL PROVISIONS FOR SAFE ABORTION SERVICES

Health workers involved in the care of women should be well aware of the provisions of this guideline, which is an official interpretation of the law on safe abortion services as outlined below. Knowledge of the law is essential so that providers not only know what is expected of them but also can also inform and educate women and the community at large.

Article 551 of the Penal Code of the FDRE allows termination of pregnancy under the following conditions:

1. Termination of pregnancy by a recognized medical institution within the period permitted by the profession is not punishable where:
 - a. The pregnancy is a result of rape or incest; or
 - b. The continuation of the pregnancy endangers the life of the mother or the child or the health of the mother or where the birth of the child is a risk to the life or health of the mother; or
 - c. The fetus has an incurable and serious deformity; or
 - d. The pregnant woman, owing to a physical or mental deficiency she suffers from or her minority, is physically as well as mentally unfit to bring up the child.
2. In the case of grave and imminent danger which can be averted only by an immediate intervention, an act of terminating pregnancy in accordance with the provisions of Article 75 of this Code is not punishable.

Timing and place for terminating pregnancy

1. Termination of pregnancy as permitted by the law can be conducted in a public or private facility that fulfills the pre-set criteria.
2. A woman who is eligible for pregnancy termination should obtain the service within three working days. This time is used for counseling and diagnostic measures necessary for the procedure.
3. All health facilities that have the skilled personnel, equipment and supplies as specified under "Section X:

Abortion Services by Level of Care" can perform termination of pregnancy as permitted by Article 551 for pregnancies less than 12 weeks of gestation from the first day of the LNMP.

4. Termination of pregnancy between 13 and 28 weeks of gestation should be done in a secondary or tertiary level of care.
5. Women who are eligible for pregnancy termination should have the necessary information to seek abortion care as early in pregnancy as possible.

IV. IMPLEMENTATION GUIDE FOR SAFE ABORTION SERVICES

1. Implementation guide for Article 551 sub-article 1A

⇒ *Where the pregnancy is a result of rape or incest*

- Termination of pregnancy shall be carried out based on the request and the disclosure of the woman that the pregnancy is the result of rape or incest. This fact will be noted in the medical record of the woman.
- Women who request termination of pregnancy after rape and incest are not required to submit evidence of rape and incest and/or identify the offender in order to obtain an abortion services.

2. Implementation guide for Article 551 sub-article 1B

⇒ *Where the continuation of the pregnancy endangers the life of the mother or the child or the health of the mother or where the birth of the child is a risk to the life or health of the mother*

- The provider should, in all good faith, follow the knowledge of standard medical indications that necessitate termination of pregnancy to save the life or health of the mother.
- The woman should not necessarily be in a state of ill health at the time of requesting safe abortion services. It is therefore the responsibility of the health provider in charge to assess the woman's conditions and determine in good faith that the continuation of the pregnancy or the birth of the fetus poses a threat to her health or life.

3. Implementation guide for Article 551 sub-article 1C

⇒ *Where the fetus has an incurable and serious deformity*

- If the physician after conducting the necessary tests makes the diagnosis of a physical or genetic abnormality that is incurable and/or serious, termination of pregnancy can be conducted.

4. Implementation guide for Article 551 sub-article 1D

⇒ *Where the pregnant woman, owing to a physical or mental deficiency she suffers from or her minority, is physically as well as mentally unfit to bring up the child*

- The provider will use the stated age on the medical record for age determination to determine whether the

person is under 18 or not. No additional proof of age is required.

- A disabled person is one who has a condition called disability that interferes with his or her ability to perform one or more activities of everyday living. Disability can be broadly categorized as mental or physical.
- It is therefore the responsibility of the health provider in charge to assess the woman's conditions and determine in good faith that the woman is disabled either mentally or physically.
- Termination of pregnancy under Article 551 sub-article 1D will be done after proper counseling and informed consent.

5. Implementation guide for Article 551 sub-article 2

⇒ *In the case of grave and imminent danger, which can be averted only by an immediate intervention, an act of terminating pregnancy in accordance with the provisions of Article 75 of this Code is not punishable*

- Health providers responsible for the provision of comprehensive abortion care services are authorized to perform abortion procedures on women whose medical conditions warrant the immediate termination of pregnancy.

Applicable for all sub-articles:

- The provider has to secure an informed consent for the procedure using a standard consent form, which is annexed to this guideline (Appendix I).
- The provider shall not be prosecuted if the information provided by the woman is subsequently found to be incorrect.
- Minors and mentally disabled women should not be required to sign a consent form to obtain an abortion procedure.

V. PRE-PROCEDURE CARE

The first steps in providing abortion care are to establish that the woman is pregnant and, if she is, to estimate the duration of the pregnancy. Taking the woman's history, performing a bimanual pelvic examination, conducting the required laboratory investigations, counseling the client to help her decide between alternative options, and obtaining her consent are all part of the pre-procedure care.

1. Counseling and informed decision-making

a. Counseling

- Provide sufficient and accurate information on the comparative risks of continuing the pregnancy to term or terminating the pregnancy and on the potential risks associated with the method of pregnancy termination.

- The information and counseling provided to women requesting safe termination of pregnancy must include a minimum of the following:
 - Options counseling: continuing or terminating the pregnancy
 - Available methods of pregnancy termination and pain control medications (including the advantages and disadvantages of each)
 - What will be done during and after the procedure
 - Possible short- and long-term risks associated with the method of termination of pregnancy
 - When to expect resumption of menses
 - Follow-up care
- The information should be clear, objective, and non-coercive, and should be provided in a language understandable to the woman. The information should be supplemented with written materials whenever possible.

b. Informed decision making

- All women undergoing pregnancy termination should, after receiving objective counseling, consent to the procedure of termination in writing.
- The health-care institution and the health worker who provides the service has an ethical obligation not to disclose the information provided by the woman unless permitted by the woman or ordered by a court of law.

2. Diagnosis of pregnancy

Before any procedure to terminate a pregnancy, a detailed medical history and confirmation of the pregnancy and gestational duration must be documented.

a. The medical history. Ask and document the following:

- Age
- Reproductive history (number of pregnancies, deliveries, abortions)
- First day of LNMP
- Gestational age based on LNMP (note that lactating women may not report a missed period)
- History of drug allergy
- Any medical or surgical illness (Note: assessment of life-threatening illnesses as indication for termination and known medical and surgical illnesses that may need special care shall be given due emphasis)

b. Physical examination. Undertake the following:

- General physical examination to establish the general health of the woman
- Bimanual pelvic examination to establish:
 - Uterine size and position
 - The presence of other uterine pathology, such as fibroids

c. Laboratory investigation. Do the following laboratory tests if available (the absence of such tests should not be reason to prevent safe abortion services):

- Blood group and RH factors
- Urine analysis

- Pregnancy test
- VDRL
- Smear and Gram's stain of vaginal discharge as appropriate
- Cervical cancer screening
- Ultrasound and genetic tests as appropriate

3. Exclude extra-uterine pregnancy

Suspect ectopic pregnancy if:

- A woman presents with amenorrhea, severe lower abdominal pain and tenderness, and vaginal bleeding; and/or
- Uterus is smaller than expected for gestational duration, and there is an adnexal mass discovered upon bimanual pelvic examination; and/or
- A woman with a positive pregnancy test above six weeks of gestational duration has no intrauterine gestational sac or is found to have an extra-uterine gestational sac on trans-abdominal ultrasonography.

If ectopic pregnancy is suspected, make sure the woman is evaluated by the most senior health provider around or refer her to the next level of care.

4. Assessment of gestational age

Assess gestational duration based on:

- The first day of the LNMP
- Physical findings (abdominal and pelvic examination)
- Ultrasound (optional)

5. Cervical preparation

The following groups of women need cervical preparation regimens:

- Nulliparous women and those aged 18 or below with gestational duration of more than nine weeks
- All pregnant women at gestations more than 12 weeks

Depending on their availability, administer either of the following drugs in the recommended dosages:

- Misoprostol 400 micrograms (μg) vaginally or orally three to four hours before the procedure; or
- Mifepristone 200 milligrams (mg) orally 36 hours before the procedure.

VI. PROCEDURES DURING TERMINATION

All health institutions that are given the authority should provide termination of pregnancy by one of the recommended methods, depending on the gestational duration.

1. Medical abortion

Administer the following combination of drugs in the specified dosage:

- Up to nine completed weeks since the LNMP:
 - Mifepristone 200mg orally, followed 36 to 48 hours later by
 - Misoprostol 800 μg vaginally (insert misoprostol deep into the vagina or instruct the woman to do so herself). For gestations up to seven completed

weeks, you may administer misoprostol 400 μg orally.

- Unless clinical evidence of incomplete abortion is present, routine surgical evacuation is not necessary.
- Depending on the need for pain control, non-narcotic analgesics should be prescribed during and after medical abortion.

Contraindications:

- Mifepristone
 - Suspected ectopic pregnancy or undiagnosed adnexal mass
 - IUD in place (remove before administering medication)
 - Chronic adrenal failure
 - Concurrent long-term corticosteroid therapy
 - History of allergy to mifepristone
 - Hemorrhagic disorders or concurrent anticoagulant therapy
 - Inherited porphyrias
- Misoprostol
 - History of allergy to prostaglandins, including misoprostol

Rule out the above clinical conditions before administering either of the two drugs.

After administering mifepristone, advise women to come back 36 to 48 hours later to take misoprostol. Also, inform women to expect bleeding and possible expulsion of the products of

conception, and tell them whom to contact in case complications arise.

Once misoprostol has been administered during the second visit, observe women for four hours, during which time up to 90% of them will expel the products of conception. If abortion does not occur during the observation period, women should be advised to come back to the health facility about two weeks later to confirm that the abortion has been completed. In cases of severe bleeding or other complications, women should be advised to report to the health facility immediately. If by the end of the two-week follow-up period the abortion has failed, use surgical methods to complete the process.

2. Surgical methods

For pregnancies 12 weeks of gestation or less from the first day of the LNMP, the preferred surgical method of termination is manual or electric vacuum aspiration. Dilatation and curettage should be used only where vacuum aspiration or medical methods are not available. All efforts should be made to replace dilatation and curettage and sharp metallic curettage (SMC) with vacuum aspiration at all levels of care.

a. Vacuum aspiration. Vacuum aspiration is an alternative, safe method of terminating an otherwise uncomplicated pregnancy up to 12 completed weeks' gestation from the first day of the LNMP. Considerations include:

- The procedure should be done as an outpatient procedure.
- Ensure that an assistant is present.

- Communication, reassurance, and respect are important for building confidence and improving the quality of care.
- Administer prophylactic antibiotics for women considered at high risk for reproductive tract infections.
- Follow steps for cervical preparation as in Section V.5 above.
- Make sure the vacuum aspiration instrument is functioning properly. Inspect the instrument for optimal use.
- Observe steps to ensure that the products of conception are evacuated completely.
- Inspect the evacuated tissue for floating villi to confirm that it is the products of conception.
- Staff should protect themselves and clients by applying universal precautions routinely (see Appendix II).
- Staff should follow recommended steps for instrument processing (per Appendix III).
- Safely handle and dispose blood, blood-soaked materials, sharps, and products of conception as per the guideline for infection prevention.

b. Sharp metallic curettage. Where vacuum aspiration is available, dilatation and curettage and SMC are not recommended. If SMC is to be used for termination of pregnancy, it should be done by a trained health officer, medical doctor, or gynecologist. While all general recommendations for vacuum aspiration should be practiced, these specific procedures should also be followed:

- SMC procedure should be done in a procedure room equipped for providing general anesthesia.
- Local or general anesthesia should be administered irrespective of the gestational period.
- Dilate cervix using dilators of gradually increasing size. Exercise caution while using metallic dilators and curettes in order to minimize the risk of cervical injury and uterine perforation.
- Following the procedure, observe the woman until her vital signs are stable and she is able to walk unassisted.

VII. POST-PROCEDURE CARE

Post-procedure care is as essential as care during the procedure in ensuring the best outcome in abortion services.

- Monitor vital signs; look for pallor; do an abdominal examination for tenderness and fluid accumulation; perform a pelvic examination if there is excessive vaginal bleeding.
- Identify, manage, and refer for complications as appropriate.
- Give discharge instructions (using simple language that is sequential and appropriate for the level of understanding of the woman) on symptoms and signs that indicate complications and the availability of 24-hour care for any condition.
- Give post-procedure counseling, as appropriate, on STDs, VCT, GBV, contraception, and other issues.
- Provide the chosen method of contraception immediately after abortion, following the WHO eligibility criteria.

- Administer TT for all eligible women before discharging.
- Do Papanicolaou smear or VIA for all women, whenever available.
- Provide STD screening, partner tracing, and sexual health counseling.
- In the absence of complications, the woman can be discharged as soon as she feel able and her vital signs are stable.
- Give a follow-up appointment seven to 10 days after the procedure.

Special considerations: Anti-D Ig G 250 iu should be given IM for all non-sensitized RhD negative women after termination of pregnancy by any method.

VIII. REFERRAL ARRANGEMENTS

A well-functioning referral system is vital to providing safe and high-quality abortion services. All health personnel involved in the care of the woman have an ethical responsibility to direct her to appropriate services at any time. Referral arrangements enable women to access routine care and prompt treatment for complications.

- Refer a woman if the type of care that she needs is beyond the capacity of your institution.
- Clearly state her condition at the time of referral, what was done, and the reason for referral on the referral paper.
- Alert the receiving health facility, particularly if the woman is suffering from complications and needs immediate care; transportation; care during transport,

including accompanying health personnel; and/or free services, as appropriate.

- A referral should only be made by the most senior health professional on duty.
- The referral center should provide feedback to the referring center on the type of complication ascertained, the care provided, the outcome of the treatment, and the plan for subsequent care.
- If VCT services are not provided in your health facility, refer the woman to the nearest center.
- Inform victims of rape about legal and psychological support and refer as needed.
- All women referred to the next level are entitled to care without any precondition.
- Referral arrangements for social support and care are an integral part of overall abortion care.

IX. PROVIDERS' SKILLS AND PERFORMANCE

In order to effectively discharge their responsibilities, providers should acquire basic knowledge and skills during their pre-service training and get periodic updates through on-the-job training. Training content should address both technical and clinical skills as well as the attitudes and beliefs of service providers. Values clarification exercises that help providers distinguish between their own values and their clients' right to safe reproductive health services are an essential component of all training programs. The selection of training sites should take into consideration the volume of patients, so that providers will get the opportunity to acquire adequate skills in managing abortion and its complications.

In order to make safe abortion services as permitted by law accessible to all eligible women, the role of midlevel providers such as nurses and midwives should be expanded to include providing comprehensive abortion services, including uterine evacuation using MVA and medical abortion. Pre-service and in-service training for midlevel providers should reflect this expanded role.

The following table illustrates the tasks that are required to provide comprehensive abortion care and the role of certain categories of reproductive health providers, namely general medical practitioners (GMPs), health officers, midwives, clinical nurses, and public health nurses.

Table 1: Abortion care tasks by provider category

Task	GMPs	Health officers	Midwives	Clinical nurses
Patient assessment				
History taking	✓	✓	✓	✓
Physical examination	✓	✓	✓	✓
Bimanual pelvic exam	✓	✓	✓	✓
Dating gestation	✓	✓	✓	✓
Counseling	+	+	✓	✓
Uterine evacuation				
MVA	✓	✓	✓	✓
SMC	✓	✓	X	X
Medical abortion	✓	✓	✓	✓
Pain medications				
Analgesics	✓	✓	✓	✓
Narcotics/sedatives	✓	✓	✓	X
Paracervical block	✓	✓	✓	X
Treatment of complications				
Identification	✓	✓	✓	✓
Antibiotics	✓	✓	✓	✓
IV fluids	✓	✓	✓	✓
Blood transfusions ¹	✓	✓	X	X
Maintain airways	✓	✓	✓	✓
Repair of minor injuries	✓	✓	✓	X
Abdominal surgery	✓	✓		

¹ While the decision to transfuse blood shall be made by a senior clinician, all categories of nurses can administer and monitor blood transfusions.

Task	GMPs	Health officers	Midwives	Clinical nurses
Post-procedure care	✓	✓	✓	✓
Follow-up care	✓	✓	✓	✓
Universal precautions	✓	✓	✓	✓
Postabortion contraception	✓	✓	✓	✓
Information	✓	✓	✓	✓
Counseling	+	+	✓	✓
Method choice	✓	✓	✓	✓
Informed choice/referral	✓	✓	✓	✓
Linkages with other RH services				
Counseling	✓	✓	✓	✓
Screening	✓	✓	+	+
Treatment	✓	✓	✓	✓
Referral	✓	✓	✓	✓
Instrument processing	✓	✓	✓	✓
Education on:				
The dangers of unsafe abortion	✓	✓	✓	✓
Prevention of unwanted pregnancy	✓	✓	✓	✓
Legal provisions for abortion	✓	✓	✓	✓
Training junior health professionals and community health workers	✓	✓	✓	✓
Maintain records and submit reports	✓	✓	✓	✓

Key:

- ✓ = Roles expected from that category of professionals
- X = Roles not expected of that category of professionals
- + = Members of that category may initiate and/or partly perform the task

Training curricula on abortion care should enable health providers to competently perform the tasks described in the above table. The following health workers are authorized to perform abortion procedures for first-trimester pregnancy using medical abortion and/or MVA:

- Clinical nurses
- Midwives
- Health officers
- GMPs and above

GMPs and health officers with additional training on the specific skills needed for second-trimester abortion and specialists in obstetrics and gynecology are authorized to perform second-trimester abortion procedures.

X. ABORTION SERVICES BY LEVEL OF CARE

In organizing abortion care services, program planners and facility managers should take into consideration:

- Emergency abortion services that provide life-saving procedures on a 24-hour basis.
- Elective abortion services that are performed at the request of the woman or on the recommendation of the health-care provider.

The following table summarizes the elements of abortion services and staffing patterns at different levels of care.

Table 2: Abortion services by level of care

Level of care	Type of health personnel available	Abortion services
Community	<ul style="list-style-type: none"> • Traditional birth attendants (TBAs), community health workers (CHAs), community-based reproductive health agents (CBRHAs) 	<ul style="list-style-type: none"> • Recognize signs and symptoms of pregnancy • Recognize signs and symptoms of abortion and its complications • Provide RH education, including FP and the risks of unsafe abortion • Distribute appropriate contraceptives, including emergency contraceptives • Inform communities and women on the legal provisions for safe abortion • Refer women to postabortion and safe abortion services
Health posts/stations	<ul style="list-style-type: none"> • Frontline health workers (health extension workers) 	<p>The above activities plus:</p> <ul style="list-style-type: none"> • Check vital signs • Provide pain medication
Health centers	<ul style="list-style-type: none"> • Health officers, midwives, clinical nurses, public health nurses, laboratory technicians 	<p>The above activities plus:</p> <ul style="list-style-type: none"> • Counseling • General physical and pelvic examination • Vacuum aspiration up to 12 completed weeks of

Level of care	Type of health personnel available	Abortion services
		<p>pregnancy</p> <ul style="list-style-type: none"> • Medical abortion up to nine completed weeks of pregnancy • Administer antibiotics and IV fluids • Train community-level workers and junior health professionals in abortion service provision
District/zonal hospitals	<ul style="list-style-type: none"> • Same as above, plus GMPs, with or without an obstetrician-gynecologist 	<p>The above activities plus:</p> <ul style="list-style-type: none"> • Uterine evacuation for second-trimester abortion • Treatment of most complications • Blood cross-matching and transfusion • Local and general anesthesia • Laparotomy and indicated surgery • Diagnosis and referral for serious complications such as peritonitis and renal failure • Train all cadres of health professionals (pre- and in-service)
Referral hospitals	<ul style="list-style-type: none"> • Same as above plus obstetrician-gynecologists 	<p>The above activities plus:</p> <ul style="list-style-type: none"> • Treatment of severe complications (including bowel injury, tetanus, renal failure, gas gangrene, severe sepsis) • Treatment of coagulopathy
Private facilities:		

Level of care	Type of health personnel available	Abortion services
Lower clinics	<ul style="list-style-type: none"> • Staffed by nurses and assistants 	<ul style="list-style-type: none"> • Perform functions described under health posts/stations
Medium clinics	<ul style="list-style-type: none"> • Staffed by a health officer or GMP and a team of other health workers 	<ul style="list-style-type: none"> • Perform functions described under health centers
Higher clinics	<ul style="list-style-type: none"> • Staffed by a specialist or a GMP and a team of other health workers 	<ul style="list-style-type: none"> • Perform functions described under health centers
MCH centers and hospitals	<ul style="list-style-type: none"> • Staffed by specialists (obstetricians/gynecologists), a GMP, and a team of other health workers 	<ul style="list-style-type: none"> • Perform functions described under district and referral hospitals

XI. ESSENTIAL EQUIPMENT AND SUPPLIES

Health facilities providing safe abortion services should be equipped with basic equipment, instruments, and consumables that have to be replenished regularly, such as pain medications, antibiotics, IV fluids, disinfectants, and so on. Following is a list of these basic supplies that should always be available in sufficient amounts in all health facilities rendering services. Program managers, facility directors, and other responsible persons should include these items in the routine budgeting, procurement, and distribution systems.

1. Basic supplies:

- IV fluids with give sets
- Syringes and needles
- Sterile gloves of different sizes

- Cotton balls or gauze sponges
- Antiseptic solutions
- Antibiotics
- Pain medications
- Long needle holders
- Equipment and supplies for instrument processing

2. Instruments and equipment for first-trimester uterine evacuation:

- a. Basic uterine evacuation
 - Sponge forceps or uterine packing forceps
 - Malleable metal sound
 - Pratt or Denniston dilators: sizes 13-27 French
 - Medium self-retaining speculum
 - 50ml container for local anesthesia
 - 500ml container for antiseptics
 - Plastic strainer
 - Clear glass dish for tissue inspection
 - Long sponge forceps
 - Container for cleansing solution
 - Single tooth tenaculum forceps
- b. Vacuum aspiration with electric pump
 - Basic uterine evacuation supplies
 - Vacuum pump with extra glass bottles
 - Connecting tubing
 - Cannulae (any of the following)
 - Flexible: 4,5,6,7,8,9,10,12mm
 - Curved rigid: 7,8,9,10,12,14mm
 - Straight rigid: 7,8,9,10,12mm
- c. Manual vacuum aspiration

- Basic uterine evacuation supplies
- Vacuum aspirators
- Adapters
- Flexible or semi-rigid cannulae, sizes 4-12mm

- d. Twelve-weeks plus
 - Basic uterine evacuation supplies
 - Pratt or Denniston dilators: sizes 29-43
 - Curette: size 1 or 2

3. Drugs for medical abortion:

- Mifepristone 200mg
- Misoprostol 200µg

XII. MONITORING AND EVALUATION

Health facilities and clinical providers should maintain data on abortion services through regular recording systems such as logbooks, clinical records, and daily activity records. The logbook for registering clients receiving abortion services that is shown in Appendix IV should be used by all health facilities providing abortion services. Data from the logbook should be regularly reported through the health management and information system, following the reporting format attached as Appendix V.

Program managers should monitor services to assess whether they are being provided up to standard, so that they can take corrective measures as appropriate. Among others, monitoring abortion services should include:

- Analyzing patterns or problems using service statistics
- Documenting the proportion of women seeking repeat abortions

- Observing counseling and clinical services
- Ensuring regular and continuous supply of equipment and supplies
- Aggregating data from the health facility upwards
- Reviewing measures to improve services

Evaluation of abortion services should provide data on the extent to which those services have contributed to reducing maternal mortality from unsafe abortion. However, the gathering of such data, which requires a vital events registration system or the study of a very large population, may not be feasible in the Ethiopian setting. Instead, as many maternal mortality reduction programs do, it is imperative to focus on process or output indicators. The following indicators can be used when evaluating abortion services:

- The number, type, and percentage of facilities providing abortion services by geographic area (by woreda, zone, or region, or countrywide)
- The increase in the use of legal abortion services (access)
- Changes in patterns and rates of hospital admissions for abortion complications
- The number and categories of providers trained in abortion care
- An assessment of the quality of training
- The number and percentage of eligible providers performing abortion by level of facility and geographic distribution
- Costs of abortion services and treating abortion complications
- Providers' KAP, needs, and ideas for improving services
- Deaths from unsafe abortion

Table 3: Aspects of abortion care services to be included in monitoring plans

Type of services to be monitored	Indicators for measuring activities	Sources of information	Types of questions to ask
Infection prevention	<ul style="list-style-type: none"> Percentage of cases in which infection prevention practices were adhered to fully 	<ul style="list-style-type: none"> Observe services using checklist 	<ul style="list-style-type: none"> Was no-touch technique used? Were MVA instruments properly processed?
Management and organization of services	<ul style="list-style-type: none"> Average amount of time abortion care clients spend in the facility Average amount of time from arrival to procedure Hours during which service are available 	<ul style="list-style-type: none"> Observe and evaluate patient flow Review client records and conduct interviews with staff 	<ul style="list-style-type: none"> During which time(s) of the day does the client waiting time increase?
Counseling	<ul style="list-style-type: none"> Number and percentage of clients receiving counseling 	<ul style="list-style-type: none"> Observe counseling sessions using performance checklist Review cases from logbook 	<ul style="list-style-type: none"> Were women with special needs given referrals?
Contraceptive counseling and services	<ul style="list-style-type: none"> Number and type of contraceptives dispensed on site Number and percentage of women who 	<ul style="list-style-type: none"> Observe counseling Conduct exit interviews Review logbooks 	<ul style="list-style-type: none"> How well were women counseled about available contraceptive methods?

Type of services to be monitored	Indicators for measuring activities	Sources of information	Types of questions to ask
	<ul style="list-style-type: none"> received contraceptive counseling Number and percentage of women desiring contraception who received a method 		<ul style="list-style-type: none"> Did women leave with a desired method or information? Did women have to go to another facility to receive a contraceptive method?
Client satisfaction	<ul style="list-style-type: none"> Percentage of women who indicate that they received respectful care Percentage of women who agree that services fees are reasonable 	<ul style="list-style-type: none"> Conduct exit interview Review service fee charges 	<ul style="list-style-type: none"> Did women feel that they were treated respectfully? Did women think the amount that they had to pay for services was reasonable?

The table above could serve as a useful tool for monitoring quality of care at the facility level. Facility directors and program managers are encouraged to develop and apply such tools as part of their monitoring plans.

Appendix I: Consent Form

Consent Form for Uterine Evacuation

After having consulted with my health service provider about my health condition, I, (name of client), hereby consent to a procedure for safe termination of pregnancy. I have been counseled and informed about the alternative methods and about the possible side effects and outcomes of the procedure.

In the event of complications arising during the procedure, I request and authorize the responsible health service provider to do whatever is necessary to protect my health and wellbeing.

I confirm that the information that I provided to my health service provider is accurate.

Signature _____

Date _____

Appendix II: Universal Precautions

Health-care workers involved in providing abortion services should follow these universal precaution measures in order to prevent the transmission of infection from providers to patients, from patients to providers, and to the community:

- Wash hands thoroughly with soap and water immediately before and after contact with each patient.
- Use high-level disinfected or sterile gloves, replacing them between patients and procedures.
- Never use gloved hands to open and close doors or to process instruments.
- Wear clean gowns, aprons, goggles, and masks.
- Clean floors, beds, toilets, walls, and rubber draw sheets with detergents and hot water. If they are soaked with blood or body fluids, use a 0.5% chlorine solution.
- Wear heavy-duty gloves when cleaning surfaces and washing bed sheets spilled with blood and body fluids and when processing equipment for reuse.
- Dispose of waste contaminated with blood, body fluids, laboratory specimens, or body tissues safely, following facility protocols.
- Avoid recapping needles whenever possible. If necessary, use the scoop method.
- Dispose of sharps in puncture-resistant containers and bury or incinerate them.
- All reusable instruments should be soaked in a 0.5% chlorine solution and cleaned with soap and water immediately after use and sterilized or high-level disinfected.

Appendix III: Instrument Processing

Follow specific instructions for processing medical instruments, as appropriate. For instruments and equipment that can be reprocessed through high-level disinfection, follow the steps described below:

- Decontamination: Soak instruments in a 0.5% chlorine solution for 10 minutes.
- Cleaning: Clean instruments with warm water and detergent; do not use soap. Wear masks and heavy-duty gloves during cleaning. Disassemble the instrument and make sure all the parts are cleaned thoroughly.
- High-level disinfection:
 - Soak in a 0.5% chlorine solution for 20 minutes; or
 - Boil for 20 minutes.Note: Rinse with sterile water after processing with chemicals and dry with a sterile towel.
- Store or use immediately: After instruments are processed, they should be kept in a dry, sterile or high-level disinfected container, protected from dust and other contaminants. Instruments processed with boiling or solutions should be reprocessed every two days until used.
- Metallic instruments such as tenaculum, speculum, and curettes should be sterilized using steam autoclave at a temperature of 121°C at a pressure of 106 KPa for 20 minutes (following the instructions of the autoclave being used).

Appendix IV: Logbook for Abortion Procedures

Appendix V: Quarterly/Monthly Reporting Format for Abortion Services

Region: _____

 Name of Health Facility: _____
 Zone: _____

	Total	Safe Abortion	Postabortion
Number of women who received abortion care			
Completed gestation (weeks)			
Less than 8 weeks			
8 to 12 weeks			
Greater than 12 weeks			
Type of procedure/method			
MVA			
SMC			
Medical abortion			
Other (specify _____)			
Women who expressed desire to delay further pregnancy			
Women who received a contraceptive method			
Women referred for a contraceptive method			
Women referred to another facility for abortion care (by reason)			
Women with major complications			
Women who died from complications of abortion			

Prepared by: _____

Approved by: _____

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